Unannounced Care Inspection Report
1 April 2019

Drapersfield House

Type of Service: Nursing Home
Address: 19 Drapersfield Road, Cookstown, BT80 8RS
Tel No: 028 8676 4868
Inspector: Jane Laird

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 45 persons.

3.0 Service details

Organisation/Registered Provider: Drapersfield Ltd **Responsible Individual:** Jill Canavan	**Registered Manager and date registered:** Margaret Kolbohm
Person in charge at the time of inspection: Margaret Kolbohm	**Number of registered places:** 45
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. LD (E) – Learning disability – over 65 years. MP (E) - Mental disorder excluding learning disability or dementia – over 65 years. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 39 Inclusive of a maximum of two named residents receiving residential care.

4.0 Inspection summary

An unannounced inspection took place on 1 April 2019 from 08.40 to 18.00.

The term ‘patient’ is used to describe those living in Drapersfield House which provides both nursing and residential care.

The inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding, quality assurance audits, communication between residents, staff and other key stakeholders and maintaining good working relationships. Further areas of good practice was identified in relation to the culture and ethos of the home, governance arrangements, listening to and valuing patients and their representatives and taking account of the views of patients.

Areas requiring improvement were identified in relation to the accurate documentation of care records, settings on pressure relieving mattresses, patients’ privacy, management of complaints and incidents and displaying the activity schedule in a suitable format.

Patients described living in the home mainly in positive terms. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others/with staff.

Comments received from patients, people who visit them and staff during and after the inspection, are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	4

Details of the Quality Improvement Plan (QIP) were discussed with Margaret Kolbohm, 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.

4.2 Action/enforcement taken following the most recent inspection dated 25 February 2019

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

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire.

A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff from 25 March 2019 to 7 April 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- three patient care records
- three patient care charts including food and fluid intake charts, elimination records and reposition charts
- a sample of governance audits/records
- complaints record
- compliments received
- a sample of reports of visits by the registered provider from January 2019
- RQIA registration certificate
- public liability insurance certificate

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as either met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 25 February 2019

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

6.2 Review of areas for improvement from the last care inspection dated 21 July 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 4 **Stated:** Second time	The registered person shall ensure that the process for recording patients' bowel motions is further developed, to ensure that the registered nurses have oversight of these records; and that evidence of any action taken in response to deficits is recorded in the daily progress notes.	**Met**

	Action taken as confirmed during the inspection: On review of the elimination records it was identified that the registered nurses had an oversight of the records and actions taken in response to deficits were recorded in the daily progress notes. This is discussed further in 6.5.	
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered person shall ensure that medicines are prepared immediately prior to the administration from the container in which they are dispensed.	**Met**
	Action taken as confirmed during the inspection: The inspector confirmed that medicines were prepared immediately prior to the administration from the container in which they are dispensed on the day of inspection.	
Area for improvement 3 **Ref**: Standard 6 **Stated:** First time	The registered person shall ensure that net pants are provided for each patient's individual use and any unlabelled items are identified and labelled or disposed of to eliminate the potential for communal use.	**Met**
	Action taken as confirmed during the inspection: The inspector did not identify any net pants on the day of inspection. The registered manager confirmed that they had been removed from the home following the previous care inspection.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

We arrived in the home at 08.40 and were greeted by the registered manager who provided a tour of the building. Patients were mainly in their bedroom and staff were attending to their needs. Some patients were seated in one of the lounges in preparation for breakfast whilst others remained in bed. Staff were friendly and welcoming and appeared confident in their role and delivery of care. Medication was being administered by the registered nurses and catering staff were preparing breakfast.

Patients indicated that they were well looked after by the staff and felt safe and happy living in Drapersfield House. One patient said “Staff are looking after me well”. We also sought the opinion of patients on staffing via questionnaires. Four questionnaires were returned from patients who were very satisfied with the service provision across all four domains.

Staffing rotas for weeks commencing 25 March 2019 and 1 April 2019 were reviewed which evidenced that there were adequate numbers of staff employed to ensure patients were kept safe and their social and physical needs are met in a timely manner. The registered manager further confirmed that contingency measures were in place to manage short notice sick leave when necessary.

A discussion with staff evidenced that they were satisfied that there was sufficient staff on duty to meet the needs of the patients. Staff said that they felt supported by management, comments included; “I love it here”, “I love my job” and “Feel supported by management”. We also sought staff opinion on staffing via an online survey. There was no response in the time frame provided.

On review of two staff recruitment records it was evidenced that they were employed following a robust monitoring system to ensure the safety of patients. Records also evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work. Patients were supported by staff that received on-going training to ensure they understood and were able to respond to patents needs. The registered manager informed us that all new staff had induction training which was confirmed by the staff on duty. One staff member said “There’s lots of training here”. A system was also in place to direct the management team of when staff were due their bi-annual supervision and yearly appraisal.

Records confirmed that a process was in place to monitor the registration status of registered nurses with the Nursing and Midwifery Council (NMC) and care assistants with the Northern Ireland Social Care Council (NISCC). There was evidence that registered nurses completed a competency and capability assessment yearly to ensure that they are competent to take charge of the home in the absence of the registered manager.

The staff we spoke with understood their responsibilities in relation to keeping patients safe and were able to describe what they would do if they suspected or witnessed any form of abuse. Discussion with the registered manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice.

A number of audits were completed on a monthly basis by the registered manager and/or clinical leads to ensure the safe and effective delivery of care. Falls in the home were monitored on a monthly basis for any patterns and trends which provided the location, time and nature of the fall. Following the review an action plan was implemented to reduce the incidences of falls where possible and the patient’s risk of falls assessment and care plan was updated. Other audits were carried out on patients’ with wounds which were well maintained and provided a clear action plan when deficits were identified. The registered manager also completed an environmental audit on a monthly basis with the most recent audit carried out two weeks prior to the date of inspection. On review of the issues identified such as surfaces not being effectively cleaned and identified rooms being left untidy, there was evidence that the registered manager discussed the findings with the cleaning staff and an action plan was implemented.

The dining room was well presented with table clothes, condiments and a range of drinks available at each table. Lunch commenced at 12.15 hours and patients were assisted to the dining room or had trays delivered to them as required. Patients received food and fluids which met their individual needs and took into account their preferences. Staff were observed assisting patients with their meal appropriately in an unhurried manner. One patient told us "The food is very good". Another patient said "great food here". There was a menu on display within one of the two dining rooms which offered a choice of two main meals. This was discussed with the registered manager who agreed to display a copy of the menu in both dining rooms going forward.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. Fire exits and corridors were observed to be clear of clutter and obstruction. Refurbishment works were ongoing to the home and areas that were identified as needing decorated such as doors, radiators, walls and floor coverings were on the home's agenda to address as part of their refurbishment plan. We further identified two broken panes of glass, and identified equipment/furniture that was damaged. Hose pipes were also identified in two communal toilets attached to the wall beside the toilet. This was discussed with the registered manager and the estates inspector for the home was notified. Confirmation of the removal of the hose pipes and replacement of the two panes of glass were forwarded to RQIA following the inspection. Reassurance was also provided that identified equipment/furniture that was damaged would be repaired or replaced as necessary.

We observed the home to be warm and comfortable throughout; however, the temperature of one identified bedroom on the top floor was lower in the afternoon than what it was in the early morning. On investigation it was evident that staff had left the bedroom windows open to air the room. This was discussed with the registered manager who provided assurances that this would be monitored going forward to ensure that windows are closed in a timely manner to preserve heat.

A window blind identified in a communal toilet on the top floor was discussed with the registered manager as a potential ligature risk due to the length and nature of the cord suspended to the side of the blind. The registered manager consulted with the Responsible Individual of the home during the inspection and the blind was removed immediately to ensure the safety of the patients.

There was access to a store room within a communal toilet on the first floor which was cluttered and untidy with a variety of items such as, plastic bin bags, incontinence products and boxes. A further store which was located on the second floor was also easily accessible and led to a roof space where water pipes and a water tank was stored. This was discussed with the registered manager who acknowledged the risk to patients and agreed to tidy the store and install locks to both doors. Confirmation was forwarded to RQIA following the inspection that the store had been tidied and locks had been fitted to both doors.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, quality assurance audits, supervision and appraisal and adult safeguarding.

Areas for improvement

There were no areas for improvement identified during the inspection in this domain.

	Regulations	Standards
Total numb of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

We reviewed three patient care records which contained the management of nutrition, patients' weight, management of infections and wound care and evidenced that care plans were in place to direct the care required and generally reflected the assessed needs of the patient. There was evidence of regular communication with representatives within the care records. A system was also in place to audit patient care records and each patient had a key worker. A daily record had been maintained to evidence the delivery of care and there was evidence that the care planning process included input from patients and/or their representatives, if necessary. One representative said "the staff keep us informed about everything".

Referrals were made to healthcare professionals such as care managers, general practitioners (GPs), speech and language therapists (SALT) and dieticians where necessary and appropriately maintained within the patients care records. Supplementary care charts such as food and fluid intake, repositioning records and elimination records evidenced that contemporaneous records were maintained on most occasions. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), SALT or the dietician.

On review of the repositioning records there were gaps identified within the charts where patients had not been repositioned as per their care plan and where skin was identified as red there was no intervention of treatment documented. It was further identified that set fluid intake targets were not consistently met and where targets were set they generally averaged as a lower intake than the total recommended daily intake with no comment within the daily notes of any action taken. An area for improvement which was identified at the previous care inspection in relation to the action taken following identified deficits in the elimination records was reviewed and although the registered nurses have an oversight of the patients elimination history and were documenting when the patient had no bowel movement within their normal pattern, they did not document what action they had taken. We discussed the above findings with the registered manager who acknowledged the shortfalls in the documentation and agreed to review all patients care plans regarding pressure care and communicate with the registered nurses to ensure they document accurately the daily events within patients care records. This was identified as an area for improvement.

It was positive to note that restrictive practice, such as the use of bedrails or floor alarm mats, had been discussed with the patient, their next of kin and care manager and appropriate consent provided prior to implementing this practice. There was also evidence within the patient's care records of an initial assessment completed to ensure safe use which was reviewed regularly and was included within the patient's care plans.

We also reviewed the settings on identified pressure relieving mattresses and on review of the patients care records the care plans regarding pressure care did not contain the recommended setting/type of pressure relieving mattress. This was discussed with the registered manager who acknowledged the importance of including such information within the patients care plan and agreed to implement this going forward. This was identified as an area for improvement.

Staff confirmed that they were required to attend a handover meeting at the beginning of each shift and were aware of the importance of handover reports in ensuring effective communication. Staff confirmed that the shift handover provided information regarding each patient's condition and any changes noted. One staff member said "Good team work here. Good handovers". Other comments included; "Good wee team" and "Detailed handovers".

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other health care professionals. Staff also confirmed that if they had any concerns, they could raise these with the registered manager or the nurse in charge.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to, communication between patients, staff and other key stakeholders.

Areas for improvement

The following areas were identified for improvement in relation to record keeping and the correct setting on pressure relieving equipment.

	Regulations	Standards
Total number of areas for improvement	1	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff interactions with patients were observed to be compassionate, caring and timely and they demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Patients were afforded choice, privacy, dignity and respect. However, it was identified that there was no nurse call bell or door locks within identified patient bedrooms. This was discussed with the registered manager who provided assurances that patients are assessed as to whether they are suitable to effectively use a nurse call bell and all bedroom door locks would be reviewed to ensure that a clear system of when patients do not wish to be disturbed and/or during personal hygiene interventions is in place. This was identified as an area for improvement.

We also observed the use of a keypad at the front door which we considered to be restrictive practice. While maintaining the security of the building, in regards to the safety and security of patients and their property is recognised, the need to ensure that patients' freedom of movement is suitably promoted and not inappropriately restricted was stressed.

The registered manager acknowledged the importance of patient's freedom of movement and placed appropriate signage below the keypad at the main exit door within reception.

Cards and letters of compliment and thanks were displayed in the home. Some of the comments recorded included:

- "Thank you for all your care"
- "Our most sincere thanks to all the staff"

There were systems in place to obtain the views of patients and their representatives on the running of the home and a suggestion box was placed at the main reception area of the home.

Consultation with 17 patients individually, and with others in small groups, confirmed that living in Drapersfield House was a mostly positive experience.

Patient comments:

- "Staff are very good here"
- "I'm fine. No problems"
- "The food is good"
- "Staff are looking after me well"
- "It's good here"
- "Staff are very rushed and too quick on occasions"

Representative's comments:

- "Couldn't be better"
- "They are all great here"

During the inspection we met with three patient representatives who were very complimentary of the homes environment and did not raise any concerns. We also sought relatives' opinion on staffing via questionnaires. Four questionnaires were returned from patient representatives. The respondents were very satisfied with the service provision across all four domains. Comments included; "Care excellent", "Very satisfied with care and attention from all staff", "Staff always approachable and willing to help" and ""Quite happy with ……. care".

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their information and action as required. Two questionnaires were returned which did not state whether they were from patients or patient representatives. The respondents were very satisfied with the service provision across all four domains.

A variety of methods were used to promote orientation, for example, appropriate signage, photographs and the provision of clocks and prompts for the date. Patients' bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences. Patients and staff spoken with were complimentary in respect of the home's environment whilst acknowledging that there were further improvements to be made.

The outdoor garden space and grounds were well maintained with a sensory garden including seated areas, plants, art work, water feature, and herbs planted by the patients and staff all of which added character to the garden. The registered manager confirmed that the herbs are used by the chefs on occasions and they also provide a great aroma when the patients are outside in the garden. The art work decorated around the walls was produced over a year by the activity therapist and patients with the support of an art tutor who visited the home once a week. The inspector commended the staff for their dedication and interaction with the patients through the diverse range of activities offered.

Within the home there were four dayrooms, two of which were not occupied by any patients throughout the inspection but were suitably furnished and one of which only had three patients. The dayroom to the side of the home on the ground floor was occupied by most of the patients with limited space for patients/staff to move around freely. A discussion with the registered manager and responsible individual evidenced that this dayroom was mainly used due to patient choice whilst recognising the potential health and safety risks both the registered provider and responsible individual agreed to review the seating arrangements.

Discussion with patients and staff and review of the activity programme evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. On the day of the inspection the activity coordinator discussed the provision of activities and the current arrangements within the home to facilitate patient involvement. The patients appeared to enjoy the interaction between the staff and each other. However, it was identified that the schedule was not on display within any of the lounges but was kept within the activity coordinators folder. This was discussed with the registered manager and identified as an area for improvement.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, listening to and valuing patients and their representatives and taking account of the views of patients.

Areas for improvement

The following areas were identified for improvement in relation to privacy arrangements in patient's bedrooms and the appropriate display of the activity schedule.

	Regulations	Standards
Total number of areas for improvement	0	2

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered. A certificate of public liability insurance was in date and on display within the foyer of the home.

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. It was identified that the full name of the employees was not documented within the duty rota. This was discussed with the registered manager and a copy of the duty rota was amended prior to the completion of the inspection. Discussion with staff/patients/representatives evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the registered manager.

We reviewed accidents/incidents records in comparison with the notifications submitted by the home to RQIA which confirmed that records were maintained appropriately and notifications were submitted in accordance with regulation. The inspector also evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA and/or other relevant bodies appropriately.

A number of governance audits were reviewed which were completed on a monthly basis by the manager and/or clinical leads. Accident/incident and wound care audits were well maintained which provided a clear action plan when deficits were identified. Environmental audits were also completed on a monthly basis which captured some of the issues identified during inspection and were in the process of being addressed.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed, however, it was identified that there was no clear system for recording whether or not the complainant was satisfied with the outcome, this was discussed with the registered manager and identified as an area for improvement.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the responsible individual. Copies of the report were available for patients, their representatives, staff and trust representatives.

Staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised. Comments included; "Management very approachable", "Very supported by management" and "Good management. Like one of us".

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, quality improvement and maintaining good working relationships.

Areas for improvement

The following area was identified for improvement in relation to management of complaints and incidents.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Margaret Kolbohom, registered manager, and Jill Canavan, responsible individual, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref**: Regulation 13 (1) (a) **Stated:** First time **To be completed by:** 1 June 2019	The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals. Specific reference to recording charts and daily records: • Action taken should be documented within daily records when set fluid targets have not been maintained • Where a patient has been repositioned the frequency should reflect the current care plan and state the intervention on each repositioning • Where a patient has not had a bowel movement within a time frame which is normal for them, the action taken must be clearly documented. Ref: 6.5
	Response by registered person detailing the actions taken: The Manager and nurse in charge are over seeing all charts to ensure that these have been correctly and fully completed, and entered into the Patients daily records if so required. Registered Nurses on night duty are recording patient's fluid intake in their daily records, over the previous 24 hour period as per their fluid balance charts. Registered Nurses are recording and reporting when set targets are not being met and documenting what their advice is when fluid intake is poor. Registered nurses are recording and reporting why fluid intake is poor i.e. patient drowsy/sleeping etc. Registered nurses are checking and signing fluid balance charts at the end of each shift. They are reminding care staff the importance of documentation of fluid/oral intake. Repositioning charts are documented with why the patient has been repositioned and within the recommended time that is required. Registered nurses are checking repositioning charts regularly and reporting any issues found. Registered nurses are checking bowel charts daily. Care staff are reminded to inform nurses if a patient's bowels have not moved in a few days, so that nurses can act promptly i.e. order laxatives, give extra laxatives as and when required as per GPs advice.

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

Area for improvement 1 **Ref**: Standard 23 **Stated:** First time **To be completed by:** 1 June 2019	The registered person shall ensure that the settings on pressure relieving mattresses are maintained at the correct setting and included in the patients care plan. Ref: 6.5
	Response by registered person detailing the actions taken: For each patient that are on a pressure relieving mattress the nurse calculates the correct setting by the weight of the patient. The correct pressure setting is documented in the patient notes/care plan and this is reviewed monthly.
Area for improvement 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 1 June 2019	The registered person shall ensure that patients have control over who accesses their room and when this happens. Arrangements must be in place to ensure that patient's privacy is upheld. Ref: 6.6
	Response by registered person detailing the actions taken: Patient's who have capacity can lock their bedroom at their own request. The maintenance men ensure that all locks are in good working order. An audit has been carried out to confirm same.

Area for improvement 3 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 1 June 2019	The registered person shall ensure that the programme of activities is displayed in a suitable format and in an appropriate location so that patients know what is scheduled. Ref: 6.6
	Response by registered person detailing the actions taken: The activity therapist ensures that the daily activities are displayed on the Whiteboard in the Corridor and on the notice board in the dayroom. Future events, parties and additional activities are also displayed on the dayroom notice board.
Area for improvement 4 **Ref**: Standard 16 **Stated:** First time **To be completed by:** 1 June 2019	The registered person shall ensure that the complaints procedure includes detail of all communications with the complainant; the results of any investigations; the actions taken; whether or not the complainant was satisfied with the outcome and how this level of satisfaction was determined. Ref: 6.7
	Response by registered person detailing the actions taken: The nurse in charge or whoever the complaint is made to, will document all communications with the complainant, investigation, action taken, if the complainant was satisfied of outcome or not and how satisfaction level was determined. This format is clearly outlined in complaints book. This is audited monthly and overseen by the registered provider when she is completing the regulation 29.

Please ensure this document is completed in full and returned via Web Portal

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care