Unannounced Care Inspection Report
3 April 2017

Clonlee

Type of Service: Nursing Home
Address: 132 Belfast Road, Muckamore, Antrim, BT41 2ET
Tel no: 028 9446 1166
Inspector: Sharon McKnight

1.0 Summary

An unannounced inspection of Clonlee took place on 3 April 2017 from 09:30 hours to 16:50 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies, staff training and development and the environment. Observation of the delivery of care and discussion with patents and staff evidenced that patients' needs were met by the levels and skill mix of staff on duty.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. We were assured that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice.

Concerns were identified in the delivery of safe care, specifically in relation to the storage of cleaning chemicals and the preservation of fire escapes; two requirements have been made. Areas for improvement were identified with staff recruitment and the systems for monitoring registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC). Two recommendations were made. Compliance with the requirements and recommendation will further drive improvements in this domain.

Is care effective?

A review of three patient care records evidenced that a range of validated risk assessments were completed at the time of admission to the home. A comprehensive assessment of need had not been completed for one patient and whilst care plans were in place to direct the care required for patients they had not been completed at the time of admission. A recommendation was made.

We reviewed the management of wound care and enteral feeding. Care records contained details of the prescribed regime. Areas for improvement to ensure that care records evidenced the prescribed care were identified and two recommendations made.

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

Is care compassionate?

We arrived in the home at 09:30 and were immediately greeted by staff who were helpful and attentive. Patients were enjoying their breakfast in the dining room or in their bedrooms as was their personal preference; some patients remained in bed, again in keeping with their personal preference.
All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. Discussion with patients individually and with others in smaller groups, confirmed that living in Clonlee was a positive experience.

We reviewed the provision of activities and observed that the activity programme for April 2017 had been delivered to each patients' bedroom. There was wide variety of activities planned throughout April 2017 with a focus on Easter festivities. The activity programme included events to meet the patients' religious wishes. There was also time in the programme for individual activities.

Ten relative questionnaires were issued by RQIA; one was returned. The relative was very satisfied with the care provided across the four domains. A number of their comments are included in the report.

Ten questionnaires were issued to nursing, care and ancillary staff; six were returned prior to the issue of this report. The staff members were very satisfied or satisfied with the care provided across the four domains.

There were no areas for improvement identified in this domain.

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

The registered manager's hours were clearly recorded in the home. Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them contact as required.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided.

Unannounced quality monitoring visits were completed on a monthly basis by a person independent of the home. Copies of the quality monitoring visits were available in the home. It was recommended that any areas identified for improvement should be reviewed on the next visit and comment on the action taken included in the report.

The term 'patients' is used to describe those living in Clonlee which provides nursing care and residential care for one identified individual.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**2**	**6**

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

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 5 September 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

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

2.0 Service details

Registered organisation/registered person: Hutchinson Homes Ltd Janet Montgomery	**Registered manager:** Perpetua Latta
Person in charge of the home at the time of inspection: Perpetua Latta	**Date manager registered:** 1 April 2005.
Categories of care: NH-I, NH-LD, RC-PH(E), NH-PH There may be a maximum of 8 patients in category NH-PH, category RC-PH (E) for 1 identified individual only. The home is also approved to provide care on a day basis to 4 persons.	**Number of registered places:** 53

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection we met with 12 patients individually and with the majority in small groups, one registered nurse, three care staff, two domestic staff and the relatives of one patient.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

Questionnaires were also left in the home to facilitate feedback from relatives and staff not on duty. Ten, staff and patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- Duty rota for all staff for the week of the inspection
- Records confirming registration of staff with the Nursing and Midwifery Council (NMC)and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment files
- competency and capability assessments of nurses
- staff register
- five patient care records
- client satisfaction survey
- record of staff meetings
- patient register
- complaints record
- record of audits
- RQIA registration certificate
- certificate of public liability
- monthly monitoring reports

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 05 September 2017

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 02 June 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 41 **Stated:** First time	It is recommended that the registered nurse in charge of the home is clearly identified on the staff duty roster when the registered manager is off duty.	**Met**
	Action taken as confirmed during the inspection: A review of the staff duty roster for the week of the inspection evidenced that the registered nurse in charge of the home when the registered manager was off duty was clearly identified. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 38 **Stated:** First time	It is recommended that a record of the date the Access NI certificates are checked should be maintained to evidence that the registered manager had checked the certificate prior to the candidate commencing employment.	**Met**
	Action taken as confirmed during the inspection: The recruitment records reviewed included the date the Access NI certificates had been checked and evidenced that the registered manager had checked the certificate prior to the candidate commencing employment. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 35.4 **Stated:** First time	It is recommended that the record of audits undertaken should include**:** • the date and signature of the person undertaking the audit should be recorded • there should be traceability of which files have been audited • where areas for improvement are identified there should be evidence of re audit to check compliance and drive improvement	**Met**
	Action taken as confirmed during the inspection: A review of audit records evidenced that this recommendation has been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for week commencing 2 April 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily. An activity co-ordinator was available three days per week to deliver activities. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; six were returned following the inspection. All of the respondents answered 'yes' to the question "Are there sufficient staff to meet the needs of the patients?"

