Unannounced Care Inspection Report
11 October 2017

Lisburn Care Home

Type of Service: Nursing Home (NH)
Address: 119 Hillsborough Road, Lisburn, BT28 1JX
Tel No: 028 92 666763
Inspector: Aveen Donnelly

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 38 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare **Responsible Individual(s):** Dr Maureen Claire Royston	**Registered Manager:** Karen Moriarty
Person in charge at the time of inspection: Fiona Archer, acting manager	**Date manager registered:** 1 April 2005
Categories of care: Nursing Home (NH) I – Old age not falling within any other category PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years TI – Terminally ill	**Number of registered places:** 38 The home is approved to provide care on a day basis only to 1 person

4.0 Inspection summary

An unannounced inspection took place on 11 October 2017 from 10.00 to 15.00 hours.

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 Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment. The patients' care records were well maintained; wound care was appropriately managed and the registered nurses had good oversight of any weight loss. Communication between residents, staff and other key stakeholders was well maintained. The culture and ethos of the home promoted treating patients with dignity and privacy. Mealtimes and activities were well managed. There were also examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents and quality improvement.

Areas for improvement made under the regulations related to the registered nurses' oversight of the patients' elimination records and in relation to the completion of the annual quality report. No areas for improvement were made under the care standards.

Patients said that they were very happy living in the home.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	2	0

Details of the Quality Improvement Plan (QIP) were discussed with Fiona Archer, manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the most recent inspection dated 25 October 2016

The most recent inspection of the home was an unannounced care inspection undertaken on 25 October 2016. Other than those actions detailed in the QIP no further actions were required to be taken.

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

5.0 How we inspect

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection the inspector met with eight patients, five care staff, two registered nurses, one kitchen staff, one domestic staff and three patients' representatives.

Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- staffing arrangements in the home
- one staff personnel file to review recruitment and selection
- staff induction and supervision records
- staff training records for 2016/2017
- accident and incident records
- records relating to adult safeguarding
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- six patient care records
- two patient care charts including food and fluid intake charts and repositioning charts
- patient register
- compliments records
- RQIA registration certificate
- certificate of public liability
- audits in relation to falls
- complaints received since the previous care inspection
- minutes of staff' meetings held since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 25 October 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be validated during this inspection.

6.2 Review of areas for improvement from the last care inspection dated 25 October 2016

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 30 (1) (c) **Stated:** First time	The registered persons must ensure that RQIA is notified of any serious injury to a patient in the home.	**Met**
	Action taken as confirmed during the inspection: Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection, confirmed that these were appropriately managed.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the week commencing 2 October 2017 evidenced that the planned staffing levels were generally adhered to. The planned staffing levels were based on the patients' dependency levels, which were assessed using the Care Home Equation for Safe Staffing (CHESS) assessment tool, developed by Four Seasons Healthcare. The manager explained that this was reviewed on a monthly basis and that the staffing levels could be adjusted as required.

Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. Discussion with patients and their representatives evidenced that there were no concerns regarding staffing levels. However, all staff spoken with stated that they felt under pressure and that they would like to spend more time with the patients. Despite this, all those spoken with confirmed that the patients' needs were always met. These comments were relayed to the management team during feedback. Staffing levels will be monitored at future inspection.

The manager explained there were currently three registered nurse and one care staff vacancies; these vacancies were being filled by agency staff or permanent staff working additional hours. Recruitment of staff was in progress. The management team also advised

that three care home assistant practitioners (CHAPS) had recently been trained and were supporting the registered nurses in relation to the completion of daily progress notes and care planning.

Communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

Discussion with the manager and a review of one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, Schedule 2. Where nurses and carers were employed, their registrations were checked with NMC and NISCC, to ensure that they were suitable for employment. The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI and satisfactory references had been sought and received, prior to the staff member starting their employment. For agency staff, their profile was maintained, which included information on the Access NI check and NMC/NISCC checks.

A record of staff including their name, address, date of birth, position held and start date was maintained electronically and provided an overview of all staff employed in the home. This additional detail supplemented the information contained in the staff recruitment files as required in accordance with Regulation 19(2), Schedule 4(6) of The Nursing Homes Regulations (Northern Ireland) 2005.

The review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare understanding and competence. Inductions were also provided to agency staff and to staff who had moved to the home from other homes within the organisation.

Discussion with the manager and staff confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision and undertook competency and capability assessments. The annual appraisal records were not available; however, we were satisfied that these were being monitored by the responsible persons' monthly monitoring visit in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. The appraisal records will be followed up at future inspection.

A review of the staff training records confirmed that training had been provided in all mandatory areas and records were kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. The records reviewed confirmed that 97% of staff had, so far this year, completed their mandatory training. This was commended by the inspector. For agency staff, the manager also received a profile which included information on their compliance with mandatory training requirements.

