The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
30 June 2016

Manor Lodge

Type of Service: Nursing Home
Address: 5 The Manor, Blacks Road, Dunmurry, BT10 0NB
Tel No: 028 9062 93331
Inspector: Heather Sleator

1.0 Summary

An unannounced inspection of Manor Lodge took place on 30 June from 09.30 to 16.45 hours.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led. The inspection commenced in the dementia unit (Suffolk) and due to a number of concerns which arose, the focus of the inspection remained centred in this unit. A further inspection to Manor Lodge will be undertaken during this inspection year, and at this time both Suffolk and Coleman units will assessed.

Is care safe?

Weaknesses were identified in the delivery of safe care, specifically in relation to the management of medicines, staffing arrangements and the deployment of staff, staffs knowledge and skills in dementia care practice and the environment of the unit. Two recommendations relating to the environment have been stated for a second time. These deficits have led to a reduction in positive outcomes for patients. Medicine management issues identified have been referred to the pharmacy inspector for further consideration. Four requirements and have been stated to secure compliance and drive improvement

Is care effective?

Weaknesses have been identified in the delivery of effective care specifically in relation to the management of care planning, the auditing of care records and the dining experience for patients. Five recommendations have been made.

Is care compassionate?

There was a lack of engagement noted between patients and staff, and during observation of the lounge area there was limited conversation or interaction between staff and patients observed. Staff stated they would welcome and appreciated the need for further training in dementia care and would also like to have more time to spend with the patients. Weaknesses have been identified in the personal care afforded to patients and the provision of meaningful activities. One requirement and two recommendations have been made.

Is the service well led?

There was evidence of systems and processes in place to monitor the delivery of care and services within the home. The regional manager stated that the organisation was aware that there were a number of areas which required improvement and due to this the organisation had assessed the home as a ‘focus’ home. Senior management were closely monitoring the home on a day to day basis. It was concerning that despite the organisations monitoring of Manor Lodge a significant number of shortfalls in the delivery of care and the environment were identified on inspection. Requirements and recommendations have been stated relating to the safe, effective and compassionate delivery of care. Requirements and recommendations have been made to seek compliance and drive improvements, as detailed within sections 4.3, 4.4 and 4.5 respectively.

A detailed action plan was submitted to RQIA on 5 July 2016. The action plan included all of the areas of concern that had been identified at the inspection. The action plan was considered

by senior management in RQIA and a decision was taken that enforcement action would not proceed at this stage. A further inspection will be undertaken to validate that compliance has been achieved and sustained.

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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes 2015.

For the purposes of this report, the term 'patients' will be used to described those living in Manor Lodge which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	5	9*

* relates to recommendations stated for a second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Stephanie McDowell, Acting Manager, and Lorraine Thompson, Regional 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 03 March 2016. There were no further actions required to be taken following the last inspection.

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

2.0 Service details

Registered organisation/registered provider: Stephanie McDowell	**Registered manager:** Stephanie McDowell
Person in charge of the home at the time of inspection: Stephanie McDowell	**Date manager registered:** Acting – No application
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI, NH-DE, RC-I	**Number of registered places:** 39

3.0 Methods/processes

Prior to inspection the following information was 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
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with 10 patients, two care staff, ancillary staff and two registered nurses. There were no relatives who wished to meet with the inspector at the time of the inspection.

Questionnaires for patients, relatives and staff to complete and return were left for the home manager to distribute. Please refer to section 4.5 for further comment.

The following were examined during the inspection:
- validation evidence linked to the previous QIP
- staff roster
- patient care records
- supplementary care records
- staff training records
- staff supervision and appraisal planner
- complaints and compliments records
- incident and accident records
- records of quality audits

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 3 March 2016

The most recent inspection of the home was an unannounced medicines management inspection. There were no requirements or recommendations made at this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 30 September 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 19.1 **Stated:** First time	Staff should undertake training in communicating effectively. **Action taken as confirmed during the inspection:** Staff training was delivered in June 2016 to 13 staff. Further training will be organised when required in the future.	**Met**
Recommendation 2 **Ref:** Standard 32.1 **Stated:** First time	A system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the orgainsation, in respect of communicating effectively and palliative and end of life care. **Action taken as confirmed during the inspection:** A system had been implemented to evidence staff had read the policies in respect of communicating effectively and palliative/end of life care. Staff had signed to state they had read the documents.	**Met**
Recommendation 3 **Ref:** Standard 32.1 **Stated:** First time	Care records should evidence that the assessment of need in respect of the end of life wishes of patients is consistently and fully completed by nursing staff. **Action taken as confirmed during the inspection:** The review of three patients' care records evidenced that end of life wishes had been assessed and detailed in the individuals assessment of need schedule.	**Met**