Patients and relatives spoken with during the inspection commented positively regarding the staff and care delivery. Patients were satisfied that when they required assistance staff attended to them in timely manner. We sought relatives' opinion on staffing via questionnaires; one completed questionnaire was returned. The respondent indicated that staff had enough time to care for their relative and provided the following comment:

"Could not be happier with the care and safety provided by all the staff."

The nurse in charge of the home was identified on the staffing rota. A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the registered manager. The assessments were signed by the registered manager to confirm that the assessment process has been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. There was no information recorded to explain gaps in employment history. This was discussed with the registered manager and a recommendation was made.

Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained.

A record of staff including their name, address, date of birth, position held, contracted hours, date commenced and date position was terminated (where applicable) was held in a staff register and provided an overview of all staff employed in the home. This additional detail supplemented the information contained in the staff recruitment files as required in accordance with regulation 19(2), schedule 4(6) of The Nursing Homes Regulations (Northern Ireland) 2005.

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the registered manager. A review of the records of NMC registration evidenced that all of the nurses on the duty rota for the week of the inspection were included in the NMC check. However the registration of two registered nurses was due to be renewed since the last check had been completed. At the time of the inspection it had not been confirmed if these nurses had renewed

their registration. We requested that the registered manager, as a matter of urgency, provide confirmation of the NMC registration status of these nurses. Prior to the conclusion of the inspection confirmation was received that the nurses had a live registration. The systems in place to monitor the registration status of registered nurses with the NMC should be reviewed to ensure that are effective. A recommendation was made.

The registered manager confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

We discussed the provision of mandatory training and the registered manager explained that all training was delivered face to face. The registered manager had identified that compliance with mandatory training in 2016 required improvement. They explained that dates for first aid, adult safeguarding and infection prevention and control have been arranged for 6 and 12 April 2017 and that they were prioritising staff who had not attended in 2016. We were assured that there were systems in place to ensure all staff received mandatory training. It was agreed that we would review compliance at the next scheduled inspection to ensure improvement has been achieved.

The registered manager and staff spoken were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified. Records evidenced that the registered manager had attended training on the role of the safeguarding champion on 8 February 2017 and was booked to attend further training on the new regional safeguarding policy and procedure in April 2017.

Review of five patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since January 2017 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Patients spoken with were complimentary in respect of the home's environment. In a number of bathrooms/toilets throughout the home containers of cleaning chemicals were observed; they were not stored in a lockable cupboard; a sluice room was observed to be unlocked and cleaning chemicals were not stored in a lockable cupboard. Cleaning chemicals must be stored securely. A requirement has been made.

Infection prevention and control measures were adhered to. We spoke with two members of housekeeping staff who were knowledgeable regarding the National Patient Safety Agency (NPSA) national colour coding scheme for equipment such as mops, buckets and cloths. Sluice rooms and bathroom/toilets were observed to be clutter free and well organised. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately.

We discussed the management of fire safety with the registered manager who confirmed that fire checks were completed weekly. The weekly testing of the fire alarm was completed during the inspection. It was good to note that patients, staff and visitors were made aware that the

fire alarms were being tested prior to the alarms being activated. Urgent action was required in relation to the storage of an upholstered chair under a stairwell which was in close proximity to an external fire exit. There also a significant number of packages of continence products stored under another stairwell. These actions were discussed with the registered manager and are required to be addressed without delay to ensure that flammable items or materials are not stored at any time adjacent to escape route staircases. A requirement has been made.

Areas for improvement

Recruitment records should include information to explain gaps in employment history**.**

The systems in place to monitor the registration status of registered nurses with the NMC must be effective.

Cleaning chemicals must be stored securely.

Flammable items or materials are not stored at any time adjacent to escape route staircases.

Number of requirements	2	Number of recommendations	2

4.4 Is care effective?

Review of three patient care records evidenced that a range of validated risk assessments were completed at the time of admission to the home. A comprehensive assessment of need had not been completed for one patient. Care plans were in place to direct the care required however, they had not been completed for a number of days, or for one patient a number of weeks, following admission. An initial plan of care based on the pre admission assessment and referral information should be in place within 24 hours of admission. Detailed plans of care should be generated from a comprehensive assessment of need which is commenced on the day of admission and completed within five days. A recommendation was made.

