Unannounced Care Inspection Report
5 October 2017

Rivervale Country

Type of Service: Nursing Home (NH)
Address: 56a Dunamore Road, Cookstown, BT80 9NT
Tel No: 028 8675 1787
Inspector: Aveen Donnelly

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 20 persons.

3.0 Service details

Organisation/Registered Provider: Rivervale Country **Responsible Individual(s):** Miss Cecelia Theresa O'Neill Ms Helena Margaret O'Neill	**Registered Manager:** Ms Helena Margaret O'Neill
Person in charge at the time of inspection: Ms Helena Margaret O'Neill	**Date manager registered:** 1 April 2005
Categories of care: Nursing Home (NH) DE – Dementia I – Old age not falling within any other category PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years MP – Mental disorder excluding learning disability or dementia MP(E) - Mental disorder excluding learning disability or dementia – over 65 years Residential Care (RC) DE – Dementia I – Old age not falling within any other category MP(E) - Mental disorder excluding learning disability or dementia – over 65 years PH(E) - Physical disability other than sensory impairment – over 65 years MP – Mental disorder excluding learning disability or dementia PH – Physical disability other than sensory impairment	**Number of registered places:** 20 A maximum of 3 persons in residential categories. No more than 1 resident in category RC-DE and no more than 5 patients in category NH-DE

4.0 Inspection summary

An unannounced inspection took place on 5 October 2017 from 09.30 to 15.30 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, training and development, infection prevention and control, risk management and the home's environment. Risk assessments and care plans were generally well maintained, there was good oversight of patients' weight loss; and communication between residents, staff and other key stakeholders was well maintained. There were good governance and management arrangements in place, complaints were appropriately managed there were good working relationships within the home.

Areas for improvement made under the regulations related to the recording of blood glucose monitoring in keeping with the patient's prescribed insulin regimen and care plan. Areas for improvement made under the care standards related to the embedding of the new regional operational safeguarding policy and procedure into practice; the completion of falls risk assessments after every fall; the further development of the bedrail risk assessment form; wound care records; the completion of validated pain assessments; and the development of a falls audit. 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.

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	1	6

Details of the Quality Improvement Plan (QIP) were discussed with Helena O'Neill, Registered Manager, and Teresa O'Neill, 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 26 June 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 26 June 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 six patients, two care staff, one registered nurse, 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.

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 confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- three 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 care records and falls
- complaints received since the previous care inspection
- minutes of staff' and patients' 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 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 6 February 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 6 February 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 15 (2) (a) **Stated:** Second time	The registered persons must ensure that accurate records are maintained in regards to patients' bowel patterns. Bowel records must be monitored by registered nurses and records maintained of any action taken.	**Met**
	Action taken as confirmed during the inspection: A review of records confirmed that the registered nurses had good oversight of the bowel functioning records.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 23.5 **Stated:** Second time	The registered persons should ensure that the records of equipment checks are further developed, to include recording of the individual setting specified for each pressure relieving mattress	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and observation on the day of the inspection confirmed that this recommendation had been met.	

Area for improvement 2 **Ref:** Standard 41 **Stated:** First time	A recommendation has been made that the duty rota is accurately maintained.	**Met**
	Action taken as confirmed during the inspection: A review of the staff rota confirmed that it was accurately maintained.	
Area for improvement 3 **Ref:** Standard 21.6 **Stated:** First time	A recommendation has been made that that bowel function, reflective of the Bristol Stool Chart, should be recorded on the patients' continence assessment, as a baseline measurement and thereafter included in the patients' care plan.	**Met**
	Action taken as confirmed during the inspection: A review of the care records confirmed that the Bristol stool chart was used to record the patients' normal bowel pattern.	
Area for improvement 4 **Ref:** Standard 37.1 **Stated:** First time	A recommendation has been made to ensure that consideration is given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times.	**Met**
	Action taken as confirmed during the inspection: Observation on the day of the inspection confirmed that this recommendation had been met.	

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 25 September 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. 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. For agency staff, their profile was maintained, which included information on the Access NI check and NMC/NISCC checks.

