Drapersfield House
RQIA ID: 1420
19 Drapersfield Road
Cookstown
BT80 8RS

Inspector: Sharon Loane
Inspection ID: IN021880

Tel: 028 8676 4868
Email: jillcanavan@aol.com

Unannounced Care Inspection
of
Drapersfield House

11 January 2016

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 11 January 2016 from 10.40 to 17.45 hours.

The focus of this inspection was continence management which was underpinned by selected criteria from:
Standard 4: Individualised Care and Support; Standard 6: Privacy, Dignity and Personal Care; Standard 21: Heath care and Standard 39: Staff Training and Development.

On the day of the inspection, concerns and areas of improvement were identified and are required to be addressed to ensure that care in the home is safe, effective and compassionate. These areas are set out in the Quality Improvement Plan (QIP) within this report. Refer also to section 1.2 below.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015.

For the purposes of this report, the term 'patients' will be used to described those living in Drapersfield House which provides both nursing and residential care.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 27 August 2015.

1.2 Actions/Enforcement Resulting from this Inspection

An urgent actions record regarding the absence of a current fire risk assessment relating to the Personal Emergency Evacuation Plan (PEEP) and fire management plan was issued to Margaret Kolbohm, manager at the end of the inspection. These actions are required to be addressed without delay to ensure the safety and wellbeing of patients in the home.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	5 *1	5

*The total number of requirements includes 1 requirement which has been stated for the second time.

The details of the Quality Improvement Plan (QIP) within this report were discussed with Mr James Mc Crystal, (registered manager) and the management team as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Mr James Mc Crystal Mrs A Mc Crystal	**Registered Manager:** Mr James Mc Crystal
Person in Charge of the Home at the Time of Inspection: Margaret Kolbohm, Manager	**Date Manager Registered:** 1 April 2005
Categories of Care: RC-MP, NH-LD, NH-LD(E), RC-I, RC-MP(E), NH-I, NH-PH, NH-PH(E)	**Number of Registered Places:** 45
Number of Patients Accommodated on Day of Inspection: 25 Nursing 11 Residential	**Weekly Tariff at Time of Inspection:** £470.00 - £593.00

3. Inspection Focus

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

Standard 4: **Individualised Care and Support, criteria 8**
Standard 6: **Privacy, Dignity and Personal Care, criteria 1, 3, 4, 8 and 15**
Standard 21: **Heath Care, criteria 6, 7 and 11**
Standard 39: **Staff Training and Development, criteria 4**

4. Methods/Process

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

Prior to inspection the following records were analysed:

- notifiable events submitted since the last care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report and returned QIP. (27 August 2015)

During the inspection, 11 patients were spoken with individually and the majority of others in small groups. Four care staff, three registered nurses, and one visiting professional were also consulted. No patient relatives or representatives were met.

The following records were examined during the inspection:

- validation of evidence linked to the previous QIP
- four patient care records
- staff training records
- staff induction records
- policies and guidance documents pertaining to the standards examined
- Regulation 29 reports.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of Drapersfield House was an unannounced care inspection dated 27 August 2015. The completed QIP was returned and approved by the care inspector.

Review of Requirements and Recommendations from the Last Care Inspection 27 August 2015

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 16 (2) (b) **Stated:** Second time	The registered person must ensure that the patients' care records are reviewed and updated in order to ensure that care plans fully reflect the patients' assessed needs. Regular audits should be undertaken of patients' care records.	**Met**
	Action taken as confirmed during the inspection: A review of four patients' care records evidenced that the care records had been reviewed and updated at regular intervals and care plans were reflective of the patients' assessed needs.	
Requirement 2 **Ref**: Regulation 15 (2) (a) (b) **Stated:** Second time	The registered person must ensure that the assessment of the patient's needs is kept under review and revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually.	**Met**
	Action taken as confirmed during the inspection: A review of four patient care records evidenced that assessments had been completed and updated according to the needs of the patients.	

