Announced Enforcement Compliance Inspection
16 November 2016

Lisadian House

Type of Service: Nursing Home
Address: 87 Moira Road, Hillsborough, BT26 6DY
Tel no: 028 9268 9898
Inspector: Sharon Loane & Sharon Mc Knight

1.0 Summary

An announced enforcement compliance inspection of Lisadian House took place on 16 November 2016 from 9.15 to 17.00 hours.

The purpose of the inspection was to assess the level of compliance achieved by the home regarding the two failure to comply notices issued on 13 September 2016. The areas for improvement and compliance with regulation were in relation to governance arrangements (FTC/NH/1264/2016/17/01) and the quality of nursing care (FTC/NH/1264/2016 -17/02). The date for compliance with the notices was 15 November 2016.

FTC Ref: FTC/NH/1264/2016-17/01
FTC Ref: FTC/NH/1264/2016-17/02

Evidence at the time of inspection was not available to validate full compliance with the above two failure to comply notices. However, there was evidence of some improvement and progress made to address the required actions within the notices. Following the inspection, RQIA senior management held a meeting on 17 November 2016 and a decision was made to extend the compliance date up to the maximum legislative timeframe of 90 days. Compliance with the notices must therefore be achieved by 14 December 2016.

This inspection was underpinned by The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	3*	10*

The total number of requirements and recommendations made includes one requirement stated for a second time and six recommendations carried forward from the last inspection.

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

Enforcement action is ongoing as a result of the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 31 August and 1 September 2016.

Following the inspection, the registered persons were required to attend a meeting at RQIA, with the intention of issuing two failure to comply notices in regards to governance arrangements and the quality of nursing care. This meeting was held 12 September 2016. Following discussion with the registered person RQIA were not fully assured that the actions discussed had been sufficiently embedded into practice: and given the potentially serious impact on patient care a decision was made that two failure to comply notices under The Nursing Homes Regulations (Northern Ireland) 2005, Regulation 10 (1), in relation to governance arrangements and Regulation 12 (1) (a) and (b), in relation to the quality of nursing care would be issued.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI'S), potential adult safeguarding issues, whistleblowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Elim Trust Corporation/Pastor Edwin Michael	**Registered manager:** Miss Esther Elizabeth Bell
Person in charge of the home at the time of inspection: Miss Esther Bell	**Date manager registered:** 14 January 2016
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 45

3.0 Methods/processes

Prior to inspection we analysed the following records:

- The requirements as indicated in the failure to comply notices

  FTC Ref: FTC/NH/1264/2016-17/01

  FTC Ref: FTC/NH/1264/2016-17/02

- the written registration status of the home
- written and verbal communication received by RQIA since the last care inspection
- the previous care inspection report
- the returned QIP from the previous care inspection
- notifications received since September 2016.

The following methods and processes used in this inspection include the following:

- a discussion with the registered manager and general manager
- discussion with staff
- discussion with patients
- a review sample of staff duty rotas
- staff training records for 2016
- two staff personnel files (including induction records)
- accident and incident records
- four care records
- a review of quality audits
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

The inspectors observed the majority of patients, some of whom were resting in bed and/or seated in the day lounges.

Three registered nurses and a sampling of care staff on duty, the activities co-ordinator and ancillary staff were consulted.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 31 August and 1 September 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. The recommendations in the previous QIP were not reviewed during this inspection due to the enforcement compliance focus. However if we identified issues linked to the matters previously identified then they would be considered. The recommendations have been carried forward for validation at a future care inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 31 August and 1 September 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 14 (2)(c) **Stated:** First time	The registered provider must ensure that the Control of Substances Hazardous to Health (COSHH) guidance is adhered to. Chemicals should be stored safely and the sluice should be kept locked at all times.	**Not Met**
	Action taken as confirmed during the inspection: At this inspection, the sluices were unlocked. An unlabelled container with a chemical solution was observed in use and stored on the floor of a number of sluice rooms. The purpose and use of this chemical was discussed with the registered manager and general manager; neither of whom were aware of the purpose or use of the chemical. This requirement was not met and has been stated for a second time.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 36 **Stated:** Second time	It is recommended that all policies are dated when issued or reviewed.	**To be validated at the next care inspection**
	Action taken as confirmed during the inspection: Due to the focus of this inspection this recommendation was not examined and will be carried forward until a future care inspection.	
Recommendation 2 **Ref**: Standard 39 Criteria 7 **Stated:** First time	The registered person should ensure that the current training arrangements are reviewed to ensure the effectiveness of training on practice and procedures.	**To be validated at the next care inspection**
	Action taken as confirmed during the inspection: Due to the focus of this inspection this recommendation was not examined and will be carried forward until a future care inspection.	

