Unannounced Care Inspection Report
5 September 2016

The Cottage

Type of Service: Nursing Home
Address: 25 Lodge Park, Coleraine, BT52 1UN
Tel No: 0287034 4280
Inspector: Aveen Donnelly

An unannounced inspection of The Cottage took place on 5 September 2016 from 08.45 to 16.15 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 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 home was clean and well maintained. There were no areas of improvement identified in the delivery of safe care.

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. A review of care records confirmed that a range of risk assessments were completed. Care plans were created to prescribe care. There were arrangements in place to monitor and review the effectiveness of care delivery. 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. Areas of improvement were identified in relation to the monitoring of patients' bowel patterns; and the completion of patients' care records within the recommended timeframe. Two recommendations have been 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.Areas for improvement were identified in relation to the security of the room used to store archived patient care records; and in relation to the need for care plans to be developed for patients who have communication difficulties. Two recommendations have been made.

Is the service well led?

There was a clear organisational structure evidenced within the home and staff were aware of their roles and responsibilities. A review of care observations 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.

Staff consulted with were knowledgeable regarding the line management structure and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. There were systems were in place to monitor and report on the quality of nursing and other services provided. There were no areas of improvement identified in the delivery of safe care.

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.

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Kathy Holmes, 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.

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 28 July 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.

Registered organisation/registered person: Merit Retail Limited Therese Elizabeth Conway	**Registered manager:** Kathleen Margaret Holmes
Person in charge of the home at the time of inspection: Kathleen Margaret Holmes	**Date manager registered:** 1 April 2005
Categories of care: NH-TI, NH-DE, NH-I, NH-PH, NH-PH(E)	**Number of registered places:** 67

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

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection

- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with six patients, six care staff, three registered nurse and six patients' representatives and one visiting health care professional.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- ten patient care records
- staff training records for 2015/2016
- accident and incident records
- audits in relation to care records and falls
- records relating to adult safeguarding
- one staff recruitment and selection record
- complaints received since the previous care inspection
- staff induction, supervision and appraisal records
- records pertaining to NMC and NISCC registration checks
- minutes of staff, patients' and relatives' meetings held since the previous care inspection
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a selection of policies and procedures

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

Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 36.2 **Stated:** Second time	All policies and procedures should be reviewed to ensure that they are subject to a three yearly review. • A policy on death and dying should be developed in line with current best practice, such as DHSSPSNI (2010) *Living Matters: Dying Matters* and should include the procedure for the management of shared rooms. • A protocol on accessing specialist equipment and medications should be developed. The policies and guidance documents listed above, should be made readily available to staff.	**Met**

	A copy of the above policies should be submitted to RQIA with the returned QIP.	
	Action taken as confirmed during the inspection: The above policies had been updated to include the management of shared rooms and the protocol for accessing specialist equipment and medications.	
Recommendation 2 **Ref**: Standard 35.4 **Stated:** Firsttime	The registered manager should formalise the process of auditing electronic patient records, specifically patients' risk assessments and care plans. Records should be retained of the audits, which should evidence the action taken to address identified deficits. Audits of the hard copy records should also be undertaken on a regular basis. Wound care audits should also be conducted on a regular basis, to address deficits identified in this inspection.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of care record audits confirmed that audits were conducted on a regular basis and there was evidence of follow up action taken to address identified deficits.	

Recommendation 3 **Ref**: Standard 46.2 **Stated:** First time	There should be an established system in place to assure compliance with best practice in infection prevention and control within the home. This relates specifically to staff changing personal protective equipment between tasks/units.	**Met**
	Action taken as confirmed during the inspection: Infection prevention and control measures were adhered to on the day of the inspection.	

The registered manager confirmed the planned daily staffing levels for the home and stated 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 the week commencing 29 August 2016 evidenced that on three of the seven days reviewed, the staffing levels fell below those discussed with the inspector. Staff consulted with confirmed that support would be provided by the registered manager, when this occurred, and discussion with patients and their representatives evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

Discussion with staff and 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 induction programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare understanding and competence. The registered manager had also signed the record to confirm that the induction process had been satisfactorily completed.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. Observation of the delivery of care evidenced that training had been embedded into practice. Overall compliance with training was monitored by the registered manager and this information informed the responsible persons' monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Review of two records and discussion with the registered manager confirmed that a competency and capability assessment was completed with all registered nurses who were given the responsibility of being in charge of the home.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, undertook competency and capability assessments and there was a system in place to ensure that all staff completed annual appraisals.

There were safe systems in place for the recruitment and selection of staff. A review of one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Personnel records were reviewed by the registered manger and checked for possible issues.