Requirement 3 **Ref**: Regulation 12 (1) (a) (b) **Stated:** First time	The registered manager must ensure that all patients with pressure care/ wound management have the relevant risk assessments for pressure care, a care plan for the care required for their identified needs and that all records pertaining to pressure / wound care management are up to date and reviewed as indicated. An urgent actions record was issued.	
	Action taken as confirmed during the inspection: A review of two care records pertaining to pressure / wound care management evidenced that one of the care records examined identified a number of shortfalls. The progress of the wound was difficult to monitor as a result of poor recording. Gaps were identified in regards to the treatment delivered in accordance with the regime of care devised. Treatment delivered in regards to dressing application was not always consistent with the plan of care. These findings were discussed with the manager and due to the continued shortfalls this requirement has been stated for a second time.	**Not Met**
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 5.3 **Stated:** Second time	It is recommended that the repositioning chart in use in the home be reviewed to address the inspection of the patient's skin at each positional change.	
	Action taken as confirmed during the inspection: A sample of repositioning charts reviewed did evidence that staff were recording information regarding their observations of the patient's skin at each positional change where appropriate. This recommendation has been met in this regard. Other shortfalls were identified in relation to repositioning practice. Refer to section 5.4.1.	**Met**

Recommendation 2 **Ref**: Standard 35 criteria 7 **Stated:** First time	The registered person should ensure completed monitoring reports provide an accurate account of all services provided.	**Met**
	Action taken as confirmed during the inspection: A review of Regulation 29 reports for November and December 2015 were reviewed. These were completed to a satisfactory standard. Discussion with the person completing the visits and reports advised how these could be further developed. This recommendation has been met.	

5.3 Continence management

Is Care Safe? (Quality of Life)

Policies and procedures regarding continence management and catheter care were available to guide staff. A policy on stoma care was not available and this was discussed with the manager. On the day of the inspection the home did not have any patients with a stoma however; it is recommended that a policy is developed to be available for staff guidance.

Best practice guidance on continence care was available in the home for staff to consult from the Royal College of Nursing (RCN); National Institute for Health and Clinical Excellence (NICE). These included:

- Urinary incontinence (NICE)
- Faecal Incontinence (NICE)
- Continence care in Care Homes (RCN)
- Catheter Care (RCN)
- Continence Care in residential and Nursing Homes (British Geriatrics Society).

Discussion with staff and the manager confirmed that staff had received training in 2015 relating to the management of urinary and bowel incontinence. Twenty three staff had completed training in relation to the use and application of incontinence aids. A review of the induction template for care staff evidenced that the management of toileting needs is included in the induction process.

Staff were knowledgeable about the important aspects of continence care including the importance of dignity, privacy and respect as well as skincare, hydration and reporting of any concerns.

Discussion with the manager and a review of the training records confirmed that 10 registered nurses were trained in 2015 and assessed as competent in urinary catheterisation. Seven registered nurses had also completed stoma care training in December 2015. A review of training records evidenced that staff have been afforded a number of training opportunities, the home are commended for their efforts in this regard.

Observation during the inspection and discussion with staff evidenced that there were adequate stocks of continence products available in the home.

A continence link nurse has been identified for the home and was available for a discussion during the inspection.

Is Care Effective? (Quality of Management)

Review of four patient's care records evidenced that a continence assessment was recorded and reviewed on a monthly basis for three patients.

The continence assessment in use did not clearly identify the patient's incontinence needs. This matter was discussed with the manager who advised that the tool had recently been reviewed and staff had indicated the tool was not comprehensive to include all areas of continence management. A recommendation has been made.

Continence care plans were in place for each of the four patients' with evidence of monthly review.

The promotion of continence, skin care, and patients' dignity were addressed in the care plans inspected. Care plans did not specify the actual product required to meets the needs of the patient. The product requirement was not included in any of the continence assessments. Care plans did not refer to patient's normal bowel patterns and bowel type. Again this information was not included in the assessment. However, bowel management records referred to the Bristol Stool Chart for the recording of bowel movements. A recommendation is made.