Recommendation 3 **Ref**: Standard 35 **Stated:** First time	The registered provider should develop a system to ensure that checks are being conducted on a regular basis in relation to staff's registration status with NMC and NISCC. Records should be kept.	**To be validated at the next care inspection**
	Action taken as confirmed during the inspection: Due to the focus of this inspection this recommendation was not examined and will be carried forward until a future care inspection.	
Recommendation 4 **Ref**: Standard 41 **Stated:** First time	The registered provider should ensure that staff meetings take place on a regular basis and at a minimum quarterly. Records are kept in accordance with Care Standards for Nursing Homes, April 2015.	**To be validated at the next care inspection**
	Action taken as confirmed during the inspection: Due to the focus of this inspection this recommendation was not examined and will be carried forward until a future care inspection.	
Recommendation 5 **Ref**: Standard 7 **Stated:** First time	The registered provider should ensure that the negative comments made by some patients during the inspection are recorded as complaints and are appropriately recorded, investigated and actioned as required.	**To be validated at the next care inspection**
	Action taken as confirmed during the inspection: Due to the focus of this inspection this recommendation was not examined and will be carried forward until a future care inspection.	
Recommendation 6 **Ref**: Standard 35 **Stated:** First time	The registered provider should ensure that there are effective management systems in place to support and facilitate good management and leadership which involve and engage staff and promotes a positive culture and ethos of the home.	**To be validated at the next care inspection**
	Action taken as confirmed during the inspection: Due to the focus of this inspection this recommendation was not examined and will be carried forward until a future care inspection.	

4.3 Inspection findings

4.3.1 FTC Ref: FTC/NH/1264/2016-17/01

Notice of Failure to Comply with Regulation 10 (1) of The Nursing Homes Regulations (Northern Ireland) 2005

The registered provider and the registered manager shall, having regard to the size of the nursing home, the statement of purpose, and the number and needs of the patients, carry on or manage the nursing home (as the case may be) with sufficient care, competence and skill.

Discussion with management and a review of information evidenced that auditing systems had been developed and implemented as outlined in the failure to comply notice. However, a sample review of audit records evidenced that these were not completed robustly; some audit findings were contrary to the findings of this inspection. For example; audits completed in relation to care records were incomplete and did not identify the areas for improvement found during this inspection.

Audits completed in regards to infection control had failed to identify a number of shortfalls we observed. For example; signage throughout the home was secured with adhesive tape, commodes and other items of equipment were not cleaned to a satisfactory standard. A review of decontamination records evidenced significant gaps with the last recorded entry, 10 November 2016.

The registered manager had limited oversight of the auditing process and their findings. Whilst some areas for improvement had been identified through the audit processes, there was no evidence in the audit records that the areas for improvement had been re-audited to check compliance. The completion of the audit cycle as a means to ensure quality improvement was discussed with management.
This action was not met.

A monthly monitoring report in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, completed for October 2016 was reviewed. The review evidenced that some progress had been made, although further improvements were required. An action plan was available, although not all shortfalls identified in the report had been included in the action plan. There was also no evidence that actions had been followed up. The report did not reflect some of the findings of this inspection.
This action was partially met.

A review of training records evidenced that the majority of staff had completed mandatory training requirements since the last inspection. A training matrix was available and had been updated for training completed; details of two staff recruited six weeks prior to the inspection had not been included. It was also evidenced that these two staff members had not received any formal training until the day prior to the inspection. At the time of inspection, the practical aspects of moving and handling training remained outstanding. A discussion with the registered manager demonstrated that no provision was made for any awareness training to support staff in the interim period until formal training could be completed. A further recommendation has been made.
This action was partially met.

