Unannounced Care Inspection Report
24 May 2016

Queenscourt

Address: 36 Doagh Road, Ballyclare, BT39 9BG
Tel No: 02893341472
Inspector: Sharon Mc Knight

1.0 Summary

An unannounced inspection of Queenscourt took place on 24 May 2016 from 09:35 hours to 16:35 hours.

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

Is care safe?
The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. A general inspection of the home confirmed that the premises and grounds were well maintained.

Areas for improvement were identified with care records, the decision making for restrictive practice, the condition of identified furniture and the unsupervised operation of the laundry. Four recommendations were made.

Is care effective?

Evidenced gathered during this inspection confirmed that there were systems and processes in place to ensure that that the outcome of care delivery was positive for patients. We examined the systems in place to promote effective communication between staff, patients and relatives and were assured that these systems were effective. Patients and staff were of the opinion that the care delivered provided positive outcomes.

Deficits were identified with the standard of record keeping; two requirements were made with regard to the assessment of patient need and the creation and review of care plans. Areas for improvements were also identified within the care records and the auditing of records; four recommendations were made.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully. Staff were also observed to be taking time to reassure patients as was required from time to time. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding issues affecting them. Patients spoken with commented positively in regard to the care they received.

There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

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

There was evidence of good leadership in the home and effective governance arrangements.

There were no areas of improvement identified in the domain of well led.

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**	**8**

Details of the QIP within this report were discussed with Mrs Valerie Reynolds, 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 announced estates inspection on 12 November 2015. Other than those actions detailed in the previous QIP there were no further actions required. 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: Eoghain King	**Registered manager:** Valerie Reynolds
Person in charge of the home at the time of inspection: Valerie Reynolds	**Date manager registered:** 17 February 2016
Categories of care: **NH-LD, NH-LD(E)**	**Number of registered places:** 43

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 eight patients individually and with the majority of others in small groups, two registered nurses and three care staff.

Ten questionnaires were issued to relatives and staff with a request that they were returned within one week from the date of this inspection.

The following information was examined during the inspection:

- three patient care records
- staff duty roster
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- complaints and compliments records
- incident and accident records
- records of audit
- records of staff meetings
- records of patient meetings
- reports of monthly visits undertaken in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 12 November 2015.

The most recent inspection of the home was an announced estates inspection. The completed QIP was returned and approved by the estates inspector and will be validated during their next inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 8 September 2015.

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 27 **Stated:** Third time **To be Completed by:** 31 December 2015	The registered person shall, having regard to the number and needs of the patients, ensure that- The premises to be used as the nursing home are of sound construction and kept in a good state of repair externally and internally. The registered person must ensure that the remaining patients' bedrooms and the corridor walls on the first floor have been repainted.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that a programme of redecoration had recently been completed. A general inspection of the home evidenced that the décor in the home was tastefully completed and in good repair. This requirement has been met.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 20.1 **Stated:** First time **To be Completed by:** 31 October 2015	The registered manager should review the policies and procedures on the management of palliative and end of life care to ensure they reflect current best practice guidance such as the Gain Palliative Care Guidelines, November 2013.	**Met**
	Action taken as confirmed during the inspection: A review of the home policies evidenced that this recommendation has been met.	
Recommendation 2 **Ref**: Standard 32.5 **Stated:** First time **To be Completed by:** 30 September 2015	The registered manager should ensure that a written protocol has been developed for timely access to any specialist equipment or drugs out of hours.	**Met**
	Action taken as confirmed during the inspection: A copy of the protocol for timely access to any specialist equipment or drugs out of hours was available in the home. This recommendation has been met.	