In addition, care plan content, in general, could have been more specific and patient centred. Refer to section 5.4.2.

Records reviewed evidenced that urinalysis was undertaken as required and patients were referred to their GPs appropriately.

The management of urinary catheters was reviewed. Registered nurses spoken with were knowledgeable regarding the management of urinary catheters and the rationale for use of urinary catheters. Urinary catheters were only inserted on the instructions of the patient's GP or consultant. There was evidence in the records reviewed that staff had consulted the relevant practitioner when issues pertaining to the management of the urinary catheter had arisen and actions had been implemented as per the advice given.

Three patient's care records relating to the management of urinary catheters were reviewed and in general were very detailed. However some inconsistencies in recording information were identified, these included; the frequency of changing the catheter, type and size of catheter, fluid targets and catheter care were not recorded consistently. Fluid target intake and outputs were not identified in the care plans, however a sample of fluid balance records evidenced that total input and outputs were being calculated. A recommendation has been made that care plans should record fully the care required for the management of urinary catheters in accordance with best practice guidelines. A review of records relating to catheter insertion and / or change evidenced that these had been completed and the necessary information was recorded appropriately.

Review of patients' care records evidenced that patients and/or their representatives were informed of changes to patient need and/or condition and the action taken.

Is Care Compassionate? (Quality of Care)

During the inspection staff were observed to treat the patients with dignity and respect. Good relationships were very evident between patients and all grades of staff. Staff were observed to respond to patients' requests promptly. Patients confirmed that they were happy in the home and that staff were kind and attentive.

Areas for Improvement

It is recommended that a policy is developed for stoma care management.

It is recommended that the continence assessment is reviewed and further developed to include a more detailed comprehensive assessment of patients' continence needs. Assessments and care plans should include all interventions required to manage patients' continence needs and should include but not limited to; bowel patterns and type and continence products required.

It is recommended that care plans pertaining to the management of urinary catheters are drafted to be specific to actual steps to provide safe and effective care of the urinary catheter.

Number of Requirements:	**0**	**Number of Recommendations**:	**3**

5.4 Additional Areas Examined

5.4.1. Quality of nursing care

During the inspection staff members were noted to communicate with patients in a dignified and respectful manner.

The majority of patients' were observed to be well groomed and appropriately dressed. However, a number of patient's personal care needs had not been adequately met in relation to nail care, unshaven and the overall presentation in relation to attention to detail was below the standard expected. This was discussed with the manager who agreed with the observations made and advised that this matter has been raised with care staff prior to this inspection. It was agreed by management that this area of practice would be monitored and that the training would be reviewed to further enhance the standard of care being delivered in this regard. A recommendation was made.

A sample review of repositioning charts for one identified patient evidenced that the care delivered on some occasions was not consistent with the regime of care in the care plan. The care plan indicated that the repositioning schedule for the patient was two-three hourly; however, gaps between four and fourteen hours were evidenced in the repositioning records on three occasions. These shortfalls could have a direct impact on the delivery of safe effective care and this was discussed with management at feedback. A requirement has been made

5.4.2 Records and record keeping

A review of patient care records evidenced that registered nurses in some instances were not care planning using a specific, measurable and person centred approach. For example, care plans stated 'ensure staff' and 'review regularly'. The inspector provided other examples during feedback and it was acknowledged by management that these statements were not appropriate. A recommendation is made.

A review of a care record evidenced that the assessments and care plans had not been completed within the identified time frame. The same care record did not include the patients details, had not been dated and signed in accordance with professional and best practice guidance. This was discussed and the manager gave assurances that this would be monitored as part of care plan audits. RQIA will continue to monitor this matter during subsequent inspections.