A review of two personnel files was undertaken. One of the files reviewed evidenced that the recruitment processes were still not in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, Schedule 2. For example; a reference had not been obtained from the staff member's current employer and a physical and mental health assessment was also unavailable. The registered manager provided a rationale for the missing health questionnaire however, a second personnel file reviewed identified that the rationale provided was inaccurate.
This action was not met.

Induction records were reviewed for two care staff recently recruited and two agency nurses rostered on the staff duty rota. An induction record was available for both care staff and was still ongoing at time of inspection. As previously discussed the induction process did not include any awareness training of areas including moving and handling training and adult safeguarding. The induction records were signed and dated appropriately for all areas of induction completed. An induction record was available for one of the agency nurses although this had not been completed in a timely manner. A review of staff duty rotas evidenced that although the identified agency nurse had worked in the home for a number of months an induction had not been completed until the 14 November 2016. An induction record was not available for a second agency nurse who was rostered on the duty rota. The registered manager advised that the agency nurse had never worked in the home before. A review of a sample of duty rotas evidenced that this information was inaccurate and in fact the agency nurse had worked a number of shifts.
This action was not met.

Evidence was not provided to validate full compliance with the following actions of the failure to comply notice.

The registered person must ensure sufficiently robust auditing systems are in place to quality assure the delivery of nursing and other services provided.

This includes; but is not limited to:

- care records
- infection control
- wound care
- accidents and incidents.

Records regarding the completion of these quality assurance audits must be available for inspection by RQIA.

The registered person must ensure that a detailed and comprehensive monthly monitoring report is maintained in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. Clear action plans, detailing all areas of improvement should be developed and monitored to ensure compliance.

The registered person must ensure that all staff have access to appropriate training, to enable them to meet the needs of patients. Systems must be established to monitor and ensure staff attendance.

The following training areas must be reviewed and actions should be taken to address any deficits identified:

- fire safety
- adult safeguarding
- infection prevention and control
- moving and handling
- basic first aid
- pressure area care
- wound care.

Records of all training completed by staff must be retained in the home.

The registered person must ensure that staff are recruited and employed in accordance with legislative requirements and the Department of Health Care Standards for Nursing Homes 2015. Records must be kept of all the documentation relating to the recruitment process.

The registered person must ensure that all newly appointed staff (including agency staff) are required to complete a structured orientation and induction. Records must be retained for inspection. Induction records should be completed contemporaneously.

4.3.2 FTC Ref: FTC/NH/1264/2016-17/02

Notice of Failure to Comply with Regulation 12 (1) (a) (b) of the Nursing Homes Regulations (Northern Ireland) 2005

The registered person shall provide treatment, and other services to patients in accordance with the statement of purpose, and shall ensure that the treatment and other services provided to each patient –

(a) meets his individual needs
(b) reflects current best practice

A review of four care records evidenced that risk assessments and care plans were either not in place, not sufficiently reviewed in response to the changing needs of patients or contained conflicting information.
This action was not met.

A review of four care records evidenced that care delivered was not in accordance with the prescribed interventions as detailed in the plan of care. Shortfalls were identified as follows; a care record reviewed in relation to the management of diabetes identified a number of deficits and further concerns which are discussed in detail in section 4.3.3. Records did not evidence that the patient's blood sugars were being monitored in accordance with the information recorded in the care plan. The patient's insulin regime had been altered on a number of occasions by medical and other health professionals however the care plan had not been updated accordingly.

A care plan reviewed in relation to skin damage evidenced that although a care plan was in place for the management of a wound, there were discrepancies in some of the information recorded. Similarly changes to the regime of care as directed by other health care professional had not been reflected accordingly. A second care record identified that a care plan had not been devised for a patient who had 'sacral pressure' damage.

A care record reviewed in relation to nutritional management evidenced that although the Malnutrition Universal Screening Tool (MUST) had identified the patient as 'high risk' of weight loss and weight monitoring records had also recorded weight loss, a care plan was not in place.

A review of the care records aforementioned evidenced that limited progress and improvements had been made in regards to this action.
This action was not met.

