Wheatfield House
RQIA ID: 1307
20 Wheatfield Gardens
Belfast
BT14 7HU

Inspector: Dermot Walsh
Inspection ID: IN021728

Tel: 028 9039 1555
Email: wheathouse1@tiscali.co.uk

# Unannounced Care Inspection
# of
# Wheatfield House

## 12 August 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 August 2015 from 09.40 to 17.15.

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.

### 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 23 March 2015.

### 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** | 4 | 9 |

The total number includes both new and restated requirements and recommendations made at this inspection.

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

## 2. Service Details

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| **Registered Organisation/Registered Person:**<br>Mr Edward McLoughlin | **Registered Manager:**<br>Mr Edward McLoughlin |
| **Person in Charge of the Home at the Time of Inspection:**<br>Mr Edward McLoughlin | **Date Manager Registered:**<br>1 April 2005 |
| **Categories of Care:**<br>NH-LD, NH-LD(E) | **Number of Registered Places:**<br>22 |
| **Number of Patients Accommodated on Day of Inspection:**<br>18 | **Weekly Tariff at Time of Inspection:**<br>£637 - £1083 |

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

During the inspection, the inspector met with eight patients, four care staff, one housekeeper, one cook, one registered nurse and one patient visitor/representative.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- a sample of staff duty rotas
- six patient care records
- accident/notifiable events records
- staff training records
- staff induction records
- policy documentation in respect of communicating effectively, palliative and end of life care
- complaints
- compliments
- best practice guidelines for palliative care and communication

## 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 23 March 2015. The completed QIP was returned and approved by the care inspector.

### 5.2 Review of Requirements and Recommendations from the Last Care Inspection

| Last Care Inspection Statutory Requirements | | Validation of Compliance |
|---|---|---|
| **Requirement 1**<br><br>**Ref:** Regulation 15 (2) (a) and (b)<br><br>**Stated:** First time | The registered person is required to ensure the assessment of need of any patient, including risk assessments evidenced regular review by a registered nurse.<br><br>**Ref: carried forward for review from the previous inspection report.** | **Partially Met** |
| | **Action taken as confirmed during the inspection**:<br>A review of two care records evidenced that some assessment of needs of the patients reviewed were not evaluated on a regular basis | |
| **Requirement 2**<br><br>**Ref:** Regulation 19 (2) Schedule 4 (7)<br><br>**Stated:** First time | The staff duty rota must accurately and fully reflect the hours worked by any staff member and in what capacity.<br><br>**Ref: 9.4** | **Partially Met** |
| | **Action taken as confirmed during the inspection**:<br>The staff duty rota for week commencing 9 August 2015 was reviewed and reflected the capacity all staff members work in however, the hours worked by six members of staff were not fully identified in the duty rota. | |

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| **Requirement 3**<br><br>**Ref:** Regulation 8 (1) (b) (iii)<br><br>**Stated:** First time | The registered manager must be in day to day control of the management of the home. The duty rota must reflect the hours worked by the registered manager, in the home.<br><br>**Ref: 9.4** | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The duty rota for week commencing 9 August 2015 reflected the hours worked by the registered manager in the home. | |
| **Requirement 4**<br><br>**Ref:** Regulation 19 (2) Schedule 4 (21)<br><br>**Stated:** First time | Staff training records, in accordance with regulation 20 (1) (c) (i) must be available for the purpose of inspection, at all times.<br><br>**Ref:9.2** | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Up to date staff training records were available for the purpose of inspection. | |
| **Last Care Inspection Recommendations** | | **Validation of Compliance** |
| **Recommendation 1**<br><br>**Ref:** Standard 12.1<br><br>**Stated:** Second time | Staff should implement a system of stock rotation in freezers and fridges by date stamping all foods and products.<br><br>Staff should ensure food products are stored correctly and packaging is sealed after use.<br><br>**This recommendation has been restated from the previous inspection report.** | **Not Met** |
| | **Action taken as confirmed during the inspection**<br>On the day of inspection there was no evidence of date stamping on any of the foods viewed.<br><br>Open food products had not been sealed and there was evidence of loose food products on the floor of the freezer. | |