5.4.3 Environment and Infection Prevention and Control

A general tour of the home was undertaken which included a random sample of bedrooms, bathrooms/shower and toilet facilities, storage rooms and communal areas. In general, the areas reviewed were found to be reasonably tidy, comfortable and warm throughout. Whilst RQIA acknowledge that the home was free from odours and outbreaks of infection, the overall cleanliness of the home was below the standard expected in accordance with infection control best practice. A discussion with the manager regarding the management of housekeeping identified that there were no established systems to ensure compliance with best practice in infection prevention and control within the home. For example, there were no devised cleaning schedules, limited records of decontamination and the responsibility for infection prevention and control was not clearly defined. The following issues were identified but not limited to:

- urinals / commodes not cleaned to a satisfactory standard
- clinical waste bins rusted
- wheelchairs/specialised chairs not cleaned to a satisfactory standard
- ceiling tiles in a bathroom stained
- door in w/c damaged and bare wood exposed
- unit in bathroom damaged bare wood exposed
- bed frames damaged with bare wood exposed.

In some areas of the home namely bedrooms, décor and furnishings appeared worn, faded and in need of replacing. The management team advised that refurbishment work has been scheduled for completion within the next six months and there were additional plans for more improvements. A review of Regulation 29 reports completed for November and December 2015 acknowledged the plans for these improvements with timescales identified. RQIA were satisfied on this occasion that the registered persons were proactively managing this however, RQIA will continue to monitor the progress of the planned improvements in accordance with the timescales identified during subsequent inspections.

The issues as listed above are not consistent with regional infection control guidance. Whilst RQIA acknowledge the plans for environmental improvements as advised by the management team, a requirement is made that the issues listed above pertaining to infection prevention and control are addressed.

5.4.4 Fire prevention and fire safety

During this inspection some issues pertaining to Fire Safety were identified. Discussion with the manager identified that the homes fire risk assessment and fire management plan had not been revised in accordance with changes to patient occupancy and risk management. This was concerning, and an urgent actions record was issued to ensure that a Personal Emergency Evacuation Plan (PEEP) was available for each patient and that the fire risk assessment was updated. A requirement has been made.

The smoking room was observed as not having an extractor fan and a fire blanket in place. This was concerning as there was a number of patients observed using this area. This matter was discussed with management at feedback. Management advised that there were plans to relocate the current smoking area to "Ash" room and this was discussed with the estates inspector at RQIA.

The issues identified have the potential to impact on the health and safety of patients and were discussed with senior management at RQIA. Post inspection, the manager submitted information by email to RQIA to advise that measures had been taken in regards to the urgent actions record issued. Both issues identified were relayed to the estates inspector who contacted Drapersfield House and has been assured that necessary actions have been taken to ensure the safety of patients in the home.

The aligned estates inspector has agreed to follow-up these issues in an announced Estates Inspection.

5.4.5 Categories of care

A review of the certificate of registration for Drapersfield House highlighted that the home were accommodating two patients outside the category of care for which the home was registered. Discussion with management indicated that they were unaware the service was operating outside the registered categories of care indicated on the certificate of registration. To comply with relevant legislation, applications should be submitted in respect of the two identified patients. Management agreed to submit same and gave an assurance that this would be closely monitored in the future. A requirement has been made to ensure that the home only accommodates patients within the categories of care for whom they are currently registered.

5.4.6 Consultation with patients and staff

During the inspection process, 11 patients were spoken with individually and the majority of others in small groups. Seven staff and one visiting professional were also consulted to ascertain their personal view of life in Drapersfield House. The feedback from patients and staff indicated that safe, effective and compassionate care was being delivered.

A few patient comments are detailed below:

- "This is a first class home."
- "The care and staff are second to none."
- "The food is fantastic."

Discussions with staff indicated that they took pride in delivering safe, effective and compassionate care to patients. No concerns were identified.

The visiting professional spoken with was very positive about the care provided in Drapersfield House. They advised that management and staff were very supportive and kept them informed of any relevant changes to patients' health and wellbeing.

