Unannounced Care Inspection Report
27 September 2016

Movilla House

Type of Service: Nursing Home
Address: 51 Movilla Road, Newtownards, BT23 8RG
Tel No: 02891819399
Inspector: Sharon Mc Knight

1.0 Summary

An unannounced inspection of Movilla House took place on 27 September 2016 from 09.50 hours to 17.10 hours.

The inspection sought to assess progress with any issues raised 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.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding.

A concern was identified in the delivery of safe care, specifically in relation to the recruitment processes; one requirement and a recommendation were made. One recommendation was made with regard to the signing of induction programmes.

Is care effective?

We reviewed the systems and processes in place which support effective care delivery.

Following a review of care records areas for improvement were identified; one requirement and two recommendations were made. We examined the systems in place to promote effective communication between staff and were assured that these systems were robust. Relatives and staff were of the opinion that the care delivered was effective.

Weaknesses have been identified in the delivery of effective care specifically in relation to the timing of the evening meal and the administration of medicines. Two recommendations were made and one recommendation is stated for a second time.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully. Numerous compliments had been received by the home from relatives and friends of former patients. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding issues affecting them. One area for improvement was identified to address any issues raised at patient meetings. Patients spoken with commented positively in regard to living in the home.

Is the service well led?

There was a clear organisational structure and staff were aware of their roles and responsibilities. A review of care confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide.

Staff spoken with were knowledgeable regarding the line management structure and who they would escalate any issues or concerns to; this included the reporting arrangements when the acting manager was off duty. An area for improvement was identified with the recording of complaints. A recommendation was made.

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

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	**1**	**9***

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

*The total number of recommendations made includes one recommendation that has been stated for a second time.

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

1.2 Actions/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 19 January 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this 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 person: Movilla House Ltd	**Registered manager:** Tracey Anderson
Person in charge of the home at the time of inspection: Jenny Bell, general manager	**Date manager registered:** 20 July 2016
Categories of care: RC-I, NH-I, NH-PH, NH-PH(E), NH-TI No more than 2 persons in category RC-I.	**Number of registered places:** 50

3.0 Methods/processes

Prior to inspection we analysed the following records:

- notifiable events 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 plan (QIP) from the previous care inspection
- the previous care inspection report.

During the inspection we met with 11 patients individually and with others in small groups, a nursing sister, one registered nurse, four care staff, two laundry assistants, a domestic and two patients' visitors/representative.

The following information was examined during the inspection:

- staff duty roster for the week commencing 26 September 2016
- four patient care records
- staff training records
- staff induction records
- staff recruitment records
- records of staff NMC/NISCC registration
- complaints and compliments records
- incident and accident records
- records of audit
- records of staff meetings
- records of patient and relatives meeting
- annual quality report
- reports of monthly quality monitoring visits.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 19 January 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 was validated during this inspection. Refer to section below for details.

4.2 Review of requirements and recommendations from the last care inspection dated 19 January 2016.

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 35.7 **Stated:** First time	It was recommended that the general manager undertake an early morning unannounced visit to review the morning routine and ensure that patients' needs are met on an individual basis and not in response to staff routine.	**Met**
	Action taken as confirmed during the inspection: Following the early morning visit by the registered manager RQIA were informed of the outcome. The general manager confirmed that patients' needs were met on an individual basis. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 12 **Stated:** First time	It is recommended that the serving of the evening tea is reviewed to ensure it meets individual patient needs. This review should include the opinion of patients and the deployment of staff. RQIA should be notified of the outcome of this review.	**Not Met**
	Action taken as confirmed during the inspection: Staff confirmed that the serving of the evening tea had been reviewed and changes made to the routine to ensure individual needs were met. However we observed that the serving of the evening tea commenced at 16.00 hours. The serving of the evening tea is further discussed in section 4.4. This recommendation has not been met and is stated for a second time.	

Recommendation 3 **Ref**: Standard 12.1 **Stated:** First time	It is recommended that the provision of snacks at morning and afternoon tea is reviewed to ensure that there is provision for patients who require a specialist diet.	**Met**
	Action taken as confirmed during the inspection: Staff confirmed that snacks were available at morning tea and afternoon tea for patients who require specialised/modified diet. We observed a selection of pudding type snacks on the trolley. This recommendation as stated has been met. The provision of snacks at supper time for patients who require a specialist diet is discussed in section 4.5 and a recommendation made.	