We reviewed the management of wound care for one patient. Care records contained details of the prescribed regime. We reviewed the delivery of wound care for the period 4 February to 3 April 2017. Care records reflected that wound care was being delivered by the registered nurses in the home, the community podiatrist and during visits to the out patients department of the local hospital. Dressing changes were not consistently recorded. We were unable to evidence what wound care had been delivered during the period 4 to 20 February 2017 and 13 to 20 March 2017. Whilst the records evidenced that there was a multidisciplinary approach to wound care, in accordance with NMC guidelines, contemporaneous nursing records must be kept of all nursing interventions, activities and procedures carried out in relation to each patient. Where there is a multidisciplinary approach to the delivery of wound care records should reflect every occasion when dressings are renewed. A recommendation was made.

We examined the management of enteral feeding for two patients. The dietetic reports which detailed the prescribed nutritional regime were available in one of the two patient's care records reviewed. The importance of ensuring that the most recent report, including the current prescribed regime, are stored with the patients' current care records and readily available to staff was discussed with the registered manager.

The administration of the prescribed enteral feed was recorded on the medication administration record. The time the feed was commenced and completed was not consistently

recorded. The administration of water via the enteral route was also recorded on the medication administration record. The records did not evidence if the totals were being reconciled on a 24 hours basis to ensure compliance with the prescribed regime. The registered manager should review the recording of prescribed enteral feeding regimes to ensure that it is in accordance with best practice. Daily fluid intake should be reconciled on a 24 hours basis to evidence that the prescribed fluid intake has been administered each day. A recommendation was made.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), SALT and dieticians.
The registered manager confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

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

The registered manager confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed. The most recent staff meeting was held on 22 February 2017 with care staff.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a patient register. This registered provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas for improvement

A comprehensive assessment of need should be commenced on the day of admission and completed within five days.

An initial plan of care based on the pre admission assessment and referral information should be in place within 24 hours of admission. Detailed plans of care should be generated from the completed comprehensive assessment.

Contemporaneous nursing records must be kept of all nursing interventions, activities and procedures carried out in relation to each patient. Where there is a multidisciplinary approach to the delivery of wound care records should reflect every occasion when dressings are renewed.

The recording of prescribed enteral feeding regimes should be reviewed to ensure that it is in accordance with best practice. Daily fluid intake should be reconciled on a 24 hours basis to evidence that the prescribed fluid intake has been administered each day.

Number of requirements	0	Number of recommendations	3

4.5 Is care compassionate?

We arrived in the home at 09:30 and were immediately greeted by staff who were helpful and attentive. Patients were enjoying their breakfast in the dining room or in their bedrooms as was their personal preference; some patients remained in bed, again in keeping with their personal preference.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Discussion with patients individually and with others in smaller groups, confirmed that living in Clonlee was a positive experience. One patient explained that the garden furniture and ornaments outside their bedroom window had been brought from home. It was obvious from the patient's conversation the pleasure that having these personal items to enjoy brought them.

All of the patients spoke highly of the staff. It was evident that patients knew staff and the registered manager well. Patients and staff confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

We reviewed the provision of activities and observed that the activity programme for April 2017 had been delivered to each patients bedroom; some patients had displayed their programme on their wall commenting that it help to remind them when there was something that the particularly wanted to participate in. Another patient commented that whilst they didn't join in with most of the activities there were certain events they enjoyed and it was good to know when these were planned. There was wide variety of activities planned throughout April 2017 with a focus on the Easter festivities. The activity programme included events to meet the patients' religious wishes. There was also time in the programme for individual activities. One patient informed us that they were looking forward to having a manicure and their nails painted in the afternoon in preparation for a trip out with their family the following day.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives on the running of the home. A satisfaction survey was conducted annually by the home. Surveys were sent out in January 2017; 17 out of 50 were returned. The registered manager advised that the results were currently being collated and would be displayed in the home in the next few weeks. We reviewed the completed surveys. The following are examples of comments provided:

"Very relieved that my mother is so well looked after."
"Thank you to all the staff for being so caring and supportive…this meant a lot to me and the rest of the family knowing mum is safe and secure and having the best care."

Ten relative questionnaires were issued; one was returned within the timescale for inclusion in this report. The relative was very satisfied with the care provided across the four domains. The following comments were provided:
"Care is very effective. Staff are always willing to help if there is ever any cause to. They are always pleasant and very approachable."
"…The staff always make time for her and always treat her with dignity. They take time to chat to her and have conversation with her, this is very important."
"The manager always has a friendly word when you go in."

Ten questionnaires were issued to nursing, care and ancillary staff; six were returned prior to the issue of this report. The staff members were very satisfied or satisfied with the care provided across the four domains. One staff member commented that "sometimes there could be a bit more communication between staff." Overall they were very satisfied that care was effective.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

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

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

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required.

Discussion with the registered manager and review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

The registered manager confirmed that monthly audits were completed, for example care records and infection prevention and control. The records of audit evidenced that any identified areas for improvement had been reviewed to check compliance and drive improvement

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

Review of records evidenced that quality monitoring visits were completed on a monthly basis by a person independent of the home. Recommendations were made within the report to address any areas for improvement. The report of the subsequent visit did not always include evidence of a review of the previous areas for improvement. A recommendation was made. Copies of the quality monitoring visits were available in the home.

Areas for improvement have been identified in the safe and effective domains with regard to the safe storage of cleaning fluids, fire safety, staff recruitment and monitoring of staff registration, care records and the monthly monitoring visits. These areas for improvement were discussed with the registered manager at the conclusion of the inspection. Compliance with these requirements and recommendations will further drive improvements in the quality of care delivered in the home.

Areas for improvement

Recommendations made as a result of the quality monitoring visits should be reviewed on the next visit and comment on the action taken included in the report.

Number of requirements	0	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Perpetua Latta, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation14(2)(c) **Stated:** First time **To be completed by:** 1 May 2017	The registered provider must ensure that unnecessary risks to the health and safety of patients are identified and so far as possible eliminated. Cleaning chemicals must be stored securely. **Ref section 4.3**
	Response by registered provider detailing the actions taken: Reminder to all staff about the storage of chemicals, new lockable cupboards purchased for the Home
Requirement 2 **Ref:** Regulation 27(4)(c) **Stated:** First time **To be completed by:** 1 May 2017	The registered provider must ensure that flammable items or materials are not stored at any time adjacent to escape route staircases. **Ref section 4.3**
	Response by registered provider detailing the actions taken: On the day of inspection there had been a donation of incontinence pads that had not been stored in the proper cupboard, as a rule all items have their own storage space
Recommendations	
Recommendation 1 **Ref**: Standard 38.3 **Stated:** First time **To be completed by:** 1 May 2017	The registered provider should ensure that recruitment records include information to explain gaps in employment history**.** **Ref section 4.3**
	Response by registered provider detailing the actions taken: In order that this requirement will not be over looked in the future, a note will be made on the interview questions.
Recommendation 2 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 1 May 2017	The registered provider should ensure that the systems in place to monitor the registration status of registered nurses with the NMC are effective. **Ref section 4.3**
	Response by registered provider detailing the actions taken: To ensure this is not overlooked it will be reviewed monthly, and relevant nurses's audited. All nursing staff employed within Home only work within the home and have direct debit payments to NMC

Recommendation 3 **Ref**: Standard 4.1 **Stated:** First time **To be completed by:** 1 May 2017	The registered provider should ensure that a comprehensive assessment of need is commenced on the day of admission and completed within five days. An initial plan of care based on the pre admission assessment and referral information should be in place within 24 hours of admission. Detailed plans of care should be generated from the completed comprehensive assessment. **Ref section 4.4**
	Response by registered provider detailing the actions taken: Trained staff made aware of above point and with be audited monthly
Recommendation 4 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 1 May 2017	The registered provider should ensure that in accordance with NMC guidelines, contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each patient. Where there is a multidisciplinary approach to the delivery of wound care records should reflect every occasion when dressings are renewed. **Ref section 4.4**
	Response by registered provider detailing the actions taken: Trained staff made aware of above statement and the NMC guidelines and weekly assessments recorded as well as record of dressing renewal
Recommendation 5 **Ref**: Standard 4.8 **Stated:** First time **To be completed by:** 1 May 2017	The registered provider should review the recording of the administration of prescribed enteral feeding regimes to ensure that it is in accordance with best practice. Daily fluid intake should be reconciled on a 24 hours basis to evidence that the prescribed fluid intake has been administered each day. **Ref section 4.4**
	Response by registered provider detailing the actions taken: Fluid balance chart ammended for residents with PEG feeding and more accurate records maintained.

Recommendation 6 **Ref**: Standard 35.7 **Stated:** First time **To be completed by:** 1 May 2017	The registered provider should ensure that the recommendations made as a result of the quality monitoring visits are reviewed on the next visit and comment on the action taken included in the report. **Ref section 4.6**
	Response by registered provider detailing the actions taken: Above statement discussed with the regulation 29 inspector and please find attached to this report her response

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

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