Areas for Improvement

The delivery of personal care should be monitored and training should be reviewed and provided to further enhance the standard of care being delivered. A recommendation has been made.

Patients should be repositioned according to their assessed needs and care plan interventions. Repositioning records should reflect all care given or not given. A requirement has been made.

Care plan interventions should be specific, measurable and person centred. A recommendation has been made.

Systems should be developed to ensure best practice guidelines for infection prevention and control are been adhered to. A requirement has been made.

The fire risk assessment should be updated in accordance with changes to patient occupancy and risk management. A requirement has been made.

The home must only accommodate patients within the categories of care for which they are registered. A requirement has been made.

Number of Requirements:	**4**	**Number of Recommendations:**	**2**

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed as part of the inspection process. The timescales commence from the date of inspection.

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

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

6.1 Statutory Requirements

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

6.2 Recommendations

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

6.3 Actions Taken by the Registered Manager/Registered Person

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

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained in this report do not absolve the registered provider/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 provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref**: Regulation 12 (1) (a) (b) **Stated:** Second time **To be completed by:** **18 January 2016**	The registered manager must ensure that all patients with pressure care/ wound management have the relevant risk assessments for pressure care, a care plan for the care required for their identified needs and that all records pertaining to pressure / wound care management are up to date and reviewed as indicated. **Ref Section 5.1**
	Response by Registered Person(s) Detailing the Actions Taken: All wound/ pressure care management systems are in place. Our Tissue Viability Nurse is continually carrying out audits to ensure all records are put in place within the given timescale for new patients admitted with wounds. All registered nurses are aware that it is also their responsibility to ensure that wound management, care plans, risks etc are in place and updated.
Requirement 2 **Ref**: Regulation 27(4)(a) **Stated:** First time **To be completed by:** **13 January 2016**	The registered person shall have in place a valid fire risk assessment and fire management plan. The fire risk assessment must be reviewed annually, or whenever the fire risk has changed. The fire management plan must be reviewed and modified to ensure satisfactory fire safety controls are implemented. An urgent actions record was issued. **Ref Section 5.4.4**
	Response by Registered Person(s) Detailing the Actions Taken: The fire risk assessment and fire management plan have been updated to include specific risks as identified. The Home has a HTM84 risk assessment also in place. All patients have PEEPs in place. Copies are also included in the individual patients notes, as well as in the fire management records, in the event of a fire, the fire warden has immediate access. Northern Ireland Fire and Rescue Services have an updated plan and risk assessment in place since their visit in May 2015.
Requirement 3 **Ref**: Regulation 13 (1) (b) **Stated:** First time **To be completed by:** **18 January 2016**	The registered person must ensure that patients are repositioned as per the repositioning regime identified in the care plan and where shortfalls are identified these are actioned accordingly. **Ref Section 5.4.1**
	Response by Registered Person(s) Detailing the Actions Taken: All staff are continually reminded of the importance of completing the patients repositioning charts 2-3hourly as per patients risk assessment and care plans. Measures have been put in place, to ensure auditing of shortfalls are identified.

Requirement 4 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:** **18 January 2016**	The registered person must ensure that infection prevention and control issues identified are actioned as required. Systems and protocols must be established to ensure compliance with best practice in infection prevention and control within the home. **Ref Section 5.4.3**
	Response by Registered Person(s) Detailing the Actions Taken: An audit system has now been introduced to reinforce best practice for prevention and control of infection. Our Cleaning schedule has been updated. Staff have been encouraged to adhere to existing policy and procedures. All staff have been informed to update their infection control modules within their training programme. Infection Control training is booked to take place on 10th March 2016. Infection Control audits continue to be carried out on a monthly basis or sooner if necessary. Infection Control policy is in place and staff have been advised to read this policy again.
Requirement 5 **Ref**: Regulation 15 (e) **Stated:** First time **To be completed by:** **18 January 2016**	The registered person must ensure that the home only accommodates patients within the category of care for whom they are registered. An application for variation must be submitted for the two patients identified at this inspection. **Ref Section 5.4.5**
	Response by Registered Person(s) Detailing the Actions Taken: The homes new registration has now been issued and variation of categories of care have been updated to include all residents accommodate within the Home. The new certificate is on display.
Recommendations	
Recommendation 1 **Ref**: Standard 36 Criteria 2 **Stated:** First time **To be Completed by:** **29 February 2016**	It is recommended that a policy and procedure regarding Stoma care management is developed in accordance with best practice guidelines. **Ref Section 5.5.3**
	Response by Registered Person(s) Detailing the Actions Taken: A new policy and procedure on Stoma care is now in place and available for all staff to read. Staff have been issued guidance notes .