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| **Recommendation 2**<br><br>**Ref:** Standard 32.1<br><br>**Stated:** Second time | The cleanliness of the minibus should be included in the auditing process. Where shortfalls are identified the remedial action taken should be detailed. A timeframe for auditing the cleanliness of the minibus should be decided and adhered to.<br><br>**This recommendation has been restated from the previous inspection report.** | **Not Met** |
| | **Action taken as confirmed during the inspection**<br>The last recorded audit of the minibus was noted to have been carried out in April 2015. The minibus was not clean internally on this inspection. | |
| **Recommendation 3**<br><br>**Ref:** Standard 12.4<br><br>**Stated:** First time | The daily menu should be displayed in a suitable format and in an appropriate location, so that patients, and their representatives, know what is available at each mealtime.<br><br>**Ref: 9.1** | **Not Met** |
| | **Action taken as confirmed during the inspection**:<br>There was no menu on display on the day of the inspection. | |
| **Recommendation 4**<br><br>**Ref:** Standard 34.3<br><br>**Stated:** First time | A system should be put in place to ensure that staff have the availability of protective clothing i.e. disposable aprons and gloves, throughout the home, at all times.<br><br>**Ref:9.2** | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Protective clothing i.e. disposable aprons and gloves were available throughout the home. | |

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| **Recommendation 5**<br><br>**Ref:** Standard 25.16<br><br>**Stated:** First time | There should be written accounting and financial control procedures that meet professional standards of good practice and legislative requirements operational in the home. Records should be present of all financial transactions in the home.<br><br>**Ref: 9.3** | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Individual patient accounts were available in the home. Every transaction was signed off by two staff. All receipts matched monies spent. A policy and procedure for financial control was present in the home. A transaction record of all monies given to the kitchen to purchase food products was maintained and all receipts were given to the homes accountant. | |
| **Recommendation 6**<br><br>**Ref:** Standard 5.6<br><br>**Stated:** First time | Patients' nursing care records should reflect the most current information in respect of any patient. When a patient is weighed the actual weight should be transferred to the patient's nursing care record so as an accurate determination of the patient's wellbeing can be made by a registered nurse.<br><br>**Ref: carried forward for review from the previous inspection report.** | **Met** |
| | **Action taken as confirmed during the inspection:**<br>A review of two care records evidenced that the patients had been weighed monthly at least over the past three months and the Malnutrition Universal Screening Tool had been updated and calculated accordingly. | |

## 5.3 Standard 19 - Communicating Effectively

### Is Care Safe? (Quality of Life)

A policy was not available on communication. This was discussed with the registered manager and a recommendation has been made that a policy on communication should be developed. Regional guidance on breaking bad news was available in the home. Discussion with three staff confirmed that they were knowledgeable regarding breaking bad news.

A sampling of staff training records evidenced that 12 staff had completed online training on communicating effectively with patients and their families/representatives within the past year.

**Is Care Effective? (Quality of Management)**

There were no patients on the day of inspection in need of palliative or end of life care. Recording within records included reference to the patient's specific communication needs and actions required to deal with barriers such as language, cognitive ability or sensory impairment.

There was no evidence within two records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs. A requirement is made.

**Is Care Compassionate? (Quality of Care)**

Having observed the delivery of care and staff interactions with patients it was evident that effective communication was well maintained and patients were observed to be treated with dignity and respect. Observation evidenced patients being assisted to redirect their anxieties by staff in a very positive way.

The inspection process allowed for consultation with eight patients individually and others in small groups. Patients who could verbalise their feelings on life in Wheatfield commented positively in relation to the care they were receiving. Patients who could not verbalise their feelings appeared, by their demeanour, to be relaxed and comfortable in their surroundings and with staff.

One patient representative discussed care delivery and confirmed that the care their son was getting made him happy which in turn made her happy. Some other patient representative comments are recorded in section 5.4.1 below.

**Areas for Improvement**

The registered manager should develop a policy and procedure on communication in line with best practice guidelines and make reference to regional guidance on breaking bad news.

The registered manager should involve patients and/or patient representatives in the assessment, planning and evaluation of care or document a reason if this is not possible.

| **Number of Requirements:** | **1** | **Number of Recommendations**: | **1** |
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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 not available in the home. There was no best practice guidance such as the Gain Palliative Care Guidelines, November 2013, available in the home. A recommendation has been made.

A review of training records evidenced that four staff had completed training in respect of palliative care and six staff had completed training on grief and loss within the last year. This was discussed with the manager who confirmed remaining staff would complete online palliative care training.