Recommendation 3 **Ref**: Standard 32.3 **Stated:** First time **To be Completed by:** 30 September 2015	The registered manager should ensure that a palliative care link nurse has been identified for the home.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that a registered nurse has been identified as a palliative care link nurse. The minutes of the staff meeting held on 13 January 2016 confirmed that the issue had been discussed with the registered nurses. This recommendation has been met.	
Recommendation 4 **Ref**: Standard 32 **Stated:** First time **To be Completed by:** 30 September 2015	The registered manager should review the arrangements to support staff following the death of a patient. **Ref: Section 5.4**	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed, that where appropriate, they meet with staff following the death of a patient and offer support through reflective practice. The home also has access to a counselling service for staff. Staff spoken with were satisfied that they were supported following the death of a patient.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and advised that these levels were subject to regular review to ensure the assessed needs of the patients were met. The registered manager provided examples of the indicators they used to evidence that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for week commencing 22 May 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff and the activity leader, staffing rosters confirmed that administrative, maintenance, catering, domestic and laundry staff were on duty daily. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Observation of care delivery and responses by staff to requests made by patients evidenced that care was delivered in a timely manner.

The registered nurses spoken with were aware of who was in charge of the home when the registered manager was off duty. The nurse in charge was clearly identified on the staffing roster. The registered manager confirmed that a competency and capability assessment was completed with all nurses who were given the responsibility of being in charge of the home in the absence of the registered manager.

Discussion with the registered manager and a review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed. The registered manager was knowledgeable regarding the management of the Northern Ireland Social Care Council (NISCC) registration process for newly employed care staff.

The recruitment procedures were discussed with the registered manager who confirmed that recruitment records were maintained by the Human Resources (HR) administrator. We met with them and reviewed two personnel files. One file contained two references; however neither were from the employee's most recent employer; all of the other records required were maintained.

The second file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Following discussion with the HR administrator we were assured that they were knowledgeable of the information and documentation required and it was agreed that the required reference would be obtained. Confirmation was received by electronic mail on 9 June 2016 that this reference had been received.

The record maintained of Access NI checks was reviewed. The records included the date the certificate was issued, the registration number of the certificate and that date the certificate was checked by the home. Records evidenced that the outcome of the Access NI check had been confirmed prior to the candidate commencing employment.

Discussion with staff and a review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The programme included a written record of the areas completed and the signature of the person supporting the new employee. The induction programme reviewed was ongoing. The registered manager confirmed that on completion of the induction programme they would signed the record to confirm that the induction process had been satisfactorily completed. We met with a member of staff who was completing their period of induction. They explained that they were working supernumerary for one week and were twinned each day with an experienced member of staff for support. The member of staff spoke positively regarding the support they were receiving and the effectiveness of the induction process.

Training was available via an e learning system known as "EVO training." There were nine mandatory training sessions which staff were required to complete. There was also a range of optional training modules for staff. Training opportunities were also provided by the local health and social care trust. There were systems in place to monitor staff attendance and compliance with training.

Discussion with the registered manager and a review of their supervision and appraisal schedule confirmed that there were systems in place to ensure that staff received supervision and appraisal.

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

Review of three patient care records evidenced that a range of validated risk assessments were completed. Areas for improvement were identified with care records. These are discussed in section 4.4.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. The registered manager completed a monthly analysis of accidents to identify any trends or patterns. The importance of ensuring that care records were updated following an accident to reflect any identified risks was discussed and a recommendation made.

We observed that care plans were in place for patients who were subject to restrictive practice. The care plans detailed the necessity for the restrictions and which article of The Human Rights act the practice could potentially contravene. There was no evidence in the care records to confirm that the decision to use restrictive practice had been discussed with relevant healthcare professionals involved in the patients' care. A recommendation was made.

As previously discussed in section 4.2 a general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling, clean and appropriately heated. A number of bedrooms had fitted furniture units which were in a poor state of repair. A rolling programme should be implemented to replace the fitted furniture which cannot be repaired to an acceptable standard. A recommendation was made.

Fire exits and corridors were observed to be clear of clutter and obstruction. It was noted in the record of a staff meeting that laundry equipment was in use during the evening when the laundry was unsupervised. The unsupervised operation of the laundry should be discussed with the fire risk assessor and advice sought how to best manage the laundry with regard to fire safety. RQIA should be informed of the outcome of this discussion. A recommendation was made.