4.3 Is care safe?

The general manager confirmed the current occupancy of the home and the planned daily staffing levels. They advised that these levels were subject to regular review to ensure the assessed needs of the patients were met. Examples were provided of the indicators used to evidence that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for week commencing 26 September 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff, staffing rosters confirmed that administrative, catering, domestic, laundry and maintenance staff were on duty daily. There was also an activity leader to provide activities for the patients. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Patients and relatives commented positively regarding the staff and care delivery.

We also sought staff and relatives' opinion on staffing via questionnaires; one completed relative and two staff questionnaire were returned following the inspection. All of the respondents were satisfied that there were sufficient staff to meet the needs of the patients and were very satisfied with this aspect of patient care. One staff member commented on the impact patient dependency has on staffing.

Staff spoken with were aware that a nurse was identified to be in charge of the home when the registered manager was off duty. The nurse in charge of the home was clearly identified on the staffing roster.

A review of two personnel files evidenced the following:

- the first personal file contained only one reference. There was no reference from the candidate's present or most recent employer
- the second file did not contain a full employment history and the reasons for leaving each post were not recorded
- there was no evidence to confirm if one applicant's registration with the Nursing and Midwifery Council (NMC) had been checked as part of the recruitment process.

All information required in regard to the selection and recruitment of staff must be obtained prior to the commencement of employment. A requirement was made.

The record maintained of Access NI checks was reviewed. One file contained the date the certificate was issued, the second file had a tick recorded in the section "Access NI". A record of the date the home is notified of the outcome of the Access NI checks should be maintained to evidence that the registered manager had checked the certificate prior to the candidate commencing employment. A recommendation has been made.

The arrangements in place to confirm and monitor the registration status of registered nurses with the Nursing and Midwifery council (NMC) and care staff registration with the Northern Ireland Social Care Council (NISCC) were discussed with the registered manager.
A review of records evidenced that the arrangements for monitoring the registration status of registered nurses were appropriately managed.

At the time of the inspection there were five care staff listed on the monthly checks with no information recorded regarding their registration status with the NISCC. This issue was discussed with registered manager who confirmed that the staff had completed their application and were awaiting registration. The importance of ensuring that records accurately reflect the registration status of all staff was discussed.

Discussion with staff and a review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Two completed induction programme were reviewed. The programmes included a written record of the areas completed and the signatures of two staff. There was no designation or printed name of the staff who had completed the form. It was recommended that the completed induction programme contains the name and designation of the staff who have completed the form. Completed induction programmes should be signed by the registered manager to confirm that the induction process had been satisfactorily completed.

Training was available via an e learning system and internal face to face training arranged by the home. Systems were in place to monitor staff attendance and compliance with training. These systems included a print out of which staff had completed an e learning training and signing in sheets to evidence which staff had attended face to face training in the home. Training opportunities were also provided by the local health and social care trust. The general manager confirmed that when they receive notification of training from the Trust the dates would be displayed in the home and staff would be encouraged to attend. Training was also commissioned by the home in response to the needs of staff; for example male catheterisation and wound management.

The registered manager confirmed that they were currently introducing systems to ensure that all staff received supervision a minimum of twice a year. They confirmed that staff would also have an annual appraisal.

Review of three patients' care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk and inform the patient's individual care plans.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. The registered nurses and care staff were aware of whom to report concerns to within the home. Annual refresher training was considered mandatory by the home.

A review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. A monthly analysis of accidents to identify any trends or patterns was included in the monthly programme of audits undertaken.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling, clean and appropriately heated. Both of the relatives' responses we received in the returned questionnaires confirmed their satisfaction with the environment of the home.

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

There were no issues identified with infection prevention and control practice.

Areas for improvement

All information required in regard to the selection and recruitment of staff must be obtained prior to the commencement of employment.

A record of the date the Access NI certificates are checked should be maintained to evidence that the registered manager had checked the certificate prior to the candidate commencing employment.

Completed induction programmes should contain the name and designation of the staff who have completed the form. They should also be signed by the registered manager to confirm that the induction process had been satisfactorily completed.

Number of requirements	1	Number of recommendations	2

4.4 Is care effective?

We reviewed four patients' care records with regard to the prevention of pressure ulcers and the repositioning of patients. Risk assessments were completed and identified the level of risk for each patient as either moderate or high. There were no care plans in place to prescribe the care required to minimise the risk of patients developing pressure ulcers. The repositioning charts completed for these four patients did not evidence regular repositioning.