A review of completed food and fluid intake charts evidenced some improvement; however the improvement was not consistent across all records reviewed. Some of the records reviewed reflected meals and fluids refused however other records evidenced that patients had only received fluids once in a 24 hour period. There was evidence that the 24 hour fluid intake received was totalled although some of the calculations were inaccurate.
This action was not met.

A review of three care records evidenced that registered nurses were recording the total fluid intake in the patients daily progress notes, however, as previously discussed some of the calculations were inaccurate. In addition, registered nurses were not recording information in the records to demonstrate, if the actual fluid intake was appropriate or what actions had been taken when fluid intake was inadequate. A comparison of information recorded within food and fluid charts and daily progress notes for individual patient's identified inconsistencies and inaccuracies. For example, one registered had recorded "fair diet and fluids taken" when the food and fluid chart indicated that the patient had only taken a "bowl of porridge", there was no record of any further intake. There were other examples of similar inaccuracies. Entries in the daily evaluation notes were often vague and meaningless. As previously referenced, registered nurses did not always record the action taken when food and/or fluid intake was inadequate.
This action was not met.

A review of records for monitoring patients' weight evidenced that weights, including the actual date the patients were weighed, were recorded for all patients in September and November 2016. However, records reviewed for October 2016 were incomplete. During the inspection, we were informed that the 'hoist scales' were broken. Conflicting information was provided by staff as to the timeframe for example; some staff advised they had been broken for a week when other staff reported from the beginning of November 2016. The registered manager was unable to confirm when the scales would be repaired and a request was made by the inspectors that this would be followed up as a matter of urgency and reported to RQIA. This information has been received by RQIA.

A review of information evidenced that five patients had experienced significant weight loss in November 2016. The identified weight loss ranged from 3.8kgs to 4.6kgs. This information was discussed with staff who attributed the weight loss to "faulty weighing scales". The records reviewed did not reference that the recordings may not be accurate. A review of a care record for one identified patient evidenced a weight loss of 7.9kgs within one month. Staff were of the opinion that this weight loss was attributed to the patient's healthcare needs being managed more effectively since their admission to the care home. A further weight loss of 1.7kg was recorded on the 10 October 2016; no further weight was recorded since. An entry recorded in the daily evaluation notes on the 14 November 2016 advised that "unable to weigh" due to hoist scales not working. As previously discussed the registered manager was advised to attend to this matter urgently.
This action was not met.

As previously referenced a review of care records pertaining to wound management identified that the care plan for wound management had not been updated to reflect the current regime of care. A second care record reviewed evidenced that a care plan had not been implemented for a patient, who according to the repositioning records had 'sacral breaks' on the 15 November 2016. Another care record reviewed in relation to wound care did not identify the wound site. In addition, recommendations made by the podiatrist and tissue viability nurse provided two different treatment plans and there was no evidence that registered nurses had followed up this conflicting advice to ensure that the treatment given was appropriate.
This action was not met.

A review of repositioning records for two identified patients evidenced some improvement however again this was not consistent. A review of charts evidenced regular repositioning was carried out on some occasions, however long gaps were also noted, for up to and including seven hours, when the patient required 'two-three hourly' repositioning. Records reviewed evidenced that the condition of the skin was only checked once daily and on some occasions there was no record of any check being completed. Repositioning schedules, as directed within the patients care plans, were not adhered too. There was no evidence that records of repositioning were being monitored by registered nurses.
This action was not met.

A review of three patients care records evidenced that risk assessments were available and included urinary and faecal continence management. The assessments reviewed did not include any information on patients' normal bowel pattern or normal stool type.
This action was not met.

A review of bowel management records evidenced that records were maintained of all patients bowel functions. The information recorded was reflective of the 'Bristol Stool chart'. However, care plans reviewed for continence management did not include any information on patients' normal bowel pattern and type. Additional concerns were identified in relation to bowel management and are discussed in further detail in section 4.3.3 of the report.
This action was partially met.

Evidence was not provided to validate full compliance with the following actions of the failure to comply notice.

The registered person must ensure that care plans are established and maintained to meet the assessed care needs of patients.

The registered person must ensure that care is delivered to patients in accordance with the prescribed interventions of any plan of care.

The registered person must ensure food and/or fluid intake charts are recorded accurately, to include food and fluids refused. These charts must also be accurately reconciled.