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

Areas for improvement

Any decision to use restrictive practice should be discussed, and agreed, with the relevant health care professionals and, where appropriate, the patient and their representatives/relatives. Records should be maintained of these discussions.

Care records should be updated following an accident to reflect any identified risks.

A further phase of refurbishment should be implemented to replace the fitted furniture which cannot be repaired to an acceptable standard.

The unsupervised operation of the laundry should be discussed with the fire risk assessor and advice sought how to best manage the laundry with regard to fire safety. RQIA should be informed of the outcome of this discussion.

Number of requirements	**0**	**Number of recommendations**:	**4**

4.4 Is care effective?

A review of one patient's care records evidenced that initial plans of care were based on the pre admission assessment and referral information. An assessment of patients' nursing needs was commenced at the time of the patient's admission to the home. A range of validated risk assessments were completed as part of the admission process. A review of the assessment of patient need indicated that a pain assessment should have been completed. A recommendation was made. Care plans contained details of the patient's individual needs and were reviewed monthly. The reviews contained a meaningful statement of the patient's condition since the previous review.

We reviewed the care records of two patients who had resided in the home for a number of years. Both patients had an assessment of need completed. These assessments were dated 1 January 2015 and 3 November 2014 respectively. There was no evidence that these assessments had been reviewed since completion. The assessment of patient need must be kept under review and revised no less than annually. A requirement was made.

A range of risk assessments were completed; these were not reviewed regularly. One manual handling risk assessment had not been reviewed for ten months; a falls risk assessment had only been reviewed yearly. Risk assessments should be reviewed regularly, and following any change in the patient's condition; this will ensure that patients' risks are accurately identified. A recommendation was made.

A review of care plans evidenced that a number of needs identified through assessment did not have care plans in place. One file contained some pre-printed care plans which contained generic interventions and were not personalised to meet the individual needs of the patient. Care plans must be in place to detail how the patients' needs in respect of health and welfare are to be met. We observed care plans dated 10 May 2015. The only review date recorded was17 July 2015. Care records must be kept under review. A requirement was made. It is good practice to include a summary of the patient's condition, including any changes, since the previous review.

At the commencement of the inspection the registered manager informed us that care records were not well maintained and that work was ongoing to bring them up to the required standard. A programme of audit was in place. Due to the poor standard of record keeping it was recommended that the registered manager increase the frequency with which care records were audited and ensure that the audit process included a re-audit of the areas for improvement to check compliance has been achieved. A recommendation was made.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. There was evidence within the care records communication with relatives. Registered nurses spoken with 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.

The registered manager confirmed that staff meetings were held regularly. The most recent meetings were held with all staff teams throughout February 2016; the record of each meeting with the areas discussed and decisions made was available to staff.

Staff advised that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff also confirmed that if they had any concerns, they would raise these with the registered or deputy manager.

We observed the serving of lunch. The dining room is situated in an area which provides access to the sun lounge and disability access to areas of the home; there were a lot of people moving through the dining room to get to other areas of the home; this movement created a very busy feel to the dining room. A large notice board displaying staff information, for example posters with training dates and memos, was displayed in the dining room area at the entrance to the kitchen and empty water bottles were stored beside the water cooler. The environment was generally cluttered and there were few cues to remind or prompt patients that this was a dining area.

Two of the care records we reviewed identified that the patients had good social skills at mealtimes. There did not appear to be any consideration to encourage patients with similar abilities to sit together. None of the tables were set with cutlery, crockery, or condiments prior to the meal being served. We did not observe condiments being provided or offered to any patients at lunchtime. When the meals were served the bread and butter was served on the plate alongside the patients' meal. Patients were not asked individually if they would like bread.

We observed a microwave oven brought out from the kitchen. Staff explained that all of the meals were plated and when patients who were out on the bus returned home, or patients who were late coming to the dining room, their meals would be reheated. The plated meals were observed sitting on a bench in the kitchen. Staff explained that this was daily practice; there was no attempt made to wait until the patients arrived in the dining room prior to plating their meal or to keep the food warm. Our observations of positive, individual patient care, discussed in 4.5, were in stark comparison to the management of mealtimes.