A written nursing plan must be prepared to direct the care required to meet the patient's assessed need. Where a patient is assessed as at risk of pressure damage a documented pressure damage prevention and treatment care plan must be drawn up. A requirement was made.

Contemporaneous records should be kept of all nursing interventions, activities and procedures carried out in relation to each patient. Repositioning charts should be accurately maintained to evidenced care delivery. A recommendation was made.

Supporting supplementary care records, for example repositioning charts and food and fluid intake charts were maintained electronically. Computer entries reflected the time care staff recorded the entry on the touch screens. Care staff spoken with stated that they recorded the care as soon as possible after delivering the care. We identified that if the entry was not made immediately after delivering the care, for example if another patient requested/required urgent assistance, the accuracy of the care records would be compromised. It is recommended that a review is undertaken of the systems in place for data inputting to care records to ensure that they fully support the recording of contemporaneous records. Records should accurately reflect the actual time care is delivered and not the time the entry is recorded.

As previously discussed in section 4.2 a recommendation was made as a result of the inspection on 19 January 2016 that the serving of the evening tea should reviewed to ensure it meets individual patient needs. Staff spoken with confirmed that a review had been completed by management and some changes made to the routine. During this inspection we observed that the serving of the evening tea for patients who required full assistance from staff commenced at 16.00 hours. We queried the time with care staff who confirmed that, in order to ensure they had sufficient time to meet the individual needs of all of the patients, they had to commence evening tea at this time. The intervals between meals should be delivered in accordance with best practice guidance, for example, Nutritional Guidelines and menu checklist, March 2014. This recommendation has been stated for a second time.

We were informed that supper was served around 20.00 hours. Patients would be offered a selection of breads, cakes and biscuits. Patients who required a pureed diet would generally be offered a milky drink, for example hot chocolate. As discussed in section 4.2, a previous recommendation was made regarding the provision of snacks at the morning and afternoon tea times. We observed that this recommendation as stated was met. However snacks should be available for all patients' at each customary interval. A recommendation was made.

We observed that a registered nurse in one unit had commenced the evening medication round at 15.30 hours. The registered nurse confirmed that this was their normal practice; they were knowledgeable regarding the importance of ensuring that appropriate dosage intervals were maintained. However the time of the administration was not accurately reflected on the medicine administration record. As the time was not accurately recorded we were unable to evidence if the appropriate dosage interval had been adhered to. Following discussion with the senior inspector for pharmacy regulation it was recommended that the registered manager ensure that the medicine administration records are accurately completed and the appropriate dosage intervals maintained for all prescribed medicines.

The registered manager and staff advised that they 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. A meeting took place each day, mid-morning, with the registered manager and the registered nurses for an update on patient care and operational issues. A written report was completed for the registered manager at the end of each 24 hour period.

The registered manager has recently taken up post and confirmed that they plan to hold regular staff meetings. They discussed the benefits of holding general staff meetings and also meeting with teams individually. Minutes were maintained and available of staff meetings held by the previous acting manager. The minutes evidenced who had attended and the issues discussed. The most recent meetings were held on 20 June 2016 with the nursing sisters and 17 March 2016 with care staff.

Staff advised 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 registered manager or deputy manager.

Patients spoken with commented positively in regard to the care they received. The following comments were provided:

“The care is very good, there’s nothing I need that I don’t get.”
“They (the staff) are genuinely interested in what you say”

We spoke with the relatives of two patients who commented positively regarding staffing, communication and the general care and atmosphere in the home.

Areas for improvement

Where a patient is assessed as at risk of pressure damage, a documented pressure damage prevention and treatment care plan must be drawn up.

Repositioning charts should be accurately maintained to evidenced care delivery.

A review should be undertaken of the systems in place for data inputting to care records to ensure that they fully support the recording of contemporaneous records. Records should accurately reflect the actual time care is delivered and not the time the entry is recorded.

Snacks should be available for all patients at each customary interval.

The medicine administration records should be accurately completed. Appropriate dosage intervals should be maintained for all prescribed medicines.

Number of requirements	1	Number of recommendations	4

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. Staff were observed responding to patients’ needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding patients’ likes and dislikes and individual preferences.

Patients spoken with commented positively in regard to the care they received and were happy in their surroundings. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. The staff confirmed that whilst socialisation between patients was promoted, each had a choice as to how they spent their day and where they preferred to sit throughout the day.