<table>
<tr><td rowspan="2">Recommendation 4

Ref: Standard 43

Stated: First time</td><td>The communal areas in the dementia unit should be readily accessible for patients to use; this includes the two lounge areas and the outside patio/paved area.</td><td rowspan="2">Not Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Whilst patients could access the two lounge areas in the home the environment of these areas were poorly presented and stark in appearance. The exit door to the garden had been ramped but the garden area was not maintained and did not present as an enjoyable area for patients to use.

This recommendation is stated again for a second time.</td></tr>
<tr><td rowspan="2">Recommendation 5

Ref: Standard 43

Stated: First time</td><td>Patients in the nursing unit should have a choice of which lounge they wish to use. Soft furnishings should be purchased to enhance the appearance of these areas.</td><td rowspan="2">Partially Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Patients have the choice of which of the two lounges they wish to use. However, soft furnishings had not been purchased and the appearance of both of the lounges was not inviting or comfortable. Refer to section 4.3 for further detail.

This recommendation is stated again for a second time.</td></tr>
<tr><td rowspan="2">Recommendation 6

Ref: Standard 11

Stated: First time</td><td>The acting manager should ensure staff in the dementia unit acknowledge and provide, as far as possible, recreational opportunities for patients.</td><td rowspan="2">Partially Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A personal activities leader (PAL) is employed in the home and works between the dementia unit and the nursing unit. There were few activity resources available in the dementia unit and there was a lack of equipment, for example; the DVD/CD player was broken.

This recommendation has been subsumed into a requirement of this report.</td></tr>
</table>

4.3 Is care safe?

The review of the staff duty rota for the week commencing 27 June 2016 evidenced that there was a registered nurse and two care assistants on duty from 08.00 to 20.00 hours each day. At the time of the inspection 14 patients were resident in the unit. In discussion with staff it was stated that staff felt they 'needed more time to spend with patients.'

The manager commenced in the home on 28 June 2016 and had not had the opportunity to review the dependency levels of patients in the unit to ensure that the staffing levels were appropriate to meet patients' needs. Evidence from the observations of the delivery of care, the level of engagement between patients and staff and the organisation of the day did not support that care was being organised and delivered to patients in a dementia sensitive manner and this had impacted on the care being afforded to patients. It was evident that staff required training in dementia care to enhance their knowledge and confidence in working in this specialist area of care. It was not specifically the number of staff on duty, rather it was that the dementia ethos of the unit was not in evidence and there was a lack of skilled practitioners in dementia care to lead the staff team. Requirements have been made in relation to providing an on-going dementia training and support programme for staff and to review the staffing arrangements in relation to patient need, competency of staff and leadership within the unit. This was discussed with the manager and regional manager at the conclusion of the inspection and it was agreed that the staffing arrangements would be reviewed to ensure that sufficient and competent staff were on duty to meet the patients' needs in accordance with best practice in dementia care guidelines and that training would be provided. Refer to sections 4.4 and 4.5 for further detail.

We observed the administration of medicines in the unit. The morning medications were still being administered to patients at 12.00 hours. In discussion the registered nurse stated they 'preferred to take their time with medications.' The afternoon medications were commenced at 13.30 hours. The timing of the administrations of medications was discussed with the registered nurse who stated that, due to having to attend a care review at 14.00 hours, the administration of medications was commencing at an earlier time. The registered nurse stated that it was their understanding that this could be done. We advised the registered nurse to discuss the issues with the manager prior to commencing the administration of medications. This matter was referred to the medicines management team. It is also required, as previously stated, that the manager review the deployment of staff in regard to the morning routine in the home, to ensure the needs of patients are met in a timely way.