Observation of the delivery of care evidenced that training had been embedded into practice. Overall compliance with training was monitored by the manager and this information informed

the responsible persons' monthly monitoring visit in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

The manager also confirmed that 100% of staff had so far this year, completed the first module of the Dementia Care Framework training; this included modules on dementia care; activities and engagement; communication; distressed reactions and dementia and the law.

Discussion with the manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff were appropriately managed in accordance with NMC. Similar arrangements were in place to ensure that care staff were registered with NISCC.

Staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The staff understood how they should report any concerns that they had. There were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified. Discussion with the manager also evidenced that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures.

Review of six patient care records evidenced that validated risk assessments were completed as part of the admission process and were reviewed as required. These risk assessments informed the care planning process.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were consistently completed following each incident and that care management and patients' representatives were notified appropriately. A review of care records also identified that care plans were developed in response to learning identified from any incidents.

Infection prevention and control measures were adhered to and equipment was stored appropriately. The sluice room door was observed to be unlocked and cleaning chemicals were observed to be stored in an unlocked cupboard. When we raised this with the manager, immediate action was taken to ensure that the chemicals were removed. A new lock was put in place on the day of the inspection.

There were processes in place to check that emergency equipment, such as the suction machines, were regularly checked as being in good order and fit for use. This meant that in the event of an emergency the equipment was ready for use.

A review of the home's environment was undertaken which included a number of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items.

Fire exits and corridors were observed to be clear of clutter and obstruction. The emergency evacuation register was up to date and included the details of the last patient admitted to the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

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

There were a number of examples of good practice found throughout the inspection in this domain. For example, registered nurses were aware of the local arrangements and referral process to access other relevant professionals including general practitioner's (GP), speech and language therapist (SALT), dietician and tissue viability nurse specialists (TVN). Discussion with registered nurses and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Where patients were prescribed antibiotic therapy for the treatment of acute infections, care plans had been developed in relation to this and patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

A review of wound care records evidenced that wound care was managed in line with best practice. A review of the daily progress notes of one patient evidenced that the dressing had been changed according to the care plan. Wound care records were supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines.

Patients who had been identified as being at risk of losing weight had their weight regularly monitored. This ensured that any weight loss was identified and appropriate action taken in a timely manner. Care plans in place were reflective of the recommendations of SALT and were kept under review.

A sampling of food and fluid intake charts confirmed that patients' fluid intake was monitored. Patients' total fluid intake were monitored by the registered nurses and there was evidence that appropriate action had been taken when patients were not meeting their fluid intake target.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans. The frequency of repositioning required was also recorded on the personal care booklets, to ensure that staff were aware of this information.

Patients who required urinary catheters had care plans in place to ensure that they were managed in keeping with best practice guidance. The care plan included detail on hygiene care of the catheter; the frequency of tube change; actions to take in case of blockage and monitoring of fluid intake and output.

Despite this, an area for improvement was identified in relation to the registered nurses' oversight of the patients' elimination records. For example, the records reviewed identified gaps in completion for up to ten days. It was unclear whether the records were accurate; therefore we were unable to verify whether or not appropriate action had been taken in a timely manner. This has been identified as an area for improvement under the regulations.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, general practitioner, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a patient register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective.

Staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The most recent general staff meeting was held on 13 June 2017. One staff member provided negative comment in relation to teamwork. This comment was relayed to the manager to address.

All those consulted with confirmed that if they had any concerns, they could raise these with the staff and/or the registered manager. A review of records evidenced that patients' or relatives' meetings were not held on a regular basis however, the manager obtained feedback from at least three patients/relatives on a weekly basis, to ascertain their views on the home environment and the safety of the care provided. An electronic feedback system was also situated in the reception area. This was available to relatives and other visitors to give general feedback on an ongoing basis or answer specific questions on the theme of the month. The feedback was summarised automatically by the system and the results were available to the registered manager and the regional manager. A review of the feedback provided on this system; identified that no concerns had been identified.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping; wound care management and oversight of weight loss; audits and reviews; and communication between residents, staff and other key stakeholders.

Areas for improvement

An area for improvement made under the regulations related to the registered nurses' oversight of the patients' elimination records.

	Regulations	Standards
Total number of areas for improvement	1	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with eight patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care.

Patients stated that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and their feedback had been listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

We observed the lunch time meal in the dining rooms. The lunch served appeared appetising and patients spoken with stated that they were satisfied with the meals provided. The atmosphere was quiet and tranquil and patients were encouraged to eat their food; assistance was provided by staff, as required. The menu was displayed and was correct on the day of the inspection.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. Two staff members were designated to provide activities in the home. There was evidence of a variety of activities in the home and discussion with patients confirmed that they were given a choice with regards to what they wanted to participate in. There was evidence of regular church services to suit different denominations.