Discussion with the registered manager confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the registered manager and four staff 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.

There was no palliative care link nurse identified for the home.

**Is Care Effective? (Quality of Management)**

Discussion with the registered manager and staff evidenced that environmental factors had been considered. Management had made reasonable arrangements for relatives/ representatives to be with patients who had been ill or dying.

A review of notifications of death to RQIA during the previous inspection year, were deemed to be appropriate.

Two care records evidenced that patient individual needs and wishes in respect of aspects of daily living were appropriately recorded. However, there was limited evidence that end of life issues were discussed.

**Is Care Compassionate? (Quality of Care)**

Discussion with staff and a review of care records evidenced that patients and/or their representatives had not been consulted in respect of their cultural and spiritual preferences regarding end of life care.

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.

Four staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death.

**Areas for Improvement**

The registered manager should develop a policy and procedure on palliative and end of life care in line with best practice guidelines.

It is recommended that end of life arrangements for patients are discussed and documented as appropriate and that they include patients' wishes in relation to their religious, spiritual and cultural needs.

| **Number of Requirements:** | **0** | **Number of Recommendations:** | **2*** |
|---|---|---|---|

*1 recommendations made are stated under Standard 19 above

## 5.5 Additional Areas Examined

### 5.5.1. Consultation with patients, staff and relatives

Overall, the feedback from the patients, representatives and staff indicated that safe, effective and compassionate care was being delivered in Wheatfield.

A few patient comments are detailed below:
'I really like it here.'
'I love it here.'
'It's good.'

One relative stated that she was down every day to see her son and she felt that Wheatfield was very family orientated. The relative said her son was very happy living in Wheatfield which made her happy.

In general, the staff were satisfied and enjoyed working in Wheatfield.

A few staff comments are as follows:
'I love it here. We're like one big family.'
'Wheatfield is a great place to work. The care of our clients is utmost in our work.'
'I love getting to know all the personalities.'
'We all get on very well, there's great teamwork here.'

### 5.5.2. Infection Prevention and Control and the Environment

Inspection of the home confirmed that rooms and communal areas were clean and spacious. However, a range of matters were identified that were not managed in accordance with infection prevention and control guidelines:

- not all signage and noticeboards within the home were laminated/treated to ensure the surface may be cleaned
- the arm of a patients chair in an identified room was ripped and a second chair in the room was missing the top left wing
- the type of shelving used in the home in the identified storage area did not have a cleanable surface
- there was inappropriate storage and clutter in identified rooms in the home
- a handrail in an identified bathroom was rusting

The above areas for improvement were discussed with the registered manager on the day of inspection. The registered manager agreed to follow up and address the issues identified. A recommendation has been made for management systems to be in place to ensure the home's compliance with best practice in infection prevention and control.

### 5.5.3. Staff Induction

A review of the staff induction programme showed it to be non-role specific for staff nurses and care assistants. This was discussed with the registered manager who agreed a role specific induction would benefit staff more than a general induction. A recommendation is made.

### 5.5.4. Documentation

A review of two care records evidenced a deficit in the following areas:

- not all risk assessments were completed fully or evaluated monthly for example Continence, Braden
- there was no record of patient/relative involvement in the assessment or care planning process
- not all identified risks had a care plan developed for example; incontinence, aggression, anxiety, diabetes. A requirement has been made
- not all care plans had been reflected in practice for example two hourly night checks
- a record of bowel elimination was poorly recorded in the daily care records and did not reflect the Bristol Stool Score. A recommendation has been made
- communication between staff and patients relatives/representatives was recorded sporadically in the patients' progress notes

These issues were discussed with the registered manager who agreed to address all issues with relevant staff.

### 5.5.5. Activities

Activities such as arts and crafts were carried out in the home on Monday, Tuesday, Thursday and Friday. On Wednesday and Saturday and Sunday patients who can or want too are taken on bus runs to different locations such as Bangor or Belfast for shopping and/or coffee for example.

### 5.5.6. Staff Meetings

Formal staff meetings were not carried out regularly. This was discussed with the registered manager who agreed staff meetings should be carried out at least three monthly. These meeting should have an agenda, a list of attendees, have minutes taken and the minutes of the meeting be made available for all staff to read.

## 6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with registered manager Mr Edward McLoughlin as part of the inspection process. The timescales commence from the date of inspection.