Staff consulted with stated that they had only commenced employment once all the relevant checks had been completed. The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI prior to employment and a record was maintained of the reference number and date received. Where nurses and carers were employed, their PIN numbers were checked on a regular basis, with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), to ensure their registrations were valid.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adults safeguarding. A review of the records identified that concerns had been logged appropriately. A review of documentation confirmed that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

Validated risk assessments were generally completed as part of the admission process and were reviewed as required. These risk assessments informed the care planning process.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were generally completed following each incident, care management and patients' representatives were notified appropriately.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items.

Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

The home used an electronic system for assessing, planning and evaluating patients' care needs and a review of patient care records evidenced that a range of validated risk assessments were generally completed as part of the admission process and reviewed as required. However, two care records identified that the risk assessments and care plans had not been completed within the recommended timeframe. Although a review of the regulation 29 monthly monitoring reports evidenced that the care records of newly admitted patients were reviewed during the monitoring visits; there was no system in place to monitor the records of new admissions between these visits. A recommendation has been made in this regard.

The care records in general, accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Registered nurses consulted with, were aware of the local arrangements and referral process to access other multidisciplinary professionals.

Risk assessments informed the care planning process. For example, records in relation to the management of wounds/pressure ulcers indicated that when a patient was identified as being at risk of developing a pressure ulcer, a care plan was in place to direct staff on the management of this risk.

Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day. Referrals were made to relevant health care professionals, such as GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of the patient's poor nutritional intake.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate, and there was evidence of regular communication with patient representatives within the care records.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored.

A review of bowel records confirmed that patients' bowel movements were recorded on a daily basis and were monitored by the registered manager on a weekly basis. Entries were recorded for every bowel movement; however, there was no record made when patients did not have bowel movements. This meant that we could not be assured of the accuracy of the bowel records. For example, one patient's record evidenced a gap of 12 days between bowel movements and a review of the patient care record did not evidence that the bowel chart had been monitored by registered nurses and there was no evidence of any action taken. A recommendation has been made in this regard.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition. The registered manager also confirmed that there was a mid-day meeting, where staff could again discuss any concerns in relation to patient care. Staff consulted with confirmed that communication between all staff grades was effective.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The most recent staff meeting was held on 4 March 2016 and plans were in place to schedule another meeting. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager.

Discussion with the registered manager and review of records evidenced that patients and/or relatives' meetings were held on a regular basis and records were maintained. Patients consulted with stated that they saw the registered manager on a daily basis and one patient described the registered manager as being "one of us". The most recent relatives' meeting was held on 10 May 2016. They are planned every six months. A patients' meeting is planned to be held in the upcoming weeks. Minutes of the meetings held were reviewed and confirmed attendance and the detail of the issues discussed.

Relatives are also asked to comment regarding the safety of their relative in the home. Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management.

Areas for improvement

A recommendation has been made that registered nurses review patients' bowel records on a daily basis and record any actions taken in the patients' daily progress notes. Entries should also be made when there have been no bowel movements, to ensure the accuracy of the records.

A recommendation has been made that the system to monitor the development of care plans, for patients who have been newly admitted to the home, is reviewed, to ensure that there is a robust monitoring system in place and that the care records are developed within the recommended timeframe.

Number of requirements	0	**Number of recommendations**	2

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and their feedback had been listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent. However, a storage room which contained archived personal care records was unlocked. This meant that any person entering the home could potentially access personal information about patients. Consultation with staff evidenced that they had not considered how this practice could breach confidentiality. The registered manager provided assurances that the storage room would be locked in the future. A recommendation has been made in this regard.

One patient was identified as having difficulty communicating due to a language barrier. Although a care plan was in place to address the patient's communication difficulties, it did not include any information on the patient's level of comprehension or ability to speak. Consultation with the staff confirmed that they felt they have the necessary skills to communicate effectively with the patient; however, there were no communication tools available to staff to assist them in ascertaining the patient's needs. A recommendation has been made in this regard.

Menus were displayed clearly in the dining room and were correct on the day of inspection. We observed the lunch time meal in the dining room. We saw that the atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set in advance of patients entering the dining room and the meal served appeared very appetising and patients spoken with stated that it was always very nice

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. Patients consulted with confirmed that there was a variety of activities available for them to choose from, hairdressing services were provided regularly and religious services were provided on a weekly basis. A Eucharistic minister also visited the home on a daily basis.

In the dementia residential suite, appropriate signage was used to support those who were living with dementia and needed help to recognise their surroundings. Bathrooms and toilets were clearly marked with pictures. A sensory room was also available and discussion with staff and patients' representatives confirmed that this was very beneficial to the patients who used it.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Views and comments recorded were analysed and areas for improvement were acted upon. Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included: '(my relative) was treated with dignity, kindness and love from al the staff, and he loved all the staff in return'.