Discussion with the manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. However, we were unable to evidence when the last annual quality report had been undertaken. This has been identified as an area for improvement under the regulations.

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

From discussion with the manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and their relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included praise for the 'care and attention' given to a patient, who had been cared for in the home.

During the inspection, we met with eight patients, five care staff, two registered nurses, one kitchen staff, one domestic staff and three patients' representatives. Some comments received are detailed below:

Staff

"I have no concerns."
"I have no concerns regarding the care, we give the best care the residents could have."
"The care is the very best we can do."

As previously discussed in section 4.5, all staff provided negative comment in relation to the staffing levels and stated that they were under pressure to provide the care. Given that observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty, these comments were relayed to the management team for their review and action as appropriate.

Patients

"It is very good, I would soon put them right if it wasn't."
"I am treated very well."
"I have no complaints."
"It is excellent, the girls are very nice and I would never want to go home."
"It is alright."
"I am treated very well, I get everything I need."

Patients' representative

"Everything is fine."
"I think my (relative) gets great care."
"I am always offered tea when I visit, nothing ever seems to be a problem for the staff."

Visiting professionals

"I have no concerns about the care here, they are very good."

We also issued ten questionnaires to staff and relatives respectively and eight questionnaires to patients. Four staff, five patients and four relatives had returned their questionnaires, within the timeframe for inclusion in this report. Comments and outcomes were as follows.

Patient respondents indicated that they were 'satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. Written comment received in one questionnaire included 'the home would benefit from more staff, some staff are friendly'. Following the inspection, this comment was relayed to the manager.

Relative respondents indicated that they were either 'very satisfied' or 'satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. No written comments were received.

Staff respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. Written comment received reflected the comments made to the inspector on the day of the inspection. These comments were relayed to the manager, following the inspection.

Any comments from patient representatives and staff in returned questionnaires received after the return date will be shared with the manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients. Mealtimes and activities were well managed.

Areas for improvement

An area for improvement made under the regulations related to the completion of the annual quality report.

	Regulations	Standards
Total number of areas for improvement	1	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Observation of patients and discussion with the manager evidenced that the home was operating within its' registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

The manager had only recently commenced employment in the home in an acting capacity; and had yet to form good working relationships with the staff. Despite this, all staff stated that they felt that she was 'very approachable'.

There was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager. The staff on duty within the home was also displayed at the reception area.

Discussion with the manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes 2015. Staff, patients and

patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the manager was.

Systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

As a further element of its Quality of Life programme, Four Seasons Healthcare undertakes an annual colleague engagement survey. This gives the staff the opportunity to make their views known on the working relationships within the home, including the running of the home. The manager advised that this had recently been completed and that they were awaiting the results of this survey.

A review of the patients' falls audit evidenced that this was analysed to identify patterns and trends on a monthly basis. An action plan was in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

As previously discussed in section 6.2, review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection, confirmed that these were appropriately managed.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 and copies of the reports were available for patients, their representatives, staff and Trust representatives. An action plan was generated to address any areas for improvement; discussion with the registered manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed. Overall comment was made within the quality monitoring report in relation to the delivery of safe, effective and compassionate care; and the leadership of the home. This is in line with RQIA inspection methodology and is good practice.

There was a system in place to ensure that the policies and procedures were reviewed on a three-yearly basis. The management team also advised that staff could access all policies on a 'happy app' and that this system could also be used to provide staff with news items/information from within the organisation.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents and quality improvement.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Fiona Archer, manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13 (1) (a) **Stated:** First time **To be completed by:** 8 December 2017	The registered persons shall ensure that the registered nurses' have oversight of the patients' elimination records; and that evidence of any action taken in response to identified deficits are recorded in the daily progress notes. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: Elimination records are in place, as per FSHC policy. Care staff have been delegated the task of recording these activities on a daily/per shift basis, ensuring this information is converyed to the Registered Nurses. The Registered Nurses in turn will review the records and the feedback from Carers to define actions needed. The actions and elimination activities are recorded per shift in the progress notes The need for improvement and compliance in this regard have been conveyed to all care and Nursing staff through memo and supervisions. The Home manager is reviewing/auditing compliance and providing regular feedback to all staff on the improvement process. This is evidenced through the use of memos, diary entries and audit records..
Area for improvement 2 **Ref:** Regulation 17 (1) **Stated:** First time **To be completed by:** 8 December 2017	The registered persons shall ensure that the annual quality report is completed. **Ref: Section 6.6**
	Response by registered person detailing the actions taken: The Annual Quality Report for 2016 has been written. A copy is held on file at Lisburn Care Home, with copies submitted to the Regional Manager.

Please ensure this document is completed in full and returned via Web Portal

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