During the morning period, we met with two patients sitting in the reception area of the home. Both stated that they enjoyed sitting in this area to watch who was coming and going.

Relatives confirmed that they were made to feel welcome into the home by all staff. They were confident that if they raised a concern or query with the registered manager or staff, their concern would be addressed appropriately.

Numerous compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

“Everyone who came into contact with our mum whether it was the nurses, auxiliary staff, cleaners or caterers, treated her with kindness, dignity, warmth and unfailing kindness.”

“I always had an easy mind when she was with you all.”

We discussed how patients and relatives were consulted with and involved in the issues which affected them. The general manager explained that questionnaires were sent to relatives annually, the responses analysed and included in the annual quality report. We reviewed the annual quality report for the period June 2015 – July 2016 which contained a summary of the service user annual survey . The report reflected a 77% response rate and included an overall percentage of satisfaction for each question. There were a number of questions were a low percentage (1-2%) has indicated they were not satisfied, for example, with the reporting of problems/progress. The general manager explained that an action plan had been drawn up to address the issues but as the issues were individual the details had not been included in the annual quality report. We discussed the benefits of referencing the existence of the action plan in the report and informing people it was available if they wished to view it.

Residents meetings were held monthly and chaired by the activity leader. Records were maintained of which patients attended, the issues raised and any discussion that followed. A review of meetings held from February – August 2016 evidenced that similar issues were being regularly raised; there was no evidence of what action, if any, had been taken to address them. We discussed the importance of ensuring that, when patient opinion is sought, action is taken to address any issues raised. A recommendation was made. We noted that many of the issues were of an individual nature and the general manager agreed to discuss and clarify the purpose of the patients meetings. Consideration should be given to directing patients to more appropriate systems within the home for raising individual issues specific to their care.

Ten relative questionnaires were issued; one was returned within the timescale for inclusion in this report. The relative was very satisfied with the care provided across the four domains.

Ten questionnaires were issued to nursing, care and ancillary staff; two were returned prior to the issue of this report. The staff members were very satisfied with the care provided across the three domains and very satisfied or satisfied that the service was well led.

Areas for improvement

When patient opinion is sought, action should be taken to address any issues raised.

Number of requirements	0	Number of recommendations	1

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were available in the home.

Staff spoken with were knowledgeable regarding line management and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty.

Patients and representatives spoken with confirmed that they were aware of how to make a complaint and were confident that staff and /or management would address any concern raised by them appropriately. Patients were aware of who the registered manager was.

A record of complaints was maintained. The record included the date the complaint was received, the nature of the complaint and details of the investigation. There was no information to indicate how management had concluded that the complaint was closed. The recording of complaints should be further developed to include how the complainant's level of satisfaction was determined. A recommendation was made.

There were numerous thank you cards and letters received from former patients and relatives; examples of these have been included in the previous domain.

As previously discussed there were systems in place to ensure that notifiable events were investigated as appropriate and reported to the relevant bodies. The registered manager completed a monthly analysis of falls to identify any trends or patterns.

There were arrangements in place to receive and act on health and safety information, urgent communications, safety alerts and notices; for example from the Northern Ireland Adverse Incident Centre (NIAIC).

The registered manager discussed the systems she had in place to monitor the quality of the services delivered. A programme of audits was completed on a monthly basis. Areas for audit included care records, accidents and incidents and the management of wound care.

The unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. A copy of the report was maintained and available in the home; the report included an action plan to address any identified areas for improvement.

Areas for improvement

The recording of complaints should be further developed to include how the complainant's level of satisfaction was determined.

Number of requirements	0	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Jenny Bell, general 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/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 or 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 21(1)(b) **Stated:** First time **To be completed by:** 25 October 2016	The registered person must ensure that all information required in regard to the selection and recruitment of staff is obtained prior to the commencement of employment. **Ref section 4.3**
	Response by registered provider detailing the actions taken: we are currently recruiting for a night duty care assistant, and all information will be obtained prior to any commencement of employment
Requirement 2 **Ref**: Regulation 16(1) **Stated:** First time **To be completed by:** 25 October 2016	The registered person must ensure that a written nursing plan is prepared to direct the care required to meet the patient's assessed need. **Ref section 4.4**
	Response by registered provider detailing the actions taken: I have completed the audit of care files as discussed and have included this in the audit- to be completed by 20.11.16. The files will then be re-audited week beginning 21.11.16 to ensure all aspects of care are contained within the files
Recommendations	
Recommendation 1 **Ref**: Standard 12 **Stated:** Second time **To be completed by:** 25 October 2016	It is recommended that the serving of the evening tea is reviewed to ensure it meets individual patient needs. This review should include the opinion of patients and the deployment of staff. RQIA should be notified of the outcome of this review. **Section 4.2**
	Response by registered provider detailing the actions taken: The RQIA have already been notified that evening tea has been moved to 16:45- this is to give out trays to those residents who prefer to have their evening meal in their room, any resident who is assisted with meals, their meal time has moved to 17:00 onwards

Recommendation 2 **Ref**: Standard 38 **Stated:** First time **To be completed by:** 25 October 2016	It is recommended that a record of the date the Access NI certificates are checked should be maintained to evidence that the registered manager had checked the certificate prior to the candidate commencing employment. **Ref: section 4.3**
	Response by registered provider detailing the actions taken: I as the registered manager, will be checking all access NI certificates are obtained prior to commencement of employment- they will be signed and dated by myself
Recommendation 3 **Ref**: Standard 39 **Stated:** First time **To be completed by:** 25 October 2016	It is recommended that completed induction programme contain the name and designation of the staff who have completed the form. They should also be signed by the registered manager to confirm that the induction process had been satisfactorily completed. **Ref section 4.3**
	Response by registered provider detailing the actions taken: This has always been done- the designation of the staff member is on the form, each box of area to be inducted is signed by the inductee and the registered manager. However, I have added a separate area where the overall form is signed at the bottom by the staff member, their designation and the registered manager
Recommendation 4 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 25 October 2016	It is recommended that contemporaneous notes are kept of all nursing interventions, activities and procedures carried out in relation to each patient. Repositioning charts should be accurately maintained to evidenced care delivery. **Ref section 4.4**
	Response by registered provider detailing the actions taken: The need for a repositioning care plan has been included in those care file audits of which residents need repositioned, the nurses have been advised to check the repositioning documentation regularly and to follow up if this is not being done when required. EpiCare have been contacted to include a drop down box that will enable staff to highlight the time the interventionwas completed as opposed to the time it was documented

Recommendation 5 **Ref**: Standard 35.6 **Stated:** First time **To be completed by:** 25 October 2016	It is recommended that a review is undertaken of the systems in place for data inputting to care records to ensure that they fully support the recording of contemporaneous records. Records should accurately reflect the actual time care is delivered and not the time the entry is recorded. **Ref section 4.4**
	Response by registered provider detailing the actions taken: EpiCare have been contacted to review the ability to select accurate times for each intervention and care need being delivered, rather than the time of documentation.
Recommendation 6 **Ref**: Standard 12 **Stated:** First time **To be completed by:** 25 October 2016	It is recommended that snacks are available for all patients' at each customary interval. **Ref section 4.4**
	Response by registered provider detailing the actions taken: Snacks are available at all times throughout the day for all residents. At specific designated times for snacks will have puree snacks for those that require them. Staff have been reminded the importance of assisting those with snacks that require assistance
Recommendation 7 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 25 October 2016	It is recommended that the medicine administration records are accurately completed and the appropriate dosage intervals maintained for all prescribed medicines. **Ref section 4.4**
	Response by registered provider detailing the actions taken: This issue has already been discussed with Sharon, I as the registered manager was shocked that this had happened as it is not customary practice within Movilla. All nursing staff have been spoken to individually and reminded about the importance of adhering to dosage times for medications.
Recommendation 8 **Ref**: Standard 7.6 **Stated:** First time **To be completed by:** 22 November 2016	It is recommended that when patient opinion is sought, action is taken to address any issues raised. **Ref section 4.5**
	Response by registered provider detailing the actions taken: Residents meetings are held on a monthly basis, the next one is on 25.10.16, an agenda has been sent out to all residents, after the meeting an action plan will be developed to ensure any issues that are raised have been addressed- this will then be monitored during the month and the residents will be updated at the next months residents meeting to ensure the issues have been addressed

Recommendation 9 **Ref**: Standard 16.11 **Stated:** First time **To be completed by:** 25 October 2016	It is recommended that the recording of complaints is further developed to include how the complainants' level of satisfaction was determined. **Ref section 4.6**
	Response by registered provider detailing the actions taken: This has been commenced, detailed descriptions of complaints are documented, a follow up action plan, outcomes and level of satisfaction of complainant all documented

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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