Training was available via an e learning system, internal face to face training arranged by management and training provided by the local health and social care trust. The review of staff training records evidenced that the manager had systems in place to monitor staff attendance and compliance with training. The overall statistics for completed mandatory training were 66 percent. The manager stated that a number of new staff had commenced in the home within the last four weeks which accounted for the training statistics being reduced. The regional manager was aware of this as training statistics were reviewed on a monthly basis when completing the monthly quality monitoring visit. The regional manager confirmed that it was a priority to ensure all staff completed their mandatory training requirements.

Discussion with the manager, staff on duty and a review of records confirmed that systems had recently been put in place to ensure that staff received an annual appraisal and regular supervision.

The manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Training records reflected that 79 percent of staff had undertaken safeguarding training in the past 12 months. Annual refresher training was considered mandatory by the home and the manager will inform those staff who have not, as yet, completed their training to do so within a given time period.. A review of documentation confirmed that any safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

Three patient care records were reviewed and evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Please refer to section 4.4 for further information regarding patient care records.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA, since the last care inspection in September 2015, confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The environment in Suffolk unit should be an enabling environment for persons with dementia. There was a lack of visual cues for patients, the lounges were not attractive and comfortable and the garden and patio areas had not been maintained and were not 'fit' for patients to either access or use. The dining room did not provide information and orientation for patients regarding the dining experience. This was concerning and was discussed with the manager and regional manager who were informed a requirement would be stated that a dementia audit is completed regarding the environment of Suffolk unit. An action plan must be developed in accordance with the outcome of the dementia audit and the findings of the inspection.

A comprehensive and detailed action plan in respect of the environment and dementia practice was submitted to RQIA by Lorraine Thompson, Regional Manager, on 5 July 2016. The implementation and outcome of the action plan will be assessed at the next inspection.

Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas for improvement

A dementia audit is to be completed regarding the environment of Suffolk unit. An action plan should be developed in accordance with the outcome of the dementia audit and the findings of the inspection.

A rolling programme of dementia specific training must be provided for staff. The training should include all aspects of daily life including for example; understanding dementia, personal care, the dining experience and communication (both verbal and non-verbal)

The staffing arrangements and deployment of staff for Suffolk unit must be reviewed and reflect the needs of patients and care must be safely delivered in a manner conducive to the needs of persons with dementia.

Medicines management must be reviewed to ensure all medications are administered in a timely manner and in accordance with best practice.

Number of requirements	**4**	**Number of recommendations**:	**0**

4.4 Is care effective?

A review of three patient care records evidenced that initial plans of care were based on the pre admission assessment and referral information

A lack of consistency was evident in respect of the completion and maintenance of care records in accordance with NMC guidelines, (Record Keeping Guidance). Evidence was not present in the progress records maintained by registered nurses that patients bowel function and fluid intake and output was being monitored, despite care plans which identified this as a care need being present. Care staff were recording patients' bowel function and fluid intake and output in supplementary records. The review of the supplementary records evidenced, for example, that there had been no recorded bowel function of one patient for three weeks. There was no evidence to support that this had either been reported to the registered nurses, or that any action had been taken by registered nurses during this time period. A recommendation has been made that any information in relation to patients' wellbeing is reviewed by registered nurses and actioned, where appropriate, on a daily basis in the patients' daily progress recording.

There was evidence that the manager had completed an audit of one of the care records in Suffolk unit but as the manager had only commenced in the home two days prior to the inspection the remaining care records did not evidence they had been audited. It is recommended that a robust system regarding the auditing of care records is established until such times as a consistent approach by registered nurses is in evidence. There was evidence that the care planning process included input from patients and/or their representatives, as appropriate.

Supplementary care records for example; personal care charts and food and fluid intake charts were observed in the lounge and were accessible to patients and/or visitors. A recommendation has been made regarding patient confidentiality and the storage of records and patient information. A more suitable arrangement for the storage of these records should be established.

Discussion with the manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication. Staff spoken with confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted, clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff also confirmed that if they had any concerns, they would raise these with the nurse in charge or the manager. However, one staff member commented on the changes at management level and stated, 'everyone is a bit unsettled and wondering what's going on as there's been so many different managers.' Staff also confirmed that staff meetings took place but were unsure of the frequency of the meetings. The establishment of a regular staff meeting forum may facilitate communication between management and staff in the home.

