Unannounced Care Inspection Report
9 October 2017

Drapersfield House

Type of Service: Nursing Home (NH)
Address: 19 Drapersfield Road, Cookstown, BT80 8RS
Tel No: 028 86764868
Inspector: Aveen Donnelly

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care and residential care for up to 45 persons.

3.0 Service details

Organisation/Registered Provider: Drapersfield House Ltd **Responsible Individual:** Mrs Jill Canavan	**Registered Manager:** Mrs Margaret Kolbohm
Person in charge at the time of inspection: Mrs Margaret Kolbohm	**Date manager registered:** 16 June 2016
Categories of care: Nursing Home (NH) I – Old age not falling within any other category LD – Learning disability PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years Residential Care (RC) I – Old age not falling within any other category MP – Mental disorder excluding learning disability or dementia MP(E) - Mental disorder excluding learning disability or dementia – over 65 years	**Number of registered places:** 45 A maximum of 10 residential places. 1 identified person in categories NH-LD, 1 identified person in category RC-MP and 1 identified person in category RC-MP(E).

4.0 Inspection summary

An unannounced inspection took place on 9 October 2017 from 09.00 to 14.45 hours.

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.

The term 'patients' is used to describe those living in the home 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.

There were examples of good practice found throughout the inspection in relation to staff recruitment, staff training and development, adult safeguarding, infection prevention and control, risk management and the home's environment. The care records were generally well maintained; wound care was well managed and communication between residents, staff and other key stakeholders was well maintained. The culture and ethos of the home promoted treating patients with dignity and respecting their privacy and taking account of the views of patients. Mealtimes and activities were well managed. There were good governance and management arrangements in place; complaints and incidents were appropriately managed and there were good working relationships within the home.

Areas requiring improvement made under the regulations related to the management of patients' fluid intake records and in relation to the completion of pain assessments. These areas for improvement have been stated for the second time. New areas for improvement made under the care standards related to the registered nurses' oversight of the patients' elimination records and in relation to the completion of care plans for patients who had infections.

Patients said that they were generally very happy living in the home.

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	*2	2

*The total numbers above include two areas for improvement made under the regulations that have been stated for the second time.

Details of the Quality Improvement Plan (QIP) were discussed with Margaret Kolbohm, Registered Person, and Jill Canavan, Responsible Person, 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 6 March 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 6 March 2017. 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

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing.
- 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 the inspector met with seven patients, five care staff, two registered nurses, two kitchen staff and two patients' representatives. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- staffing arrangements in the home
- one staff personnel file to review recruitment and selection
- staff induction, supervision and appraisal records
- staff training records for 2016/2017
- accident and incident records
- records relating to adult safeguarding
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- eight patient care records
- two patient care charts including food and fluid intake charts and repositioning charts
- patient register
- annual quality report
- compliments records
- RQIA registration certificate
- certificate of public liability
- audits in relation to falls
- complaints received since the previous care inspection
- minutes of staff' and relatives' meetings held since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

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

The findings of the inspection were provided to the registered persons at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 6 March 2017

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

6.2 Review of areas for improvement from the last care inspection dated 18 January 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 14 (2) (c) **Stated:** Second time	The registered persons must ensure that the any chemicals used within the home are stored securely in accordance with COSHH regulations.	**Met**
	Action taken as confirmed during the inspection: Keypad locks had been installed to the sluice room doors to ensure that they were locked at all times.	
Area for improvement 2 **Ref:** Regulation 20 (1) (c) **Stated:** First time	The registered persons must ensure that training is provided and work practices are monitored, in relation to the safe use of bedrails, to ensure that work practices are safe and without risk to health or welfare. Evidence of training, in whatever format provided, must be retained in the home for inspection.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of training records confirmed that training had been provided in relation to the safe use of bedrails.	
Area for improvement 3 **Ref:** Regulation 12 (2) (b) **Stated:** First time	The registered persons must ensure that the processes in place for checking that equipment is in good working order, are further developed and monitored, to ensure that emergency equipment is ready for use at all times.	**Met**
	Action taken as confirmed during the inspection: There was a system in place to ensure that the emergency equipment was checked on a daily basis.	

Area for improvement 4 **Ref:** Regulation 15 (2) (a) (b) **Stated:** First time	The registered persons must ensure that pain assessments are completed (if applicable) for all patients requiring regular or occasional analgesia. This assessment should review the effectiveness of the analgesia and the outcome should be reflected in the patients' care plans. The pain assessment tool to be used must be commensurate with the patient's ability to communicate.	**Partially met**
	Action taken as confirmed during the inspection: Discussion with staff confirmed that pain assessments were completed for patients who had been prescribed transdermal opioid patches and these were reviewed on a regular basis; however, pain assessments were not in place for all other patients. This area for improvement was not fully met and has been stated for the second time.	
Area for improvement 5 **Ref:** Regulation 13 (1) (a) **Stated:** First time	The registered persons must ensure that patients' total fluid intake are recorded in the daily progress notes, to evidence validation by registered nurses and to identify any action taken in response to identified deficits.	**Not met**
	Action taken as confirmed during the inspection: A review of patients' total fluid intake records and daily progress notes did not evidence that the registered nurses had oversight of the patients' total fluid intakes. This area for improvement was not been met and has been stated for the second time.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 46.2 **Stated:** First time	A recommendation has been made that where patients require a urinary catheter, records are maintained, to evidence the date the catheter bag has been changed.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and a review of records confirmed that there was a system in place to ensure that all urinary catheter bags were changed on a particular day.	

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.

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 8 October 2017 evidenced that the planned staffing levels were consistently adhered to. Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. Discussion with staff, patients and their representatives evidenced that there were no concerns regarding staffing levels.

The registered manager explained there were currently no registered nurse or care staff vacancies.

Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

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. Where nurses and carers were employed, their registrations were checked with NMC and NISCC to ensure that they were suitable for employment. The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI and satisfactory references had been sought and received, prior to the staff member starting their employment.

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.

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 completed annual appraisals.

A review of the staff training records confirmed that training had been provided in all mandatory areas and records were kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) and face to face 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.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff were appropriately managed in accordance with NMC. Similar arrangements were in place to ensure that care staff were registered with NISCC.

Staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The staff understood what abuse was and how they should report any concerns that they had. The relevant contact details were available on the noticeboard on the ground floor. There were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. The registered manager was scheduled to attend safeguarding champion training on 18 October 2017. Discussion with staff and a review of records evidenced that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures.

Review of patient care records evidenced that validated risk assessments were completed as part of the admission process and were reviewed as required. However, as discussed in section 6.2, improvements were still required in relation to the completion of pain assessments.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were consistently completed following each incident and that care management and patients' representatives were notified appropriately. A staff member was assigned to the lounge on the ground floor to ensure that patients were supervised appropriately.

A review of the home's environment was undertaken which included a number 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. Some gaps in the completion of cleaning records were identified. Given that the home was found to be clean, this was relayed to the management team to address.

Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

No areas for improvement were identified in this domain.

	Regulations	Standards
Total number 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.

Review of eight patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. With the exception of the completion of pain assessments, all other risk assessments informed the care planning process.

There were a number of examples of good practice found throughout the inspection in this domain. For example, registered nurses were aware of the local arrangements and referral process to access other relevant professionals including general practitioner's (GP), speech and language therapist (SALT), dietician and tissue viability nurse specialists (TVN). Discussion with registered nurses and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

A review of wound care records evidenced that wound care was managed in line with best practice. A review of the daily progress notes of one patient evidenced that the dressing had been changed according to the care plan. Wound care records were supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines.

There was also good practice identified in relation to the management of diabetes. The signs and symptoms of hypoglycaemia were included in the care plan. There was evidence that blood glucose monitoring was undertaken, in keeping with the prescribed insulin regimen.

Patients who were identified as requiring a modified diet, had the relevant risk assessments completed. Care plans in place were reflective of the recommendations of SALT and care plans were kept under review.

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. Advice was given to the registered manager in relation to the need for the frequency of repositioning to be recorded on the personal care booklets, to ensure that new staff were aware of this information.

Despite this, areas for improvement were identified. For example, where patients were prescribed antibiotic therapy for the treatment of acute infections, care plans had not been consistently developed. This has been identified as an area for improvement under the care standards.

A review of the patients' elimination records also identified gaps in completion and there was no evidence that the registered nurses' had oversight of the records. This meant that we were unable to verify if appropriate action had been taken. This has been identified as an area for improvement under the care standards.

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

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

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. Staff also confirmed that communication between all staff grades was effective.

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 general staff meeting was held on 11 September 2017 and a meeting with the registered nurses was held on 25 July 2017. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities.

All those consulted with confirmed that if they had any concerns, they could raise these with the staff and/or the registered manager. A combined patients' and relatives' meeting had been held on 20 September 2017 and records were available.

There was information available to staff, patients, representatives in relation to advocacy services.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping; wound care management; and communication between residents, staff and other key stakeholders.

Areas for improvement

Areas for improvement made under the care standards related to the development of care plans for patients who had infections; and in relation to the registered nurses' oversight of the patients' elimination records.

	Regulations	Standards
Total number of areas for improvement	0	2

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. Consultation with seven 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; and they were offered a choice of meals, snacks and drinks throughout the day. One patient spoken with stated that any special requests for food were always provided. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

We observed the lunch time meal in two dining rooms. The lunch served appeared appetising and patients spoken with stated that they were satisfied with the meals provided. The atmosphere was quiet and tranquil and patients were encouraged to eat their food; assistance was provided by staff, as required. Tables were set with tablecloths and specialist cutlery and plate guards were available to help patients who were able to maintain some level of independence as they ate their meal. We also observed that menus were displayed in pictorial format to assist in making choices and to provide an awareness of the meal to be served.

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. One staff member was designated to provide activities in the home every day. There was evidence of a variety of activities in the home and discussion with patients confirmed that they were given a choice with regards to what they wanted to participate in. Newspapers were provided on a daily basis. There was evidence of regular church services to suit different denominations and patients could watch religious services via live web-stream, if they wanted. Social care plans were in place to provide information to staff to ensure that patients' social care needs were met individually.

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. An annual quality audit had been undertaken; views and comments recorded were analysed and areas for improvement had been 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 their relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included praise for the skill of staff when dealing with a patient who had a communication difficulty.

During the inspection, we met with seven patients, five care staff, two registered nurses, two kitchen staff and two patients' representatives. Some comments received are detailed below:

Staff

"The care is 100 percent."
"Everything is good here."
"We are all very happy, we club together like a family."
"I would put any one of my own family in here, it is so good."
"I love it here, I have no concerns."
"I have no concerns, the care is very person-centred and we try to be warm and welcoming."

Patients' representative

"It is outstanding, my (relative) now has a new baseline since he came in here."
"It is 100 percent, very good."

Patients

"All is fine here."
"It is all very good."
"I am treated very well, you couldn't get better, it is just excellent."
"They are great here."
"I am happy, I have no complaints."
"I enjoy it, I am treated very well."

We also issued ten questionnaires to staff and relatives respectively and eight questionnaires to patients. Seven staff, five patients and four relatives had returned their questionnaires, within the timeframe for inclusion in this report. Comments and outcomes were as follows.

Patient respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. No written comments were received.

Relative respondents indicated that they were 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. No written comments were received.

Staff respondents indicated that they were 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. One written comment received related to the staffing levels and staff training. Following the inspection, these comments were relayed to the responsible person to address.

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

Areas of good practice

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

Areas for improvement

No Areas for improvement were identified in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

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.

Observation of patients and discussion with the registered manager 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.

Staff spoken with stated that there were good working relationships and that management were responsive to any suggestions or concerns raised. All those consulted with described the management team in positive terms. Staff described how they felt confident that the registered manager would respond positively to any concerns/suggestions raised.

There was a clear organisational structure within the home. Staff 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 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 Care Standards for Nursing Homes 2015. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Where complaints had been received, discussion with the management team confirmed that training and supervision had been provided to staff, to ensure that any learning had been embedded into practice.

The complaints procedure and information on advocacy services were displayed on the relatives' noticeboard. Patients 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.

Systems were in place to monitor and report on the quality of nursing and other services provided. 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.

A review of the patient falls audit evidenced that this 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 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 care inspection, confirmed that these were appropriately managed.

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.

Quality monitoring visits were completed in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. An action plan was generated to address any areas for improvement. Discussion with the registered manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

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 Kolbohm, Registered Person, and Jill Canavan, Responsible Person, 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 15 (2) (a) and (b) **Stated:** Second time **To be completed by:** 6 December 2017	The registered persons must ensure that pain assessments are completed (if applicable) for all patients requiring regular or occasional analgesia. This assessment should review the effectiveness of the analgesia and the outcome should be reflected in the patients' care plans. The pain assessment tool to be used must be commensurate with the patient's ability to communicate. **Ref: Section 6.2**
	Response by registered person detailing the actions taken: All patients that have been prescribed any type of pain relief have been commenced on a pain recording chart,relevant to the patients communication skills. I will audit frequently to ensure registered nurses are carrying this out.
Area for improvement 2 **Ref:** Regulation 13 (1) (a) **Stated:** Second time **To be completed by:** 6 December 2017	The registered persons must ensure that patients' total fluid intake are recorded in the daily progress notes, to evidence validation by registered nurses and to identify any action taken in response to identified deficits. **Ref: Section 6.2**
	Response by registered person detailing the actions taken: Registered nurse will all now check all the patients who are on a fluid balance charts at change over of all shifts to ensure fluid balance charts are fully completed. The registered nurse will sign, date and time when charts are checked. The registered nurse doing night duty will total charts, sign, date and time the patients intake and output over a 24 hr period and pass it over at the hand over report. If patients are not reaching their fluid intake, the registered nurse will document it in the daily evaluation sheet and contact the patients GP if necessary. I will audit the fluid balance charts frequently to ensure this is carried out.
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 6 December 2017	The registered persons shall ensure that care plans are developed for patients who have acute infections. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: All registered nurses are all now aware that if a patient develops an acute infection a personalized care plan needs to be devised. I will continue to audit patients notes to ensure this is carried out.

Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 6 December 2017	The registered persons 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. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: All patients have been commenced on a Bristol Stool Chart so the Registered nurses are able to identify patients normal bowel habits. This is then documented in the patients individual care plans. I will audit frequently the patients Bristol Stool charts to ensure that charts are completed. If it is noted by the registered nurse that there are any problems with the patients bowel habits, the registered nurse will contact the patients GP and document in the patients daily evaluation sheet.

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

The Regulation and Quality Improvement Authority

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