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. Discussion with agency staff also confirmed that they had received a thorough induction over a three-day period.

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.

Discussion with staff and 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 the majority of staff completed face to face training 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. Advice was given in relation to developing a training matrix which would give the registered persons better oversight of the training records. Observation of the delivery of care evidenced that training had been embedded into practice.

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. However, discussion with the registered manager confirmed that they were yet to complete training to support their role as the safeguarding champion for the home; and they were unaware of the responsibilities of this role. This meant the new regional operational safeguarding policy and procedure had not been fully embedded into practice. This has been identified as an area for improvement under the care standards.

Review of patient care records evidenced that validated risk assessments were generally completed as part of the admission process and were reviewed as required. These risk assessments informed the care planning process. However, some deficits were identified in relation to the care records. Refer to section 6.5 for further detail.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were regularly updated; however, the falls risk assessments were not consistently updated when a patient had fallen. This has been identified as an area for improvement under the care standards. It was also identified that the accidents which occurred in the home were not formally audited. This is further discussed in section 6.7.

Where patients required bedrails, to maintain their safety whilst in bed, there was evidence that risk assessments had been completed; and that regular safety checks had been carried out, when the patients were in bed. However, it was identified that the bedrail risk assessment required to be further developed to ensure that it included more information on the patients' abilities/risk level. This has been identified as an area for improvement under the care standards.

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

Infection prevention and control measures were adhered to and equipment was stored appropriately.

Fire exits and corridors were 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

Areas for improvement made under the care standards related to the embedding of the new regional operational safeguarding policy and procedure into practice; the completion of falls risk assessments after every fall; and the further development of the bedrail risk assessment form.

	Regulations	Standards
Total number of areas for improvement	0	3

6.5 Is care effective?

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

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that 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, a review of personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Repositioning records evidenced that patients were repositioned according to their care plans.

A sampling of food and fluid intake charts confirmed that patients' fluid intakes were monitored. Patients who had been identified as being at risk of losing weight had their weight regularly monitored. This ensured that any weight loss was identified and appropriate action taken in a timely manner. The patients' weights were audited by the registered manager on a monthly basis.

Patients' elimination records were monitored by the registered nurses on a daily basis, to ensure that any changes from the patients' usual bowel patterns were identified and timely action taken. Patients who were identified as requiring a modified diet, had care plans in place were reflective of the recommendations of SALT and the care plans were kept under review. Discussion with the kitchen staff confirmed that they had been informed of any changes to the patients' diets.

Despite this, a number of areas for improvement were identified in relation to the care records. For example, a review of one patient care record identified that blood glucose monitoring had not been recorded in keeping with the patient's prescribed insulin regimen and care plan. This has been identified as an area for improvement under the regulations.

Furthermore, although there was evidence in one patient care record that wound dressings had been changed according to the advice provided by the relevant medical professional; the care plan did not specify the prescribed treatment for each wound identified. There was also no evidence that wound photography was recorded in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines. This has been identified as an area for improvement under the care standards.

Patients who were prescribed regular analgesia had care plans in place, which were reviewed regularly; however, validated pain assessments were not completed. 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 staff meeting was held on 14 August 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 patients' meeting had been held on 10 July 2017 and records were available. Through discussion with patients and their representatives, it was evident that the registered persons were present in the home on a daily basis; and that they made themselves available to anyone wishing to raise any concerns.

Areas of good practice

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

Areas for improvement

Areas for improvement made under the regulations related to the recording of blood glucose monitoring in keeping with the patient's prescribed insulin regimen and care plan.

Areas for improvement made under the care standards related to wound care plans and wound photography; and in relation to the completion of validated pain assessments.

	Regulations	Standards
Total number of areas for improvement	1	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 six patients individually confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care.

Patients stated that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

We observed the lunch time meal in the dining room. 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 meals.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. 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. There was evidence of regular church services to suit different denominations.

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 report had been undertaken in September 2016; and the responsible person confirmed that there were plans in place to complete an annual report for this year. 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 'care, kindness and support' given to a patient and their family members, when the patient was receiving end of life care.

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

Staff

"It is all the very best here."
"It is excellent."
"I love it here."

Patients

"They are a great lot of girls."
"All is good here."
"I am getting on very well."
"They treat me well."
"It is very good."
"The staff are very polite."

Patients' representative

"The care is exceptional, they are very good here."
"Absolutely no concerns in here."

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

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 comment was received.

Patient respondents indicated that they were either 'very satisfied' or 'satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. One respondent provided written comment in relation to the staff. Written comment included 'the (staff) here are all brilliant, you could not find better staff anywhere. They look after me around the clock, I find it so safe here'.

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. Written comment included 'the patients always comes first' and 'management and staff give me all the support I need'.

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 during the inspection.

	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.

There were good working relationships and that management were responsive to any suggestions or concerns raised. Staff described how they felt confident that the registered manager would respond positively to any concerns/suggestions raised; and 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. 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.

There were systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to mattresses, the environment, hand hygiene and the care records. Through discussion it was evident that appropriate actions were taken immediately where any shortfalls had been identified.

As discussed in section 6.4, discussion with the registered manager confirmed that there was no formal audit completed in relation to patients' falls. Although RQIA acknowledges that there was a low incidence of falls in the home; an audit still was required to be completed, to ensure that timely action was taken in response to any identified patterns or trends. This has been identified as an area for improvement under the care standards.

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.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

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

An area for improvement made under the care standards related to the development of a falls audit.

	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 Helena O'Neill, registered manager and Teresa O'Neill, 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 13 (1) (a) **Stated:** First time **To be completed by:** 2 December 2017	The registered persons shall ensure that records of blood glucose monitoring are maintained in keeping with the patient's prescribed insulin regimen and care plan. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: Trained staff have been reminded of the importance of maintaining+ and recording blood sugar readings as prescribed and have been instructed to check their records on each shift to ensure all daily entries have been completed.
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref:** Standard 13 **Stated:** First time **To be completed by:** 2 December 2017	The registered persons shall ensure that the new regional operational safeguarding policy and procedure is put into practice. This includes training for the identified safeguarding champion, to ensure that they are aware of the responsibilities of this role. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: Two senior menbers of staff have been enrolled on a Safeguarding champion course.
Area for improvement 2 **Ref:** Standard 22.6 **Stated:** First time **To be completed by:** 2 December 2017	The registered persons shall ensure that the falls risk assessment is reviewed every time a patient falls in the home. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: Staff have been reminded to review patients falls risk assessment following any fall and a falls audit has been developed

Area for improvement 3 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 2 December 2017	The registered persons shall ensure that the bedrail risk assessment is further developed to ensure that it is reflective of the patients' abilities/risk level. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: An alternative bedrail risk assessment has been put in place as recommended, to reflect the patients abilities and level of risk.
Area for improvement 4 **Ref:** Standard 22 **Stated:** First time **To be completed by:** 2 December 2017	The registered persons shall ensure that the wound care plans include information on the prescribed dressing regiment. Wound care records should also be supported by the use of photography, in keeping with the National Institute of Clinical Excellence (NICE) guidelines. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: Wound care plans have been reviewed to include prescribed dressing regime, and potography will be used to support wound care, with the permission of the patient, or their representative.
Area for improvement 5 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 2 December 2017	The registered persons shall ensure that patients who are prescribed regular analgesia, have validated risk assessments completed. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: Validated risk assessments have been developed for patients who have been prescribed regular analgesia.
Area for improvement 6 **Ref:** Standard 35.4 **Stated:** First time **To be completed by:** 2 December 2017	The registered person shall ensure that a falls audit is completed on a monthly basis, to ensure that any patterns or trends can be identified and timely action taken. **Ref: Section 6.7**
	Response by registered person detailing the actions taken: Falls audits will be completed on a monthly basis to identify patterns and trends and to enable action if require to be taken and a plan put in place.

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

The Regulation and Quality Improvement Authority

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