The registered person must ensure registered nurses evaluate the food and/or fluid intake of each patient as required. The record of this evaluation and/or actions taken should be recorded in care records.

The registered person must ensure that patients' weights are monitored and evaluated, in accordance with their care plans and level of risk. Subsequent action taken in response to any identified deficits should be clearly recorded in the patient's individual care records.

The registered person must ensure all patients with wounds and/or pressure damage have up to date care plans in place to direct staff in the provision of wound care.

The registered person must ensure that repositioning charts are fully and accurately completed to evidence that care delivery is maintained in accordance with the prescribed care interventions.

The registered person must ensure that a comprehensive continence risk assessment, which includes bowel function, is completed on admission, and maintained under regular review.

The registered person must ensure that daily records maintained for bowel function are recorded in line with best practice guidelines, and inform the care planning process.

4.3.3 Care delivery and practice

As referred to previously in section 4.2, a review of patient care records and discussion with staff raised concerns that safe effective and timely care were not being delivered in relation to the following:

A review of care records for an identified patient receiving treatment for the management of diabetes evidenced shortfalls in the delivery of care. Blood sugar monitoring records evidenced that the patient had a high blood sugar reading on at least two occasions within a 24 hour period. There was a lack of evidence available to demonstrate that registered nurses had taken appropriate actions or sought any advice from relevant healthcare professionals. We discussed our concerns with the registered nurses and prompted them to take appropriate actions. Blood sugar readings were being recorded both on paper and on electronic records. Reviews of the records identify discrepancies in the information recorded between the two systems. Paper records were not maintained in accordance with NMC guidelines on record keeping. In addition, blood sugar monitoring was not being carried out in accordance with the care plan. It was also evidenced that the insulin regime had been altered on several occasions; however the care plan had not been updated to reflect changes to the regime.

As discussed previously, a review of bowel management records raised additional concerns in relation to the quality of nursing care. There was a lack of oversight and appropriate actions taken by registered nurses to ensure safe, effective and compassionate care. A review of care records for one identified patient evidenced that there had been no recorded bowel function for ten days. Although this information had been recorded and reviewed by staff, there was no evidence that action had been taken by registered nurses until day nine. A review of other bowel management records identified similar patterns. The lack of appropriate action in relation to bowel management had the potential to negatively impact on the patient's care and lead to a poor clinical outcome. This was concerning as shortfalls in bowel management had been raised at a previous inspection and was included in the failure to comply notice issued.

These matters were very concerning as they posed potential risks to patients health and wellbeing. A requirement and recommendations have been made.

Post inspection, this information was shared with the adult safeguarding team of the South Eastern Health and Social Care Trust.

4.3.4 Staffing

A sample review of duty rotas identified that a night duty shift was being covered by two agency nurses. The duty rota did not identify the nurse in overall charge of the shift. The registered manager verbally advised the name of the nurse in charge. The competency and capability assessment for the nurse identified in charge of the shift was requested; this nurse was an agency nurse. The registered manager advised that this was included within the induction record. However, a review of the induction record for agency nurses evidenced that the induction did not include relevant information for the role of the nurse in charge of the home. It was concerning that management had no oversight of this deficit. A requirement and a recommendation has been made.

Areas for improvement

Two requirements and two recommendations have been made. Requirements have been made in relation to patient's health and welfare and the completion of competency and capability assessments for the role of the nurse in charge. Recommendations have been made in regards to training, record keeping and the management of the staff duty rota.

Number of requirements	1	Number of recommendations	4

5.0 Quality improvement plan

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

The registered provider/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 provider 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 the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 14 (2)(c) **Stated:** Second time **To be completed by:** 16 November 2016	The registered provider must ensure that the Control of Substances Hazardous to Health (COSHH) guidance is adhered to. Chemicals should be stored safely and the sluice should be kept locked at all times. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Chemicals no longer in use have been removed from the sluice and bar locks on the doors for staff to lock and unlock the doors as needed.
Requirement 2 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** 16 November 2016	The registered person must ensure that the nursing home is conducted to promote and make proper provision for the nursing, health and welfare and where appropriate treatment for patients. This requirement has been made with particular focus to the management of diabetes and bowel care. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: A daily audit is conducted of bowel function for all the residents. A monthly audit is conducted for the management of Diabetes and these actioned upon.
Requirement 3 **Ref:** Regulation 20 (3) **Stated:** First time **To be completed by:** 16 November 2016	The registered person must ensure that a competency and capability assessment is carried out with any nurse (including agency) who is given responsibility of being in charge of the home in the absence of the registered manager. **Ref: Section 4.3.4**
	Response by registered provider detailing the actions taken: Competency and capability has been completed for all nurses taking charge of the Home and continues to be completed for any new agency staff.
Recommendations	
Recommendation 1 **Ref**: Standard 36 **Stated:** Second time **Carried forward until the next inspection**	It is recommended that all policies are dated when issued or reviewed. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: All policies are being reviewed and will be signed and dated on completion.

Recommendation 2 **Ref**: Standard 39 Criteria 7 **Stated:** First time **Carried forward until the next inspection**	The registered person should ensure that the current training arrangements are reviewed to ensure the effectiveness of training on practice and procedures. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: E-learning is now in place in order to allow staff to complete training at their own pace. There is an exam at the end of each course to test the individual's knowledge. The evidence of training in practice will be demonstrated through supervision and appraisal.
Recommendation 3 **Ref**: Standard 35 **Stated:** First time **Carried forward until the next inspection**	The registered provider should develop a system to ensure that checks are being conducted on a regular basis in relation to staff's registration status with NMC and NISCC. Records should be kept. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: This is being completed on a monthly basis.
Recommendation 4 **Ref**: Standard 41 **Stated:** First time **Carried forward until the next inspection**	The registered provider should ensure that staff meetings take place on a regular basis and at a minimum quarterly. Records are kept in accordance with Care Standards for Nursing Homes, April 2015. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Monthly staff meetings are being completed and records kept.
Recommendation 5 **Ref**: Standard 7 **Stated:** First time **Carried forward until the next inspection**	The registered provider should ensure that the negative comments made by some patients during the inspection are recorded as complaints and are appropriately recorded, investigated and actioned as required. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: A new format for documentation has been created. This is being completed and actioned as appropriate.
Recommendation 6 **Ref**: Standard 35 **Stated:** First time **Carried forward until the next inspection**	The registered provider should ensure that there are effective management systems in place to support and facilitate good management and leadership which involve and engage staff and promotes a positive culture and ethos of the home. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken:

	Deborah Oktar-Campbell is now completing the reg 29 reports on an on-going basis and providing consultancy support as required. Daily flash meetings held with staff to engage them and promote a positive atmosphere in the Home.

Recommendation 7 **Ref**: Standard 39 **Stated:** First time **To be completed by:** 30 December 2016	The registered person should provide training for staff commensurate with their roles and responsibilities in the following areas: • the management of diabetes • bowel care management • the nursing process. **Ref: Section 4.3.2 & 4.3.3**
	Response by registered provider detailing the actions taken: Training has been provided for the management of Diabetes and continence. Further continence training to be arranged. Person centred care training is available on elearning and staff are to complete this. Training on the nursing process is to be sourced.
Recommendation 8 **Ref**: Standard 4 Criteria 9 **Stated:** First time **To be completed by:** 30 December 2016	The registered person should ensure that all entries in care records are meaningful; contemporaneous; dated; timed, signed and accompanied with the name and designation of the signatory. **Ref: Section 4.3.2 & 4.3.3**
	Response by registered provider detailing the actions taken: Regular audits are being conducted and action plans compiled in order to ensure records are meaningful and maintained in accordance with NMC guidelines.
Recommendation 9 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 16 November 2016	The registered person should ensure that the duty rota identifies the name of the nurse in charge of the home on each shift. **Ref: Section 4.3.4**
	Response by registered provider detailing the actions taken: This has been completed and is on going.
Recommendation 10 **Ref**: Standard 39 **Stated:** First time	The registered person should ensure that staff receive 'awareness training' in the interim period until formal training is provided. A record should be kept of the training and information provided. **Ref: Section 4.3.1**

To be completed by:	Response by registered provider detailing the actions taken:
16 November 2016	Elearning to be completed prior to commencement of work.

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

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