We observed the serving of the midday meal in Suffolk unit. Whilst the quality of the meals provided was good, staff need to improve and enhance the dining experience for patients. The environment of the dining room did not provide any orientation or visual cues for patients, dining tables were not set with tablecloths or placements and condiments were not available for patients to use. Staff afforded patients a visual choice of meals, this was good practice. The meals come to the unit in a heated trolley and are served by a catering assistant. When asked, staff were unable to state what the meal for patients who required a modified diet were having. Further discussion with staff confirmed that patients on a modified diet were not afforded a choice of meal. This was not good practice and a recommendation has been made. The dining experience for patients should be enjoyable, pleasurable and meaningful. A recommendation is stated that the dining experience for patients is reviewed and enhanced in accordance with best practice in dementia care.

Areas for improvement

Any information in relation to patients wellbeing should reviewed by registered nurses and actioned, where appropriate, on a daily basis. Evidence should be present that registered nurses have reviewed and acted on, where applicable, any supplementary information recorded on behalf of patients. Supplementary records should inform the daily progress notes.

A robust system regarding the auditing of patients care records should be established and where a shortfall is identified the care record is re-audited to ensure that remedial action had taken place.

Any record which details patient information should be stored safely.

Patients who require a modified diet should be afforded a choice of meal at each mealtime.

The dining experience for patients must be reviewed, enhanced and be maintained in accordance with professional standards and guidelines and best practice in dementia care.

Number of requirements	**0**	**Number of recommendations**:	**5**

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. There was evidence of personalisation in some of the bedrooms. Staff informed the inspection of how they supported a patient to remain active and carry out household tasks which the patient enjoyed doing. However, as observed, there was a lack of engagement with patients and as previously stated, staff felt they didn't have time to spend with patients. We observed the personal care afforded to patients and were concerned that a number of gentlemen had not been shaved, patients' fingernails were long and not clean and it was evident ladies had not had their hair done. Hairdressing was discussed with staff who stated the hairdresser does not come on a regular basis. There was a lack of engagement between patients and staff and during observation of the lounge area there was limited conversation or interaction between staff and patients observed.

The inclusion of persons with dementia in all aspects of daily life is paramount and a rolling programme of training in dementia care practice is a requirement of this report, as stated in section 4.3. The personal care afforded to patients should be monitored on a daily basis by the manager and/or clinical lead in the Suffolk unit and a recommendation has been made. The manager should also establish robust systems to ensure knowledge gained through training is embedded into practice and a recommendation has been made.

The home employs a personal activities leader (PAL) who works Monday to Friday and also stated there was flexibility around the days of the week, for example the PAL stated they can work at weekends if there was a specific function or activity planned. We had concerns in relation to the provision of meaningful activities in the unit and of adequate resources to deliver a varied activities programme. At the time of the inspection the patients who were sitting in one of the lounges were 'listening' to a popular radio station. When the choice of music was queried with staff they stated there was no DVD or CD player in the unit and therefore more age relevant music or entertainment for patients was not possible. We observed the garden and patio area. The fenced garden (accessed by steps into the area) was unkempt and the grass had not been mown for a significant period of time. The patio and garden area immediately outside of one of the lounge areas had poor accessibility for patients as there was no handrail to assist patients when walking down the ramp to the paved area. There were no flowers, raised beds or attractive and comfortable seating for patients to sit and enjoy the outside areas. A requirement has been made that a meaningful activities programme is available for patients. The activities programme should be appropriately resourced and should be developed to meet the range of patients' needs and likes and dislikes.

In discussion with the manager it was confirmed that numerous compliments had been received by the home from relatives and friends of former patients. Thank you cards were displayed in the home and a record is maintained of all compliments which are received.

The following are some comments we received from patients:
'I like it here well enough.'
'The staff are very good to me.'
'I'm being well looked after.'

There were no relatives who wished to speak to us during the inspection.

Questionnaires

As part of the inspection process we issued questionnaires to staff, patients and patients' representatives. The returned questionnaires were generally positive regarding the quality of nursing and other services provided by the home. Specific comments are detailed below:

Some comments from staff included:
'I feel the dementia unit is understaffed on a daily basis.'
'A couple of times we didn't even get a handover report because of being short staffed.'
'We have had five managers in the last months so we don't know them too well.'
'If we make a complaint the manager said "just rise above it."'

Areas for improvement

A meaningful activities programme must be available for patients. The activities programme must be appropriately resourced, including the garden areas and must be developed to meet the range of patient needs and their known likes and interests.