Recommendation 2 **Ref**: Standard 4 Criteria (1)(7) **Stated:** First time **To be Completed by: 29 February 2016**	It is recommended that the continence assessment is reviewed and developed to ensure a comprehensive assessment is completed. Assessments and care plans should include all interventions required to manage patients' continence needs and should include but not limited to; bowel patterns and type and continence products required. **Ref Section: 5.5.3**
	Response by Registered Person(s) Detailing the Actions Taken: An updated continence assessment tool is in place, nursing staff have been reminded to carry out the assessment on admission and when necessary. All nursing staff are now documenting bowel patterns, type and continence products in care plans, risks and daily evaluation sheets. All new patients are commenced on a Bristol Stool Chart on admission. Staff attended a continence course on 24.02.16.
Recommendation 3 **Ref**: Standard 4 Criteria 8 **Stated:** First time **To be Completed by: 29 February 2016**	It is recommended that care plans pertaining to urinary catheters contain specific steps to ensure the safe management of the urinary catheter. **Ref Section: 5.5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Care plans pertaining to urinary catheters have been updated to identify specific steps, ensuring safe management and good practice. Catheter sizes are documented, when catheters are due to be changed and when newly inserted. Information details are recorded in risks assessments, care plans and daily evaluation sheets. Urinalysis and CSU are obtained as and when required by Staff Nurse. All catheter bags are changed on a weekly basis or sooner if required. All patients who have catheters in place are on a continuous fluid balance charts. Night bags are put in place while patients are on bed rest and securely attached to the catheter stand. All staff are continually updating their catheter care modules within our training programme.
Recommendation 4 **Ref**: Standard 6 Criteria 14 **Stated:** First time **To be Completed by: 29 February 2016**	It is recommended that patients personal care needs are regularly assessed and met to include (but not limited to) nails and grooming needs. Records should be completed to evidence care delivered or not delivered. Training should be provided for all care staff to further enhance the delivery of care in this regard. **Ref Section: 5.4.1**
	Response by Registered Person(s) Detailing the Actions Taken: All staff have been reminded of the importance of proper personal care for all patients. If any patients decline any personal care intervention it must be reported to Staff Nurse and they will document in the risk assessments, care plans and daily evaluation sheets. Measures have been put in place to audit personal care and reinforce good practice. All staff are currently updating their Personal Care Modules within our training programme

Recommendation 5 **Ref**: Standard 4 **Stated:** First time **To be Completed by:** **29 February 2016**	It is recommended that registered nursing staff develop care plans that are patient centred and that the content of care plans is measurable, specific and relate to the assessed needs of the patient. **Ref Section: 5.4.2** **Response by Registered Person(s) Detailing the Actions Taken:** All care plans are individually written to reflect the patients specific care needs. All registered nurses strive to ensure that all risk assessments, care plans and documentation are completed within the identified timescale. Measures have been put in place to audit care plans. Registered staff have received a training update on care planning.

Registered Manager Completing QIP	Margaret Kolbohm	**Date Completed**	24/02/2016
Registered Person Approving QIP	James McCrystal	**Date Approved**	24/02/2016
RQIA Inspector Assessing Response	Sharon Loane	**Date Approved**	07.03.2016

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