It was recommended that the dining experience is reviewed to ensure that individual needs and preferences are considered and that meal times are delivered in accordance with best practice guidance, for example, Nutritional Guidelines and menu checklist, March 2014. This review should include the environment of the dining room which must be decluttered and defined as a dining area.

Areas for improvement

Risk assessments to meet individual needs should be completed.

The assessment of patient need must be kept under review and revised no less than annually.

Risk assessments should be reviewed regularly, and following any change in the patient's condition; this will ensure that patients' risks are accurately identified.

Care plans must be in place to detail how the patients' needs in respect of health and welfare are to be met. Care plans must be kept under review.

The registered manager should increase the frequency with which care records are audited and ensure that the audit process includes a re-audit of the areas for improvement to check compliance has been achieved.

The dining experience is reviewed to ensure that individual needs and preferences are considered and that meal times are delivered in accordance with best practice guidance, for example, Nutritional Guidelines and menu checklist, March 2014.

Number of requirements	2	Number of recommendations:	4

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. We observed numerous occasions when staff offered patients' choice and took time to find out what the patients wanted when it was not always apparent and patients were unable to express their wishes clearly. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding patients likes and dislikes and individual preferences.

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

The attention to detail, by staff, with the personal appearance of the patients was commended. Patients clothing was noted to be tastefully colour co-ordinated and the ladies were encouraged with jewellery and scarves to complement their outfits. It was obvious by the interactions observed that the patients were familiar and comfortable with staff. The routine of the home was patient focused. For example patients were free to accompanied staff into the office when they had work to do; they remained with the staff member, on one occasion being given "a job" to do while the staff member completed their work. When patients asked about going out on the bus or being taken to the shop it was apparent that they had confidence in the staff response; for example when told they would be taken to the shop later.

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. The registered manager has regular, daily contact with the patients and any visitors and was available, throughout the day, to meet with both on a one to one basis if needed. The registered manager explained that many of the patients' relatives did not visit regularly. They explained that a letter would be sent informing them of significant events in the home. Patients meeting were held quarterly. The most recent had taken place in March 2016. The record of the meeting reflected that the cook had attended as a review of the menu was an agenda item. A patient's forum also met regularly. A record of issues raised by the patients was recorded. The action taken in response to issues raised was reviewed at the next meeting and patients' level of satisfaction recorded.

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

“Thank you for taking such great care of……”

“It is a blessing to know she is being taken care of and also how much she loves being there, it shows when we come to take her out.”

Ten relative questionnaires were issued; none were returned prior to the issue of this report. There were no relatives visiting during the inspection.

Ten questionnaires were issued to nursing, care and ancillary staff; four were returned prior to the issue of this report. Staff were satisfied that the care delivered was safe, effective and compassionate. They were of the opinion that the home was well led.

Areas for improvement

No areas for improvement were identified in the assessment of compassionate care

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.

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

A record of complaints was maintained. The record included the date the complaint was received, the nature of the complaint, details of the investigation and a copy of the letter sent to the complainant. The record also indicated how the registered manager had concluded that the complaint was closed.

The registered manager discussed the systems she had in place to monitor the quality of the services delivered. A programme of audits was completed on a monthly basis. Areas for audit included care records, accidents and infection prevention and control environmental audit. There was no evidence in the audit records that the areas for improvement had been re-audited to check compliance. As previously discussed in 4. 4 the audit process should includes a re-audit of the areas for improvement to check compliance has been achieved

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

The unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. An action plan was generated to address any identified areas for improvement.

Areas for improvement

No areas for improvement were identified with domain of well led.