During the inspection, we met with six patients, six care staff, three registered nurse and six patients' representatives and one visiting health care professional. Some comments received are detailed below:

Staff

"All staff pull together like a team, that is why I stay here"
"It is really good. Everyone works hard"
"We get great reviews. I would put my own family here, if I needed to"
"The care is outstanding, we are like a family here"
"All very good, I love the patients"
"I love it here, it is my favourite place to work"
"The teamwork here means everything"

Patients

"I am getting on very well"
"You couldn't get better"
"Even if you don't know what you want yourself, they get it for you"
"I have no complaints"
"I have no problems, they let me make my own bed and I like that"
"The majority (of staff) are very nice, although sometimes they are slow at responding"

Patients' representatives

"'We are very happy"
"It is all very good, Sometimes there are delays and having to wait to go to the toilet but we are very happy"
"We have no concerns"
"I am greeted by name when I visit, I have no concerns"
"Brilliant care"
"No problems here"

Visiting professionals

"They are brilliant. The staff follow up on all recommendations made. They are on the ball and usually have everything done, before they contact us".

In addition to speaking with patients, relatives and staff RQIA provided questionnaires. At the time of writing this report, five relatives and one patient had retuned their questionnaires. No staff questionnaires were returned.

Written comments were generally positive. However, two respondents indicated that additional staffing should be provided, especially around mealtimes and when patients needed assistance with their toileting needs. Other comments related to wheelchairs which were in need of repair and the variety and standard of the food served in the home. Following the inspection, these comments were communicated to the registered manager, to address.

Areas for improvement

A recommendation has been made that the room used to store archived patient care records is secured at all times, to ensure that patient confidentiality is maintained.

A recommendation has been made that comprehensive care plans are developed, as appropriate, for patients who have communication difficulties.

Number of requirements	0	Number of recommendations	2

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

The registered manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis and the staff confirmed that they had access to the home's policies and procedures. The registered manager also informed the inspector that plans were in place to make the home's policies and procedures accessible via the electronic learning system.

A copy of the complaints procedure was displayed on the relatives' notice board. Discussion with the registered manager and review of the home's complaints record evidenced 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. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the registered manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. Staff were very praiseworthy of the registered manager, when describing the level of support provided and also in terms of her approachability.

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. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

An audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. An action plan was in place to address any deficits identified. This information informed the responsible individual's monthly quality monitoring visit in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous inspection, confirmed that these were appropriately managed.

Discussion with the registered manager and review of records evidenced that monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. A notice was also displayed on the notice board near the front entrance, which informed relatives that the monthly monitoring report was available on request.

The monthly quality monitoring report provided a comprehensive overview of areas that were meeting standards and areas where improvements were required. An action plan was generated to address any areas for improvement. Discussion with the manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Kathy Holmes, 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.

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.

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.

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.

Quality Improvement Plan

Statutory requirements

No requirements were made during this inspection

Recommendations

Recommendation 1 **Ref**: Standard 4, Criterion 1 **Stated:** First time **To be completed by:** 28 November 2016	A recommendation has been made that the system to monitor the development of care plans, for patients who have been newly admitted to the home, is reviewed, to ensure that there is a robust monitoring system in place and that the care records are developed within the recommended timeframe. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: A system is in place which audits care records for patients recently admitted into the home.
Recommendation 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 28 November 2016	The registered persons must ensure that registered nurses review patients' bowel records on a daily basis and record any actions taken in the patients' daily progress notes. Entries should also be made when there have been no bowel movements, to ensure the accuracy of the records. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: A daily entry is recorded in the progress notes for each resident in regards to their bowel movements. This is monitored by the senior nurses and the Home Manager.
Recommendation 3 **Ref**: Standard 37.1 **Stated:** First time **To be completed by:** 28 November 2016	The registered persons should ensure that the room used to store archived patient care records is secured at all times, to ensure that patient confidentiality is maintained. **Ref: Section 4.5**
	Response by registered provider detailing the actions taken: The records store is kept secure. This is monitored daily by the Home Manager.

Recommendation 4 **Ref**: Standard 4 **Stated:** First time	The registered persons should ensure that comprehensive care plans are developed, as appropriate, for patients who have communication difficulties. **Ref: Section 4.5**
To be completed by: 28 November 2016	**Response by registered provider detailing the actions taken:** Care plans are in place for residents with communication difficulties. These are audited by the senior nurses and the Home Manager.

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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