The registered 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 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 | |
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| **Statutory Requirements** | |
| **Requirement 1**<br><br>**Ref:** Regulation 15 (2) (a) (b)<br><br>**Stated:** Second time<br><br>**To be Completed by:** 15 September 2015 | The registered person is required to ensure the assessment of need of any patient, including risk assessments evidenced regular review by a registered nurse.<br><br>**Ref: Stated from previous inspection** |
| | **Response by Registered Person(s) Detailing the Actions Taken:** The registered manager has discussed with his qualified nursing staff the importance of ensuring that an assessment of need of need of any resident, including risk assessments are reviewed regularly by a registered nurse. A comprehensive review of all residents care plans has commenced and assessment of individual need carried out and documented appropriatley. |
| **Requirement 2**<br><br>**Ref:** Regulation 19 (2) Schedule 4 (7)<br><br>**Stated:** Second time<br><br>**To be Completed by:** 15 September 2015 | The staff duty rota must accurately and fully reflect the hours worked by any staff member and in what capacity.<br><br>**Ref: Stated from previous inspection** |
| | **Response by Registered Person(s) Detailing the Actions Taken:** The staff duty rota accuratley details the names, designations and hours worked by each member of staff that can be observed on a weekly basis. |
| **Requirement 3**<br><br>**Ref:** Regulation 15 (1) (a) (b) (c)<br><br>**Stated:** First time<br><br>**To be Completed by:** 30 September 2015 | The registered person must ensure that all patient care risk assessments are carried out and where possible involve patients/representatives.<br><br>**Ref: Section 5.2** |
| | **Response by Registered Person(s) Detailing the Actions Taken:** The registered person will ensure that all care risk assessments carried out, will, where possible, involve patients and or their representatives. |
| **Requirement 4**<br><br>**Ref:** Regulation 16 (1) (2) (b)<br><br>**Stated:** First time<br><br>**To be Completed by:** 30 September 2015 | The registered person must ensure that any identified patient need has a care plan in place and this plan is reviewed and evaluated appropriately.<br><br>**Ref: Section 5.4.4** |
| | **Response by Registered Person(s) Detailing the Actions Taken:** The home now ensures that any identified patient need has a care plan in place and this will be clearly documented,reviewed and evaluated appropriatley. |

| Recommendations | |
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| **Recommendation 1**<br><br>**Ref:** Standard 12.1<br><br>**Stated:** Third time<br><br>**To be Completed by:**<br>15 September 2015 | Staff should implement a system of stock rotation in freezers and fridges by date stamping all foods and products.<br><br>Staff should ensure food products are stored correctly and packaging is sealed after use.<br><br>**Ref: Stated from previous inspection** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Kitchen staff have been reminded of their responsibilities involving the rotation of stock in the freezers and fridges and of date stamping all food products. The home has purchased food stickers suitable for the catering industry, and staff have been told to use these on all fresh / frozen foods. Laminated posters have also been purchased and are easily visible at eye level on cupboards and on the fridges, reminding them to adhere to the homes system of stock rotation. Staff are remiinded of the importance of storing and packaging food correctly, and again visual aids are in place to remind staff to carry this out. An auditing process has also been implemented by the home to monitor this. |
| **Recommendation 2**<br><br>**Ref:** Standard 32.1<br><br>**Stated:** Third time<br><br>**To be Completed by:**<br>15 September 2015 | The cleanliness of the minibus should be included in the auditing process. Where shortfalls are identified the remedial action taken should be detailed. A timeframe for auditing the cleanliness of the minibus should be decided and adhered to.<br><br>**Ref: Stated from previous inspection** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>The bus drivers of the minibus are required to clean the bus of any rubbish at the end of each journey. Any spillages or marks must be cleaned immediatley. The minibus must be cleaned internally at least once a week , including hoovering and washing of the floor, cleaning of the internal windows, cleaning of the dash, doors and all seats. There has been a new policy implemented that incorporates infection prevention and control. An auditing system has also commenced, and a file, recording the auditing process and any shortfalls can be accessed in the managers office. The bus drivers have been reminded of this. |