Number of requirements	0	Number of recommendations:	0

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Eoghain King, responsible person and Valerie Reynolds, registered manager 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the 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 by the registered manager. 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 service. 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 service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 15(2)(b) **Stated:** First time **To be completed by:** 21 June 2016	The registered person must ensure that the assessment of patient need is kept under review and revised no less than annually. **Ref section 4.4** **Response by registered person detailing the actions taken:** We are currently reviewing our resident's care records to ensure they are up to date.
Requirement 2 **Ref:** Regulation 16(1)&(2)(b) **Stated:** First time **To be completed by:** 21 June 2016	The registered person must ensure that care plans are in place to detail how the patients' needs in respect of health and welfare are to be met. Care plans must be kept under review **Ref section 4.4** **Response by registered person detailing the actions taken:** Our resident's records are currently being rearranged so that information can be located easily. The care plans in place clearly illustrate details of individuals needs and how such needs are being met.
Recommendations	
Recommendation 1 **Ref**: Standard 4.8 **Stated:** First time **To be completed by:** 21 June 2016	Care records should be updated following an accident to reflect any identified risks. **Ref section 4.3** **Response by registered person detailing the actions taken:** Following the review of our care plans, we are currently reviewing our evaluations system in order to ensure that we have an appropriate action plan regarding our care plans.
Recommendation 2 **Ref**: Standard 18.3 **Stated:** First time **To be completed by:** 21 June 2016	It is recommended that any decision to use restrictive practice should be discussed, and agreed, with the relevant health care professionals and, where appropriate, the patient and their representatives/relatives. Records should be maintained of these discussions. **Ref section 4.3** **Response by registered person detailing the actions taken:** Any decision to use restrictive practice will be discussed, and agreed, with the relevant care professionals and where appropriate, the patient and their representatives / relatives. Records will be maintained of these discussions.

Recommendation 3 **Ref**: Standard 44.1 **Stated:** First time **To be completed by:** 19 July 2016	It is recommended that a further phase of refurbishment is implemented to replace the fitted furniture which cannot be repaired to an acceptable standard. **Ref section 4.3**
	Response by registered person detailing the actions taken: We have commenced a one year program of step by step refurbishment in the Home where old furniture is gradually being replaced with new.
Recommendation 4 **Ref**: Standard 47.3 **Stated:** First time **To be completed by:** 21 June 2016	It is recommended that the unsupervised operation of the laundry should be discussed with the fire risk assessor and advice sought how to best manage the laundry with regard to fire safety. RQIA should be informed of the outcome of this discussion. **Ref section 4.3**
	Response by registered person detailing the actions taken: A current review of Health and Safety is being undertaken. This will include the management of unsupervised operation of the laundry.
Recommendation 5 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 21 June 2016	Risk assessments to meet individual needs should be completed. **Ref section 4.4**
	Response by registered person detailing the actions taken: The above risk-assessments process has commenced.
Recommendation 6 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 21 June 2016	It is recommended that risk assessments are reviewed regularly, and following any change in the patient's condition **Ref section 4.4**
	Response by registered person detailing the actions taken: Our car profiles are reviewed on a monthly basis making sure our care plans along with all records are kept up to date including the risk assessments.

Recommendation 7 **Ref**: Standard 35.16 **Stated:** First time **To be completed by:** 12 July 2016	It is recommended that the frequency with which care records are audited is increased. The audit process should include a re-audit of the areas for improvement to check compliance has been achieved. **Ref section 4.4**
	Response by registered person detailing the actions taken: We have increased the frequency of our record audits. We have also developed a systematic process that ensures all care files are audited/reviewed at appropriate times ensuring compliance is being achieved.
Recommendation 8 **Ref**: Standard 12 **Stated:** First time **To be completed by:** 12 July 2016	The dining experience is reviewed to ensure that individual needs and preferences are considered and that meal times are delivered in accordance with best practice guidance, for example, Nutritional Guidelines and menu checklist, March 2014. This review should include the environment of the dining room which must be decluttered and defined as a dining area. **Ref section 4.4**
	Response by registered person detailing the actions taken: The environment of our dining area is being reviewed to ensure a better dining experience for our residents and future adgherence to best practice guidelines.

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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