



The Regulation and
Quality Improvement
Authority

Inspector: Heather Sleator
Inspection ID: IN021724

Victoria
RQIA ID: 1305
22-24 Windsor Park
Belfast
BT9 6FR

Tel: 028 9066 8437
Email: victoria.nursinghome@yahoo.co.uk

Unannounced Care Inspection of Victoria

12 May 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 12 May 2015 from 09:30 to 16:30.

This inspection was underpinned by **Standard 19 - Communicating Effectively; 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.

For the purposes of this report, the term 'patients' will be used to describe those living in Victoria Nursing Home which provides both nursing and residential care.

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 12 August 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	4

The details of the Quality Improvement Plan (QIP) within this report were discussed with Helen Chambers, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Persons: Helen Lynas Robert Lynas	Registered Manager: Helen Chambers
Person in Charge of the Home at the Time of Inspection: Helen Chambers – registered manager	Date Manager Registered: 1 April 2005
Categories of Care: NH – I NH – PH NH – PH (E) NH -TI	Number of Registered Places: 33
Number of Patients Accommodated on Day of Inspection: 33	Weekly Tariff at Time of Inspection: Nursing - £593 - £636 Residential - £526

3. Inspection Focus

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

Standard 19: Communicating Effectively

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

4. Methods/Process

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

Prior to inspection the following records were examined:

- 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 (QIP) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with 12 patients, three care staff, two nursing staff and one visiting relative. There were no visiting professionals available during the inspection.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- the staff duty rota
- three patient care records
- accident/notifiable events records
- staff training records
- staff induction records
- documentation pertaining to the standard and theme of this inspection

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 12 August 2014. The completed QIP was returned and approved by the Care inspector.

5.2

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 Ref: Regulation 27 (2) (a) Stated: First time	Not inspected – Carried forward for review at the next inspection: The registered person shall, having regard to the number and needs of the patients, ensure that – (a) the physical design and layout of the premises to be used as the nursing home meets the needs of patients	Met
	Action taken as confirmed during the inspection: Inspector confirmed the additional shower room had been completed and was being used by patients. The laundry room layout had been reviewed and revised and a more useable working space was available for laundry staff. Environmental improvements had been reviewed by the estates team.	

<p>Requirement 2</p> <p>Ref: Regulation 20 (1) (c) (i)</p> <p>Stated: First time</p>	<p>The registered person shall, having regard to the size of the nursing home, the statement of purpose and the number and needs of the patients, ensure that the persons employed by the registered person to work at the nursing home receive mandatory training and other training appropriate to the work they are to perform.</p>	<p style="text-align: center;">Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>The review of the staff training matrix maintained by management confirmed mandatory training was up to date for staff and was in accordance with regulatory requirements.</p>		
<p>Requirement 3</p> <p>Ref: Regulation 13 (1) (a)</p> <p>Stated: First time</p>	<p>The registered person shall ensure that the nursing home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients.</p>	<p style="text-align: center;">Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>Inspector confirmed the supervisory arrangements put in place by management in respect of night staff. This had improved. Management met with patients on an individual basis and no new issues of concern were raised by patients.</p>		

<p>Requirement 4</p> <p>Ref: Regulation 13 (7)</p> <p>Stated: First time</p>	<p>The registered person shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff. The following issues require to be addressed:</p> <ul style="list-style-type: none"> • bedroom walls, doors and skirting boards – paint was chipped/marked and requires to be re-painted • carpets in both lounges were stained and sticky under foot • curtains between beds were stained • inappropriate storage of wheel chairs and musical instruments observed in bathroom • Personal protective equipment (PPI) stations did not contain supplies of small disposable gloves <p>Action taken as confirmed during the inspection: Inspector confirmed the paintwork in the identified bedroom had been re-painted. Carpeting in the home was clean and housekeeping staff informed the inspector of the cleaning schedule. At the time of inspection bathrooms were not being used for storage purposes and the personal protection equipment stations are checked on a daily basis to ensure adequate stock is present.</p>	<p>Met</p>
<p>Requirement 5</p> <p>Ref: Regulation 19 (2)</p> <p>Stated: First time</p>	<p>The registered person shall maintain in the nursing home the records specified in Schedule 4 –</p> <p>A record of the programme of events and activities that includes the name of the person leading the activity and the names of those who participated.</p> <p>Ref: Section 9.6</p> <p>Action taken as confirmed during the inspection: Inspector confirmed that a record of the programme of activities and events in the home had been maintained at the time of and following the previous care inspection. However, the activities co-ordinator has left employment and management have appointed another co-ordinator and are awaiting Access NI clearance certificate. Care staff are providing activities, as far as possible, in the interim period.</p>	<p>Met</p>

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 Ref: Standard 5.3 Stated: First time	It is recommended a system is implemented whereby staff are informed of the need to transfer patients from wheelchairs to lounge chairs without a substantial wait of time. Management should monitor this activity.	Met
	Action taken as confirmed during the inspection: Management implemented an audit system regarding the length of time patients waited to be transferred from wheelchairs to seating in the lounge areas. Management also met with patients and asked their preference with a number of patients stating they preferred to stay in their wheelchair.	
Recommendation 2 Ref: Standard 25.11 Stated: First time	It is recommended a system of auditing by management, is implemented to monitor and ensure: <ul style="list-style-type: none"> • the frequency of showering/personal hygiene needs of patients is undertaken by staff • cleaning of wheelchairs is undertaken on a regular basis 	Met
	Action taken as confirmed during the inspection: Individual personal care records are maintained for patients to ensure the frequency of attention to personal care is in accordance with the patient's wishes and/or completed on a daily basis. Management review the personal care records on a daily basis.	
Recommendation 3 Ref: Standard 5.3 Stated: First time	It is recommended the use of communal clothing ceases. Labelling of patients clothing should recommence.	Met
	Action taken as confirmed during the inspection: Management confirmed that the use of communal clothing had ceased. Clothing labels had been purchased as had a laundry marker to ensure patients only wore their own clothing.	

<p>Recommendation 4</p> <p>Ref: Standard 5.3</p> <p>Stated: Second time</p>	<p>It is recommended patients clothing is ironed following laundering</p> <hr/> <p>Action taken as confirmed during the inspection:</p> <p>The inspector confirmed patients clothing is now ironed. The laundry arrangements were viewed and an ironing board and iron were present. Patients clothing in wardrobes confirmed the clothing had been ironed.</p>	<p>Met</p>
<p>Recommendation 5</p> <p>Ref: Standard 5.3</p> <p>Stated: First time</p>	<p>It is recommended there is evidence of sufficient bed linen in the home and available for use, at all times.</p> <hr/> <p>Action taken as confirmed during the inspection:</p> <p>The stock in linen storage cupboards in the home was viewed and sufficient bed linen was present.</p>	<p>Met</p>
<p>Recommendation 6</p> <p>Ref: Standard 28.6</p> <p>Stated: First time</p>	<p>The registered manager should ensure that A record is kept in the home of all training, including induction and professional development activities completed by staff. This record includes:</p> <ul style="list-style-type: none"> • The names and signatures of those attending the training event • The date(s) of the training • The name and qualification of the trainer or the training agency • Content of the training programme <hr/> <p>Action taken as confirmed during the inspection:</p> <p>The review of staff training records evidenced the information detailed above was present.</p>	<p>Met</p>
<p>Recommendation 7</p> <p>Ref: Standard 12.11</p> <p>Stated: First time</p>	<p>The registered manager should ensure that, where patients fluid balance is being monitored, a record of reconciliation of fluid intake is recorded in the daily progress notes.</p> <hr/> <p>Action taken as confirmed during the inspection:</p> <p>The review of three patients care records, where fluid balance was being monitored, evidenced the daily fluid intake of these patients was recorded in the daily progress notes so as any action required may be addressed promptly.</p>	<p>Met</p>

<p>Recommendation 8</p> <p>Ref: Standard 34.3</p> <p>Stated: First time</p>	<p>A recommendation has been made for the registered manager to ensure regular monthly infection control audits are being completed.</p> <p>It is also recommended that consideration be given to appointing an infection control link nurse for the home.</p>	<p>Partially Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>Infection control audits were being undertaken however there was no outcome/action plan detailed, no evidence that where remedial action was required it had been taken and the audits were not validated by the registered manager. This recommendation will be subsumed into a requirement and detailed in the quality improvement plan of this report.</p>		

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

Policy guidance in respect of Breaking Bad News was available for staff regarding communicating effectively. Discussion with a number of care staff confirmed that they had heard of the policy. It was advised a more robust approach should be implemented by management to ensure staff were fully aware of the content of the policy.

A sampling of training records evidenced that staff had completed training in relation to communicating effectively with patients and their families/representatives when undertaking dementia awareness training. As discussed and agreed with management, training should be developed further to include the procedure for breaking bad news as relevant to staff roles and responsibilities in accordance with regional guidelines.

Is Care Effective? (Quality of Management)

Three care records evidenced that patient individual needs and wishes in respect of aspects of daily living were appropriately recorded. There was however limited acknowledgements that end of life issues are considered with the exception of Do Not Attempt Resuscitation (DNAR) directives.

Recording within care records did include reference to the patient's specific communication needs.

A review of three care records evidenced that the breaking of bad news was not discussed with patients and/or their representatives other than in respect of a DNAR directive.

There was evidence within all records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

Two registered nursing staff discussed how bad news would be shared with patients or their representatives using techniques which included; sitting down by the patient, using a calm voice, speaking clearly yet reassuringly, holding hands, allowing privacy, allowing the patient to question, and trying to display as much empathy as possible.

Care staff considered the breaking of bad news to be the responsibility of the registered nursing staff and failed initially to recognise that they would do this on a regular basis and that it does not necessarily mean informing a patient that a loved one has died. Further staff training will allow for greater understanding and development of these skills.

Is Care Compassionate? (Quality of Care)

Having observed the delivery of care and many staff interactions with patients the inspector can confirm that communication is well maintained and patients were observed to be treated with dignity and respect. Care staff referred to the communication training they had undertaken in respect of dementia practice and recognised the need to be aware of non-verbal cues such as facial expression and individuals' body language.

The inspection process allowed for consultation with 12 patients. In general the patients all stated that they were very happy with the quality of care delivered and with life in Victoria. They confirmed that staff are polite and courteous and that they felt safe in the home.

One patient's representative discussed care delivery with the inspector and also confirmed that they were very happy with standards maintained in the home.

A number of compliment card from past family members were retained in the home.

Areas for Improvement

Training in communication skills including breaking bad news for all staff will further enhance the quality of life in the home. Improvements in recording communication outcomes into care records must be made.

Number of Requirements:	0	Number of Recommendations:	2
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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)

Policies and procedures 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 Gain Palliative Care Guidelines, November 2013, and included guidance on the management of the deceased person's belongings and personal effects.

Training records did not evidence that staff were trained in the management of death, dying and bereavement. However, registered nursing staff and care staff were aware of and able to verbally demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

A review of staff training records and discussion with the registered manager confirmed that training in respect of palliative/end of life care had not been undertaken by any staff in the home. It was agreed this training would be sourced and made available for staff, both nursing and care staff.

Discussion with two registered nurses and a review of care records confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the manager, two registered nurses and a review of three 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.

Information regarding the timely access to any specialist equipment or drugs was in policy documentation. It was agreed in house training would take place at the next staff meeting, scheduled for 4 June 2015, at which time staff would be updated regarding the protocol.

The registered nursing staff confirmed that they are able to source a syringe driver via the community nursing team if required. It was also confirmed that staff are trained in the use of this specialised equipment.

A palliative care link nurse had just been identified within the home however the nurse had not completed, as yet, any training in this area. It was agreed this training would be viewed as a priority.

Is Care Effective? (Quality of Management)

A review of three care records evidenced that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain management and symptom management. There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

At the time of inspection there was a patient considered, by medical staff, to be at end of life. The review of the patient's records demonstrated a well-developed end of life care plan which addressed all areas such as the patient's religious wishes, the management of pain and the management of hydration. The patient and family member/s were being supported by staff throughout this period. Information was available in the care records as to not only the patient's wishes but the level of support needed by family. As discussed in section 5.1 above, further training in communication especially in 'breaking bad news will enhance the quality of verbal and written skills of the staff team. The registered manager stated that her experience, to date, evidenced that the breaking of bad news was undertaken by medical/hospital staff but did agree training in the areas of communicating effectively and end of life and palliative care would be valuable for staff.

Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

Discussion with the registered manager, two registered nurses, three care staff and a review of three care records evidenced that environmental factors had been considered when a patient was at the end of life. Staff informed the inspector that management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. Facilities have been made available for family members to spend extended periods with their loved ones during the final days of life. Meals, snacks and emotional support had been provided by the staff team.

A review of notifications of death to RQIA during the previous inspection year evidenced that all had been reported appropriately.

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of an end of life care plan evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences. The end of life care plan had been appropriately maintained with attention given to the wishes of family members and the staff had ensured that the patient would be reassured and supported fully up to the time of death.

Arrangements were in place in the home to facilitate, as far as possible the patient's wishes, for family/friends to spend as much time as they wish with the person. Staff discussed openly a number of deaths in the home and how the home had been able to fully support the family members in staying with their loved ones for as long as they were able or wished to.

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.

From discussion with the registered manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included 1:1 support from the home manager and support through staff meetings.

Areas for Improvement

Whilst staff appeared knowledgeable regarding how the home manages the end of life care of patients there is a need identified by both staff and the inspector for further formal training. This should be made available for all grades of staff. With appropriate training and support staff should be able to improve in these areas and the quality of support for patients and their families will be greatly enhanced.

Number of Requirements:	0	Number of Recommendations:	2
		The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)	

5.5 Additional Areas Examined

Environmental issues

The inspector examined a number of patients' bedrooms and communal areas as part of the inspection process. The home was generally clean and well maintained. However, whilst a number of bedrooms had been repainted the home does require further redecoration. Attention should be given to the paintwork in the home including the skirting boards and doors in all areas of the home. This was discussed with the registered manager who agreed and stated it was hoped a redecoration programme would be commenced. Written confirmation of the commencement date and extent of the redecoration programme is to be submitted to RQIA.

Consultation with patients, their representatives, staff and professional visitors

The inspector was able as part of the inspection process to meet with 12 patients individually and to most others in small groups. Comments from patients regarding the quality of care, food and in general the life in the home were very positive. A few comments received are detailed below;

'They are all very good'

'staff listen to your problems and help as much as possible'

'very nice people'

'staff are wonderful'

'like it here, get my washing done for me'

'staff always make my visitor welcome and make her a cup of tea'

Questionnaires were issued to a number of nursing, care and ancillary staff and these were returned during the inspection visit. Some comments received from staff are detailed below;

'staff are very kind at a time like this (bereavement)'

'I have seen staff breaking their hearts over the loss of a resident'

'The residents could do with more activities but we do our best to keep them in high spirits'

One patient representative discussed the quality of care delivery with the inspector and all agreed that they have no concerns in recommending the home and they were very happy with the standards of service provided.

'staff made my relative very welcome'

'very attentive to my..., nothing is a problem for them'

Registration status

RQIA were informed during the inspection that the home had a registration category for three residential care places. Residential care was not reflected on the registration details of the home as retained by RQIA. The registered manager stated the category was added to their registration at the time regulation was undertaken by the Registration and Inspection Unit of the Eastern Health and Social Services Board. This query was investigated by the registration team in RQIA and the 'deeming' application did not evidence the residential care category.

The registered manager was informed an application for the additional category of care was required to be submitted and RQIA would consider the application.

Review of the quality of nursing and other services provided by the home

The review of patients' care records did not evidence all care records were maintained in accordance with NMC guidelines. For example, the assessment of need and evaluation of care plans were not undertaken in a consistent and timely way by all nursing staff. Regular audits of care records should identify any irregularities in the maintenance of care records.

The review of the infection control audits did not evidence that where a shortfall had been identified remedial action had been taken to address the shortfall. These issues were discussed with the registered manager who was informed a robust system for the review of the quality of nursing and other services provided by the home must be implemented.

Regulation 30, notification of death, illness or other events

The review of accident recording did not evidence nursing staffs and managements understanding of what was reportable to RQIA in accordance with Regulation 30, The Nursing Homes Regulations (Northern Ireland) 2005. Accidents or incidents which warranted a submission of a notification to RQIA had not been recognised as reportable and not forwarded. Management must provide training and information to nursing staff. Accident recording should be monitored and validated by the registered manager.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Helen Chambers 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. It is the responsibility of the registered person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

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

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk (non-paperlite) and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 Ref: Regulation 17 (1) Stated: First time To be Completed by: 30 August 2015	The registered person must implement a robust system to review the quality of nursing and other services provided by the home. Audits should be present of the review of: <ul style="list-style-type: none"> • nursing care records • infection control procedures • accident records
	Response by Registered Person(s) Detailing the Actions Taken: New forms have been developed to ensure that Nursing Care records, Infection control procedures and accidents records are audited
Requirement 2 Ref: Regulation 30 Stated: First time To be Completed by: 31 July 2015	The registered person must ensure RQIA are informed of any accident or event which occurs in the home in accordance with the requirement of Regulation 30.
	Response by Registered Person(s) Detailing the Actions Taken: The home will ensure that all accidents or events which occur in the home are reported to the RQIA in accordance with regulation 30
Recommendations	
Recommendation 1 Ref: Standard 4.9 Stated: First time To be Completed by: 31 July 2015	Nursing staff should adhere to professional standards in respect of care records. The registered person should monitor nursing staff adherence to NMC guidelines
	Response by Registered Person(s) Detailing the Actions Taken: Staff Nurses meeting to take place 11/06/2015 this recommendations and all points discussed throughout inspection will be passed on to Nursing staff to ensure that this recommendation is addressed. Home manager will ensure Nursing staff adhere fully to the NMC Guidelines in relation to care records
Recommendation 2 Ref: Standard 19.6 Stated: First time To be Completed by: 30 August 2015	Training on communicating effectively should be provided for staff. The training should be in accordance with DHSSPS 'Breaking Bad News' regional guidelines.
	Response by Registered Person(s) Detailing the Actions Taken: Training has been sourced from appropriately trained individual to ensure all staff are provided with training in Communicating Effectively

Recommendation 3 Ref: Standard 32.1 Stated: First time To be Completed by: 30 August 2015	Training on palliative and end of life care should be provided to staff. Training provided should be in accordance with regional guidance, for example, Gain Palliative Care Guidelines 2013		
	Response by Registered Person(s) Detailing the Actions Taken: Training on palliative and end of life care has been sourced and will be provided to all staff in July 2015		
Recommendation 4 Ref: Standard 32.1 Stated: First time To be Completed by: 30 July 2015	Patients' care records should reflect that individuals' wishes regarding end of life care have been considered, as far as possible.		
	Response by Registered Person(s) Detailing the Actions Taken: This recommendation will be fully addressed at the Nurses Meeting taking place 11/06/2015.		
Registered Manager Completing QIP	Helen Chambers	Date Completed	10/06/2015
Registered Person Approving QIP	Dr Lynas	Date Approved	11/06/2015
RQIA Inspector Assessing Response	Heather Sleator	Date Approved	11/06/15

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