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| **Recommendation 3**<br><br>**Ref:** Standard 12.4<br><br>**Stated:** Second time<br><br>**To be Completed by:**<br>15 September 2015 | The daily menu should be displayed in a suitable format and in an appropriate location, so that patients, and their representatives, know what is available at each mealtime.<br><br>**Ref: 9.1**<br><br>**Ref: Stated from previous inspection** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Photographs and menus of all meals cooked, prepared and served in the home, in a manner that is familiar to the residents and their representatives, are in place in the home, and are displayed on a daily basis, in the dining room where the residents have access and are visible that reflects the meals that are being served in the home on that day. |
| **Recommendation 4**<br><br>**Ref:** Standard 36 Criteria (1) (2)<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>15 September 2015 | The registered person should ensure that a policy on communication is developed which includes reference to current best practice guidelines.<br><br>A policy on palliative and end of life care and a policy on death and dying should be developed in line with current regional guidance, such as GAIN (2013) Palliative Care Guidelines.<br><br>A system to implement the policies should confirm that all relevant staff have read the document with evidence of staff signature and date.<br><br>**Ref: Section 5.3** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>A policy on communication is being developed by the home that aims to include reference to the current best practice guidelines.<br>A policy on death and dying has been developed and is in place in the home that is inline with current regional guidance including GAIN (2013) Palliative care guidelines. This has been printed and put in place in the clinical room for all staff to access. A separate sheet has been attached requesting staff signatures as evidence of having read the document and same dated. A second copy has been put in the Homes policy file that can be accessed in the office. |
| **Recommendation 5**<br><br>**Ref:** Standard 20 Criteria (2)<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>30 October 2015 | The registered person should ensure that end of life arrangements for patients are discussed and documented as appropriate, and include patients' wishes in relation to their religious, spiritual and cultural needs.<br><br>**Ref: Section 5.3** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>The registered manager will ensure that end of life arrangements for residents are discussed and documented as appropriate, including residents' wishes in relation to their religious, spiritual and cultural needs. |

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| **Recommendation 6**<br><br>**Ref:** Standard 46 Criteria (1) (2)<br><br>**Stated:** First time | The registered person should ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control.<br><br>Particular attention should focus on the areas identified on inspection.<br><br>**Ref: Section 5.4.2** |
| **To be Completed by:**<br>15 September 2015 | **Response by Registered Person(s) Detailing the Actions Taken:**<br>With reference to section 5.4.2, the registered person will ensure that robust systems are in place that will ensure compliance with best practice in infection prevention and control, specifically focusing on the areas as identified on inspection. |
| **Recommendation 7**<br><br>**Ref:** Standard 39 Criteria (1) (4)<br><br>**Stated:** First time | The registered person should ensure the induction programme for newly appointed staff is role specific in meeting the needs to fulfil the post.<br><br>**Ref: Section 5.4.3** |
| **To be Completed by:**<br>30 September 2015 | **Response by Registered Person(s) Detailing the Actions Taken:**<br>The induction programme for newly appointed staff has been reviewed and is now more role specific in meeting the staffs needs in order to fufil the post |
| **Recommendation 8**<br><br>**Ref:** Standard 21 Criteria (11)<br><br>**Stated:** First time | The registered person should ensure that bowel function, reflective of the Bristol Stool Chart is recorded on admission as a baseline measurement and thereafter in the patients'/residents' daily progress records.<br><br>**Ref: Section 5.4.4** |
| **To be Completed by:**<br>30 September 2015 | **Response by Registered Person(s) Detailing the Actions Taken:**<br>The registered manager will ensure that bowel function, reflective of the Bristol Stool Chart is recorded on each residents admission as a baseline measurement and thereafter in the residents' daily progress records. New documentation has been developed by the home to ensure this is accuratley recorded in the residents care plans |

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| **Recommendation 9**<br><br>**Ref:** Standard 41<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>15 October 2015 | The registered person should ensure staff meetings occur at least three monthly.<br><br>**Ref: Section 5.4.6** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Planned dates for staff meetings have been distributed to the staff and are on display on the notice boards in the main hall. All staff are required to attend. These will occur at least three monthly and will include an agenda,register of attendance including staff signatures, minutes of what is discussed and actions following any issues raised at the meetings. |

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| **Registered Manager Completing QIP** | Edward McLoughlin | **Date Completed** | 02.10.2015 |
| **Registered Person Approving QIP** | Edward McLoughlin | **Date Approved** | 02.10.2015 |
| **RQIA Inspector Assessing Response** | Dermot Walsh | **Date Approved** | 23.10.2015 |

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