The personal care afforded to patients should be monitored on a daily basis by the manager and/or clinical lead in the Suffolk unit.

Robust systems should be established to ensure knowledge gained through training is embedded into practice.

Number of requirements	1	Number of recommendations:	2

4.6 Is the service well led?

Discussion with the home manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. As previously stated in sections 4.3 and 4.5 staff also commented on the number of managers there has been in the home recently and that this had unsettled the staff team.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

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 DHSSPS Care Standards for Nursing Homes 2015. As discussed in section 4.5 a staff member commented that they felt when an issue/s were brought to the attention of previous managers staff were told to 'rise above it'. The frequent change of managers in the home has had a destabilising effect on staff, the current manager was advised to ensure communication channels in the home were 'open' and staff were listened to.

Discussion with the manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the manager and review of records evidenced that 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, incidents/ accidents. 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

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.

Discussion with the manager and review of records evidenced that monthly quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and Trust representatives. The regional manager stated that the home was currently viewed as a 'focus home' by the organisation and as such senior management within Four Seasons Healthcare were closely monitoring the home and action plans had been developed. Despite this, and as discussed in this report, there were many areas identified for improvement as a result of the inspection.

Areas for improvement have been identified in the sections discussing the delivery of safe, effective and compassionate care.

Feedback at the conclusion of the inspection was given to Stephanie McDowell, Manager, and Lorraine Thompson, Regional Manager. Ms Thompson had assumed regional responsibility of Manor Lodge recently and as previously stated the manager had commenced in the home two days prior to the inspection. Both Ms McDowell and Ms Thompson demonstrated their commitment to address the issues identified during the inspection and a detailed action plan, incorporating all the identified areas was submitted to RQIA on 5 July 2016. The areas identified will be assessed at the next inspection of the home.

Areas for improvement

Five requirements and seven recommendations have been made in relation to safe, effective and compassionate care to further secure compliance and drive improvements.

Number of requirements	**5**	**Number of recommendations**:	**7**

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Stephanie McDowell, Manager, 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 may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to nursing.team@rqia.org.uk for review 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 12 (1) (b) and (c) **Stated:** First time **To be completed by:** 31 August 2016	The registered person must ensure the environment of the home and the delivery of dementia care reflects current best practice guidelines for dementia care. A dementia audit should be completed and an action plan developed and implemented based on the findings of the audit. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: A baseline dementia audit was completed on 29 July and identified issues have been incoporated into an action plan previously in place. A follow up audit will be undertaken before the end of August to ensure that issues have been appropriately addressed.
Requirement 2 **Ref:** Regulation 20 (1) (c) (i) **Stated:** First time **To be completed by:** 30 November 2016	The registered person must ensure that an on-going programme of staff training in relation to dementia practice is undertaken by staff and a robust system is established that evidences training undertaken by staff is embedded into practice. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The home has commenced the FSHC Dementia Care Framework. Resident experience training was completed on 10 & 11th August with further training dates schedule within the the next month. Staff are completing reflective pratice accounts to ensure knowledge is embedded into practice. All staff to complete E Learning dementia framework module As the Dementia Framework progresses further face to face interactive learning sessions will be delivered In order to evidence how the learning has been embedded in practice The Dementia Care resident TRaCA process has been commenced and will evolve to provide this evidence.
Requirement 3 **Ref:** Regulation 20 (1) (a) **Stated:** First time **To be completed by:** 31 August 2016	The registered provider must ensure that the staffing and deployment arrangements; including the number, competency and experience of staff in Suffolk unit is appropriate for the health and welfare of patients and embodies best practice in dementia care. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Staffing levels have been reviewed using CHESS dependency model, and staffing is currently in line with the outcomes. This will be reviewd on an ongoing basis. Deployment of staff has been reviewed and staff who are best suited to the dementia unit have been allocated to this area of the home.

Requirement 4 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 31 July 2016	The registered provider must ensure that the administration of medicines is completed in a safe and timely manner and registered nurses are competent in the safe administration of medicines. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: All nurses currently working in the home have medicine competencies in place Observations of the medication rounds have been completed and staff are completing medication administration in a timely manner
Requirement 5 **Ref:** Regulation 18 (2) (n) **Stated:** First time **To be completed by:** 31 August 2016	The registered provider must ensure that a meaningful activities programme is available for patients. The activities programme must be appropriately resourced and must be developed to meet the range of patient needs and their known likes and dislikes. **Ref: Section 4.5**
	Response by registered provider detailing the actions taken: Life story work has been completed for all residents in the Dementia unit. Care plans are in place and these reflect residents individual likes/preferences A Programme of activities has been implemented and is under continual review. A new Personal Activity leader is being supported to develop the range of theraputic individual choice activities
Recommendations	
Recommendation 1 **Ref:** Standard 43 **Stated:** Second time **To be completed by:** 31 August 2016	The registered provider should ensure that the communal areas in the dementia unit should be readily accessible for patients to use; this includes the two lounge areas and the outside patio/paved area.
	Response by registered provider detailing the actions taken: Both lounges are accessible for residents to use. Residents have a choice on a daily basis of the lounge they prefer to be seated in. The outside grounds are accessible as a ramp is in place with a hand rail to be fitted w/c 15/8/16.
Recommendation 2 **Ref:** Standard 43 **Stated:** Second time **To be completed by:** 31 August 2016	The registered provider should ensure that patients in the nursing unit have a choice of which lounge they wish to use. Soft furnishings should be purchased to enhance the appearance of these areas.
	Response by registered provider detailing the actions taken: Residents are offered a choice on each occassions as to the lounge they prefer to be seated in daily. Both lounges have soft furnishing in place.

Recommendation 3 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** 31 August 2016	The registered provider should ensure that any information in relation to patients' wellbeing is reviewed by registered nurses and actioned, where appropriate, on a daily basis. Evidence should be present, in the daily progress records, that registered nurses have reviewed and acted on, where applicable, any supplementary information maintained on behalf of patients. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Supervisons have been undertaken with Registered Nurses in Dementia unit regarding the need to review and act upon information recorded in the supplementary records. The Registered Manager, on behalf of the Registered Provider, will review this on a daily basis, recording findings in the Home Managers Daily Audit.
Recommendation 4 **Ref:** Standard 4.10 **Stated:** First time **To be completed by:** 31 August 2016	The registered person should ensure that a robust system regarding the auditing of patients care records is established and where a shortfall is identified the care record is re-audited to ensure that remedial action has taken place. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: A programme of auditing care records via the FSHC Quality of Life programme is in place and where shortfalls are identified care records will be re-audited to ensure actions are addressed. The Quality of Life Programme evidences the follow up actions taken. A matrix to guide quality auditing is in place
Recommendation 5 **Ref:** Standard 37.1 **Stated:** First time **To be completed by:** 8 August 2016	The registered person should ensure that any record retained in the home which details patient information is stored safely and in accordance with DHSSPS policy, procedures and guidance and best practice standards. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Supplementary files are now stored in a transportable trolley and stored in the nurses station

Recommendation 6 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 31 August 2016	The registered person must ensure that the dining experience for patients reflects current best practice guidelines for dementia care. The manager must ensure staff adhere to best practice guidelines at all times. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: A Dining audit was completed on 11 July and any actions identified have been incorporated into the on-going acion plan. A follow up audit is to be completed within four weeks to evidence that the identified improvements have been achieved.
Recommendation 7 **Ref:** Standard 12.13 **Stated:** First time **To be completed by:** 8 August 2016	The registered provider should ensure that patients who require a specialised diet are afforded a choice of meal at each mealtime. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Menus have been reviewed and choices are available for specialised diets at each meal time. A record of the modified diet choice id retained.
Recommendation 8 **Ref:** Standard 39.7 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that a robust system is established that evidences training undertaken by staff is embedded into practice. **Ref: Sections 4.3, 4.4 and 4.5**
	Response by registered provider detailing the actions taken: TheFSHC Resident Experience Team have been supporting the Registered Home Manager. Supervison sessions are currently being completed to evidence that training is embedded into practice. This will also include the use of reflective practice.
Recommendation 9 **Ref:** Standard 6.14 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that the personal care afforded to patients is monitored on a daily basis by the manager or clinical lead until such times as the manager is satisfied with the standard of personal care delivery. **Ref: Section 4.5**
	Response by registered provider detailing the actions taken: The Home Manager or designated senior staff member is completing a daily review which is recorded on the Home Managers daily check record form

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

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews