Parkdean
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Belfast
BT15 4AN

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Unannounced Care Inspection
of
Parkdean

12 May 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced care inspection took place on 12 May 2015 from 09.30 to 16.40 hrs. This inspection was underpinned by one standard and one theme from the DHSSPSNI Care Standards for Nursing Homes (2015). **Standard 19 - Communicating Effectively; Theme 'End of Life Care' incorporating criteria from Standard 20 – Death and Dying; and Standard 32 - Palliative and End of Life Care.**

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 19 June 2014.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**2**	**5**

The details of the Quality Improvement Plan (QIP) within this report were discussed with the manager, Margaretha Erasmus and the registered person, Emer Bevan, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Mrs Emer Bevan	Registered Manager: See below
Person in Charge of the Home at the Time of Inspection: Ms Margaretha Erasmus	**Date Manager Registered:** Ms Margaretha Erasmus (application to be submitted. Refer to section 5.1.3)
Categories of Care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 64
Number of Patients Accommodated on Day of Inspection: 57	**Weekly Tariff at Time of Inspection:** £581 (£50 top up)

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the standard and theme have been met:

Standard 19: Communicating Effectively
Standard 20: Death and Dying
Standard 32: Palliative and End of Life Care

4. Methods/Process

Specific methods/processes used in this inspection include the following:

- discussion with the manager
- discussion with patients
- discussion with staff
- review of care records
- observation during an inspection of the premises
- evaluation and feedback.

The inspector met with ten patients individually and the majority of others in groups, three registered nurses, six care staff and two patient’s visitors/representatives.

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report

The following records were examined during the inspection:

- staff duty rotas
- staff training records
- staff competency and capability records
- staff induction records
- four care records and a number of daily charts
- a selection of policies and procedures
- incident and accident records
- care record audits
- regulation 29 monthly monitoring reports
- annual quality report
- guidance for staff in relation to palliative and end of life care

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an announced finance inspection on 6 October 2014. The completed QIP was returned and approved by the finance inspector.

5.2 Review of Requirements and Recommendations from the last Care Inspection

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 17 (1), (2) and (3) **Stated:** Third time	The registered person shall introduce and ensure systems are maintained for reviewing the quality of nursing and other service provision in the nursing home. A report is to be written on an annual basis and evidence consultation with patients and their representatives. It is recommended the annual quality report includes, for example, evidence of consultation with patients, representatives and staff, outcome and action taken in response to patients/representatives satisfaction questionnaires, action taken to address any deficits identified through audit or consultation.	**Met**
	Action taken as confirmed during the inspection: The annual report for 2014 was reviewed and found to contain the information cited above. This requirement has been met.	

<table>
<tr><td rowspan="2">Requirement 2

Ref: Regulation 14 (4)

Stated: First time</td><td>The registered person must make arrangements by training staff or by other measures, to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse by
Referring any potential safeguarding issue to the designated safeguarding officer in the health and social care trust in accordance with regional guidance</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Discussion with the home manager and a review of incident notifications evidenced that safeguarding referrals had been made appropriately to the Trust. This requirement has been met</td></tr>
<tr><td rowspan="2">Requirement 3

Ref: Regulation 30 (1) & (2)

Stated: First time</td><td>The registered person must give notice to RQIA without delay regarding any potential safeguarding issue.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
RQIA have been appropriately informed of any potential and ongoing safeguarding issues in relation to the home.</td></tr>
<tr><td>Requirement 4

Ref: Regulation 15 (2) (a & b)

Stated: First time</td><td>The registered person must ensure that the assessment of the patient’s needs is kept under review and revised at any time when it is necessary to do having regard to any change of circumstances by :
recording the wound observation chart each time a wound is dressed
weight loss or gain must be diligently recorded and analysed in patients’ care records.
ambiguity regarding the accuracy of one identified patient’s weight should be addressed as a priority
food and fluid charts should be consistently recorded in line with the home’s recording system (the codes used in relation to amount taken).
regular photographic evidence of wounds should be present in the patient’s care records
the daily fluid intake and output chart should be totalled over the 24 hour period.</td><td>Met</td></tr>
</table>

	• MUST scores should be re-assessed monthly	
	Action taken as confirmed during the inspection: A review of care records evidenced that wound care records were well maintained and reflective of specialist advice. Patients were weighed regularly and any weight loss was responded to appropriately. Food and fluid charts were consistently well recorded. Some of the bedside charts were not totalled but the total fluid intake and output was reconciled in to the progress notes daily and any concerns responded to promptly. MUST scores were consistently reviewed monthly. This requirement has been met.	
Requirement 5 **Ref**: Regulation 16 (2) (b) **Stated:** First time	The registered person must ensure that care plans are kept under review and the following information is recorded: • a care plan in relation to pain management should be developed where need has been assessed as present • the frequency of wound dressings should be clearly stated • information leaflets regarding wound management and skin care should be given to patients and/or representatives, where appropriate and same recorded. • the care plan in respect of one patient should be reviewed in response to the current assessed classification of the wound. • care plans should include the specific care related to the prevention of any further deterioration of skin integrity to include the pressure relieving / reducing equipment in use • repositioning of patients should take place in accordance with assessed need as prescribed in the care plan and records should be made contemporaneously in relation to this activity. • one patient's care plan should reflect the dietician's advice. • a referral to the dietician may need to be considered for another patient on reviewing the patient's weight and MUST score.	**Met**

	• evaluations of care should be meaningful and accurately reflect the patient’s response to planned care interventions.	
	Action taken as confirmed during the inspection: A review of care records evidenced that care plans were in place in relation to pain management where appropriate. The frequency of wound dressings was consistently well recorded. Care plans reflected the current status of patients’ wounds and specified the equipment in use for pressure relief. The frequency of repositioning of patients was reflective of the care plans and contemporaneous records of repositioning were being well maintained. There was evidence in the care records and in discussion with the staff nurses that referrals were being made to the dietician as appropriate and their recommendations were included in the care plans. This requirement has been met.	
Requirement 6 **Ref**: Regulation 13 (4) (b) **Stated:** First time	The registered person must ensure that medicine which is prescribed is administered as prescribed to the patient for whom it is prescribed (this requirement relates to topical treatment)	**Partially Met**
	Action taken as confirmed during the inspection: A review of the records and discussion with the manager and care staff could not evidence that sufficiently robust systems were in place for the administration and recording of topical treatments. The manager was able to evidence that she was undertaking a review of this and had plans to initiate a new system which should improve practice. This requirement is not yet met and has been stated for a second time.	
Requirement 7 **Ref**: Regulation 19 (2), schedule 4 (12) (b) **Stated:** First time	The registered person must maintain in the nursing home the records of any incident which is detrimental to the health or welfare of the patient. Accident /incidents records should be recorded contemporaneously in date order.	**Met**
	Action taken as confirmed during the inspection:	

	A review of the accident and incident records evidenced that these were being recorded contemporaneously and in date order. This requirement has been met.	
Requirement 8 **Ref**: Regulation 27(4)(p) 27(4)(q) **Stated:** First time	The Registered Persons should keep RQIA up to date with progress in relation to resolving the corridor lighting issue. In the interim until the permanent solution to this issue has been achieved, staff should remain vigilant and the corridors should be checked daily. A record for these checks should be kept in the home available for review during future inspections.	**Met**
	Action taken as confirmed during the inspection: An inspection of the premises and discussion with the home manager evidenced that this issue had been resolved. This requirement has been met.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 25.12 **Stated:** First time	It is recommended that the following is addressed in relation to Regulation 29 visit reports • consideration is given to how the identity of patients, relatives and staff is redacted in reports made available to patients/ their representatives. • the time of commencing and finishing the visit is stated.	**Not Met**
	Action taken as confirmed during the inspection: A review of the regulation 29 reports could not evidence that sufficient consideration had been given to protecting the identity of patients, relatives or staff in the reports. The start and finishing times of the visits were not consistently recorded. This recommendation has not been met and will be stated for the second time.	

Recommendation 2 **Ref**: Standard 25.11 **Stated:** Second time	It is recommended a system to re-evaluate any shortfalls noted during audits undertaken in the home is introduced. The registered manager should confirm shortfalls have been addressed in a timely manner.	**Not Met**
	Action taken as confirmed during the inspection: No care record audits had been completed. The manager was in the process of reallocating patients to named nurses who would be responsible for updating the care records for their patients. The manager gave assurances that once the reorganisation of the named nurse system was complete that these audits would be completed and the results fed back to the appropriate named nurse. This recommendation has not been met and has been stated for the third time.	
Recommendation 3 **Ref**: Standard 25.13 **Stated:** Third time	It is recommended the information supplied in patients/representatives questionnaires be collated, an action plan developed and a report written and made available for patients and representatives information.	**Met**
	Action taken as confirmed during the inspection: Evidence of the patients/representatives feedback was contained in the regulation 29 reports and in the annual report for the home. This recommendation has been met.	
Recommendation 4 **Ref**: Standard 5.6 **Stated:** Second time	It is recommended a consistent and agreed approach to care planning and recording is implemented and adhered to by all staff	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that care plans were consistently reviewed monthly. The care files were well organised and the information kept in the same format for ease of access. This recommendation has been addressed.	

Recommendation 5 **Ref**: Standard 26.1 **Stated:** Second time	It is recommended the policy on quality assurance for the home includes information/arrangements for the regulation 29 monthly monitoring reports and the completion of the annual quality report. Information should also be detailed that these reports are available in the home and patients and/or their representatives may read the reports if they so wish.	**Met**
	Action taken as confirmed during the inspection: A review of this policy evidenced that the required information had been included as recommended. A sign was clearly displayed on the notice board that these reports were available to view on request. This recommendation has been met.	
Recommendation 6 **Ref**: Standard 5.3 **Stated:** Second time	It is recommended the registered manager ensures patients and representatives are aware of the individual's named nurse.	**Not Met**
	Action taken as confirmed during the inspection: Consultation with patients and one relative could not evidence that a named nurse system was in place. The manager is currently working on reorganising this system. This recommendation has not been met and has been stated for the third time.	
Recommendation 7 **Ref**: Standard 25.12 and 25.13 **Stated:** Second time	It is recommended patients and their representatives should be made aware of the availability of the regulation 29 reports and the annual quality report in the home, should they wish to read them.	**Met**
	Action taken as confirmed during the inspection: A notice was clearly displayed alerting patients and their representatives to the availability of the Regulation 29 monthly reports. This recommendation has been addressed.	

<table>
<tr><td rowspan="2">Recommendation 8

Ref: Standard 10.4

Stated: Second time</td><td>It is recommended nursing staff undertake training on restraint, restrictive practices and physical interventions. The training should include the procedures to follow regarding the use of restrictive practice in accordance with RCN guidelines</td><td rowspan="2">Partially Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The registered provider stated that she had attempted to source training in respect of restraint and restrictive practices but had been unsuccessful. However, a policy was in place and up to date guidelines were available to staff. The use of restrictive devices, such as bed rails, was consistently well documented in individual patient care records and evidenced discussion with the patients and their representatives.

Given that significant progress has been made in the management and documentation of restrictive practices this recommendation will not be restated.</td></tr>
<tr><td rowspan="2">Recommendation 9

Ref: Standard 32.8

Stated: First time</td><td>Confirm that the weighing scales used by patients have been re-checked and if necessary re-calibrated in accordance with the manufacturers' instructions by a suitably qualified person</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Weighing scales were checked and found to have been recently serviced. Staff confirmed the actions they would take if weighing scales were found to be inaccurate.

This recommendation has been met.</td></tr>
</table>

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating effectively which reflected current best practice, including regional guidelines on Breaking Bad News. These guidelines were available within a palliative resource folder for staff. Staff were knowledgeable regarding this policy and procedure.

Staff had not completed training in relation to communicating effectively with patients and their families/representatives. However, staff were generally knowledgeable about the important aspects of breaking bad news sensitively. One staff nurse indicated that she would value some supervision or training in this regard.

Is Care Effective? (Quality of Management)

Two out of the four care records reviewed reflected patients' individual needs and wishes regarding the end of life care. It was unclear if staff were avoiding discussion of this important area or if patients had simply not expressed any wishes in this regard. Whilst the inspector acknowledges there will be occasions when patients and/or their relatives do not wish to discuss end of life care, this should be recorded in the patients care records. It is important that staff do not avoid discussion of this important area until it is too late for the patient and their family members.

Records included reference to the patient's specific communication needs, including cognitive and sensory impairments.

A review of care records evidenced that the breaking of bad news was discussed with patients and/or their representatives, options and treatment plans were also discussed, where appropriate. There was evidence within the records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

A registered nurse gave examples of how they would communicate sensitively with patients and/or representatives when breaking bad news by ensuring privacy, imparting information clearly, allowing time for questions and being there to support the patient or family. Another registered nurse was less confident.

Is Care Compassionate? (Quality of Care)

Staff gave examples in discussion of how they communicated with patients and relatives. The importance of privacy, sensitivity, respect for their wishes and the giving of clear information was emphasised. In addition, staff confirmed that they documented these discussions and their outcomes in the patients' records.

Staff were observed to be caring and patient when delivering care. Good relationships were evident between the staff and patients and patients' needs were responded to promptly.

A number of cards were posted on the notice board from relatives and friends thanking staff for their care and attention.

Areas for Improvement

A recommendation has been made that staff are supported by training, or other effective means, to ensure that they are competent and confident in communicating effectively to identify end of life care needs.

A recommendation has also been made that end of life arrangements for patients are discussed and documented as appropriate, including the patients' wishes in relation to their religious, spiritual and cultural needs.

Number of Requirements:	0	Number of Recommendations:	2

5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

An up to date policy and procedure on the management of palliative and end of life care and death and dying were available in the home. These documents reflected best practice guidance such as the Guidelines and Audit Implementation Network (GAIN) Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, December 2013.

The policy also included guidance on the management of the deceased person's belongings and personal effects. The manager had compiled a comprehensive resource folder containing up to date guidelines in relation to palliative and end of life care, including information on sources of referral to specialist services, the management of distressing symptoms and syringe drivers.

Discussion with the manager and a review of training records evidenced that four nursing staff had attended a recent full day's training in the management of death, dying and bereavement. In addition, two staff had attended training on the management of the McKinley syringe drivers. Registered nursing staff were aware that the manager had compiled a resource folder but were not able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

Discussion with staff and a review of the care records confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services. There was evidence that patients had been referred in a timely way to the Trust's palliative care nurse specialist.

Discussion with the manager, staff and a review of care records evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

A protocol for timely access to any specialist equipment or medications was in place and nursing staff confirmed their knowledge of the protocol.

A palliative care link nurse for the home had been identified.

Is Care Effective? (Quality of Management)

A review of four care records evidenced that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis in the care plans. This included the management of hydration and nutrition, pain management and symptom management.

There was evidence, in two out of the four records examined, that the patient's wishes and their social, cultural and religious preferences were considered and documented.

In two out of the four care records examined there was evidence of discussion between the patient, their representatives and the GP in respect of death and dying arrangements and preferred place of care/death. Staff confirmed that some GP's were more proactive in undertaking advanced care planning with patients than others. They confirmed that they could refer patients to GP's for this to be undertaken if appropriate. Furthermore, the Trust's palliative care nurse also had discussions with patients regarding their needs and wishes at the end of life. The outcome of these discussions was reflected in the care plans. All four patients and their representatives had been involved in discussions regarding their wishes on resuscitation in the event of a cardiac arrest.

A key worker/named nurse was identified for each patient approaching end of life. There was evidence that referrals had been made to the specialist palliative care team and where instructions had been provided, these were evidently adhered to.

Discussion with the manager, staff and a review of care records evidenced that environmental factors had been considered, for example, noise and lighting levels or placement in the home. Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. Discussion with the manager and staff evidenced that relatives were welcome to stay with their loved one. They generally stayed in their room and were given a comfortable chair, blankets, pillows, regular beverages and snacks.

A review of notifications of death to RQIA during the previous inspection year evidenced that these were being made appropriately.

Is Care Compassionate? (Quality of Care)

Four care staff consulted demonstrated knowledge of the patients' physical needs at the end of life and clearly articulated their role and responsibilities in this regard. However, three of the four care staff consulted did not sufficiently demonstrate an awareness of the need for comfort, compassion and reassurance of the patient at the end of life.

Arrangements were in place in the home to facilitate, as far as possible, in accordance with the persons wishes, for family/friends to spend as much time as they wished with the person. Staff indicated that they always welcomed relatives and tried to support them as much as possible. Staff indicated that they developed close professional relationships with the patient and their family.

From discussion with the manager and staff and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives during this time. It was evident from the cards on the notice board that relatives had commended the management and staff for their efforts towards the family and patient.

Discussion with the manager and a review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

All staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death. There was one questionnaire respondent who stated that they did not get an opportunity to pay their respects. This was fed back to the manager and registered person. They confirmed that, as far as possible, staff were facilitated to pay their respects and attend memorial services.

Two of the staff consulted admitted to becoming distressed following the death of residents. They stated that they received support from their team. The manager confirmed in discussion, that her door was always open for staff to discuss any concerns.

Information regarding support services was available and accessible for staff, patients and their relatives. This information included leaflets on managing bereavement, funeral arrangements and advocacy services.

Areas for Improvement

As previously stated in standard 19, a recommendation has been made that staff are supported by training, or other effective means, to ensure that they are competent and confident in communicating effectively to identify end of life care needs.

As previously stated in standard 19, a recommendation has also been made that end of life arrangements for patients are discussed and documented as appropriate, including the patients' wishes in relation to their religious, spiritual and cultural needs.

Number of Requirements:	**0**	**Number of Recommendations:** *2 recommendations are made as stated under Standard 19 above	**2**

5.5 Additional Areas Examined

5.5.1 Comments by staff, patients and patient representatives

As part of the inspection process patients, their representatives and staff were consulted and questionnaires issued. All comments were generally positive. Some comments received are detailed below.

Patients

Patients were unable to complete the questionnaires but comments made in discussion included:

"They couldn't be better."
"Ten out of ten."
"The food is very good."
"I have no complaints and I couldn't say a bad word about any of them."

One patient was unsure if an appropriate referral had been made on their behalf and this was discussed with the manager who confirmed that this referral had already been made.

Patients' representatives

One visiting relative stated that they could not ask for better and that staff were always available. They felt they had made the right decision choosing the home for their relative.

Another visitor commented that they found staff to be very good.

Staff

Staff spoken with were positive about the home and the manager. They raised no concerns in discussion. Three staff members completed questionnaires and one respondent was unsatisfied with the training provided in relation to whistleblowing and management of distressing symptoms at the end of life. These concerns were fed back to the manager and the registered person. They stated that they had been putting particular emphasis on the importance of whistleblowing and there had been some positive results. They agreed to continue to emphasise this to staff. A recommendation has been made regarding staff training needs in relation to communicating effectively with patients at end of life.

5.1.2 Competency and Capability Assessments

The competency and capability assessments for the nurse in charge of the home in the absence of the manager were reviewed. One registered nurse had a completed assessment but two others had not. An examination of the off duty evidenced that these two staff members were left in charge of the home in the absence of the manager. A requirement has been made that these assessments be completed for any nurse given the responsibility of being in charge of the home in the absence of the manager.

5.1.3 Registration of the manager

The registration status of the manager was discussed as she is currently not registered with RQIA. In discussion the manager and the registered person were unsure as to why she had not been registered. It was agreed that this would be followed up by RQIA following the inspection. In consultation with RQIA registration team it became apparent that a notification had been received of the change of manager but the correct application form had not yet been submitted. This was relayed to the manager via a phone call on 22 May 2015 and she indicated her intention to submit an application.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Margaretha Erasmus, manager, and Emer Bevan, registered person, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref:** Regulation 13 (4) (b) **Stated:** Second time	The registered person must ensure that medicine which is prescribed is administered as prescribed to the patient for whom it is prescribed (this requirement relates to topical treatment)
	Response by Registered Person(s) Detailing the Actions Taken: As a result of the care inspection we have introduced new charts detailing each resident's name and prescribed creams. The chart also depicts the specific area to which the cream should be applied and provides space for a signature of the person applying the cream. All care staff are in the process of supervision in relation to the application of creams. This will be completed by the end of July (31st).
Requirement 2 **Ref:** Regulation 20 (3) **Stated:** First time **To be Completed by:** 12 July 2015	A competency and capability assessment must be carried out with any nurse who is given the responsibility of being in charge of the home in the absence of the manager.
	Response by Registered Person(s) Detailing the Actions Taken: All nurses who are given the responsibility of being in charge of the home in the absence of the Manager are in the process of completing a competency and capability assessment. The assessments will be completed before 12th July 2015.
Recommendations	
Recommendation 1 **Ref:** Standard 25.12 **Stated:** Second time	It is recommended that the following is addressed in relation to Regulation 29 visit reports • consideration is given to how the identity of patients, relatives and staff is redacted in reports made available to patients/ their representatives. • the time of commencing and finishing the visit is stated.
	Response by Registered Person(s) Detailing the Actions Taken: Room numbers have been used in reports rather than unique identifier following inspection in 2014, when advised the unique identifer should not be used. Following 2015 inspection, Regulation 29 reports will include unique identifier redacted. Regulation 29 and Standard 25.12 (old standards) have been consulted and neither makes reference to time visit commences and ends. The revised Standards (April 2012) have also been consulted however there is no Standard 25.12. The time the visit commences and ends will therefore not be included in the Regulation 29 reports moving forward.
Recommendation 2 **Ref:** Standard 25.11	It is recommended a system to re-evaluate any shortfalls noted during audits undertaken in the home is introduced. The registered manager should confirm shortfalls have been addressed in a timely manner.

Stated: Third time	**Response by Registered Person(s) Detailing the Actions Taken:** On completion of all audits an action plan will be developed. This action plan will identify the person responsible for addressing any shortfalls and a timescale for completion. The action plan will be reviewed and signed off by the Manager to indicate the outcome is satisfactory.
Recommendation 3 **Ref**: Standard 5.3 **Stated:** Third time	It is recommended the registered manager ensures patients and representatives are aware of the individual's named nurse.
	Response by Registered Person(s) Detailing the Actions Taken: A list of all Resident's and their named nurse is now available on the relatives noticeboard. Family members are now being informed who their relatives named nurse is on admission to the home.

Recommendation 4 **Ref**: Standard 20 **Stated:** First time	Staff should be supported by training, or other effective means, to ensure that they are competent and confident in communicating effectively to identify end of life care needs. **Response by Registered Person(s) Detailing the Actions Taken:** Nurses and care staff have been identified to attend Palliative Awareness training provided by the Nursing Home Support Team. Also in-house training is being sourced for all staff.
Recommendation 5 **Ref**: Standard 20.2 **Stated:** First time	End of life arrangements for patients should be discussed and documented as appropriate, including the patients' wishes in relation to their religious, spiritual and cultural needs. **Response by Registered Person(s) Detailing the Actions Taken:** All trained staff have been advised to discuss end of life arrangements with family when their relatives condition deteriorates. Following this discussion an End of Life care plan will be compiled containing all arrangements and this will be reviewed by the family before it is implemented.

Registered Manager Completing QIP	[signature]	**Date Completed**	23/6/15
Registered Person Approving QIP	[signature]	**Date Approved**	23/6/15.
RQIA Inspector Assessing Response	[signature]	**Date Approved**	25/6/15

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

Please provide any additional comments or observations you may wish to make below: