Unannounced Care Inspection Report
27 October 2016

The Court Care Home

Type of Service: Nursing Home
Address: 1a Queens Avenue, Ballymoney, BT53 6DF
Tel no: 028 2766 6866
Inspector: Sharon Loane

1.0 Summary

An unannounced inspection of The Court Care Home took place on 27 October 2016 from 11.00 to 16.45 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Significant concerns were identified during this inspection in respect of the general governance arrangement in the home and with the delivery of care specifically in the general nursing unit. The deficits identified in both governance arrangements and care delivery had the potential to impact negatively on patient outcomes.

As a consequence, a meeting was held with senior management in RQIA and it was agreed that a meeting with the registered persons would be held with the intention of issuing two failure to comply notices in regards to the quality of nursing care and governance arrangements.

The registered persons were required to attend a meeting in RQIA on 2 November 2016. The registered person; Dr Maureen Claire Royston was unable to attend the meeting and nominated the Resident Experience Regional Manager, Ruth Burrows, to attend on her behalf. The regional manager, Louisa Rea also attended the meeting. The registered manager was unable to attend due to prior commitments.

During the intention meeting management representatives acknowledged the failings identified and submitted a detailed and comprehensive action plan to address the identified concerns. It was acknowledged that whilst work was ongoing to address these concerns, RQIA were not fully assured that these had been sufficiently embedded into practice. Given the need to develop governance arrangements, imbed improvements into practice, and the potential impact on patient outcomes, it was decided that two failure to comply notices under Regulation 10 (1) and Regulation 12 (1) (a) and (b) of the Nursing Homes Regulations (Northern Ireland) 2005 would be served. The date when compliance must be achieved is 5 January 2017. Further inspection will be undertaken at this time to validate compliance.

Full details of the enforcement action taken can be viewed at www.rqia.org.uk.
The Court Care Home were required to share some of the concerns identified at this time with the safeguarding team of the Northern Health and Social Care Trust. Relevant Stakeholders have also been advised of the enforcement action taken.

Is care safe?

Weaknesses were identified in the delivery of safe care, specifically in relation to infection prevention and control practice, training and staffing arrangements. The shortfalls identified at this inspection had the potential to impact on the delivery of safe, effective patient care.
Two requirements and one recommendation are stated to drive improvements within this domain.

Is care effective?

Significant weaknesses were identified in the delivery of effective care in the general nursing unit of The Court Care Home. Deficits were evidenced specifically in relation to the management of wound care, nutrition, weight loss and the nursing process. This was concerning, and had the potential to negatively impact on patients' health and welfare. Given the findings of this inspection, the issues identified under this domain were required to be actioned under a failure to comply notice served under Regulation 12 (1)(a) and (b) of the Nursing Homes Regulations (Northern Ireland) 2005.

Is care compassionate?

There was evidence of good communication in the home between staff and patients and patients were praiseworthy of staff. Staff interactions were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. During the inspection, activities were provided and patients were observed participating at various levels and appeared to enjoy these.

No areas of improvement were identified within this domain.

Is the service well led?

Weakness identified, evidenced that there was a lack of management and governance systems in place to assure the delivery of safe and effective quality care.

Following this inspection RQIA were concerned that the quality of governance of care delivery within The Court Care Home was below the standard expected. Whilst the dementia nursing unit was evidenced to be functioning appropriately it was concerning that the general nursing unit evidenced such significant concerns. It was further concerning that the governance arrangements had not identified the inconsistencies in systems and processes between the units.

Given the findings of this inspection, the issues identified under this domain were required to be actioned under a failure to comply notice served under Regulation 10 (1) of the Nursing Homes Regulations (Northern Ireland) 2005.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Louisa Rea, regional manager and Louise McIlwrath, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action resulted from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 2 June 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Four Seasons (No.11) Limited/Dr Maureen Claire Royston	**Registered manager:** Mrs Louise McIlwrath
Person in charge of the home at the time of inspection: Mrs Louise McIlwrath	**Date manager registered:** 03 April 2013
Categories of care: NH-DE, NH-I, NH-PH A maximum of three persons in category NH-PH. A maximum of 14 patients in category NH-DE to be accommodated in the dementia unit.	**Number of registered places:** 45

3.0 Methods/processes

Prior to inspection we analysed the following records:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from inspections undertaken in the previous year
- the previous care inspection report
- pre inspection assessment audit.

During this inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with four patients individually and with the majority of others in small groups. Two registered nurses, four care staff, one activities co-ordinator, one domestic assistant and two catering staff and one patient's representatives were consulted with at this inspection.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- a review sample of staff duty rotas
- five patient care records
- staff training records for 2015/2016
- accident and incident records
- two staff personnel files (including induction records)
- complaints received since the previous care inspection
- records of NMC checks for registered nurses and records of NISCC for care staff
- minutes of staff meetings
- a review of quality audits
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 02/06/16

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

4.2 Review of requirements and recommendations from the last care inspection dated 17/02/16

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 32.8 **Stated:** First time	The registered manager should ensure that patient's spiritual, cultural and religious needs and preferences have been documented in end of life care plans.	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that care plans included the information as outlined in this recommendation.	

Recommendation 2 **Ref**: Standard 32.3 **Stated:** First time	The registered manager should identify a palliative care link nurse for the home.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that a palliative care link nurse has been identified and that the home were trying to organise additional training for the staff member to assist them with their role as link nurse for palliative care. The registered nurse had completed palliative care training as part of Four Seasons Health Care training programme. This recommendation has been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and 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 week commencing 24 October 2016 evidenced that the planned staffing levels were adhered to.

Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels. However a review of minutes from a staff meeting held recently included comments that indicated that “registered nurses were experiencing difficulty in getting paperwork completed”. This information was discussed further with the registered manager who advised that staffing levels on night duty had been reviewed by the regional manager and that there had been some recent changes to the allocation of staff on night duty in the general nursing unit. The registered manager advised that following the review, one registered nurse and one care assistant were now rostered on duty from 12 midnight; whereas previously two care assistants were allocated. Observations made during this inspection evidenced that the dependency levels of patients accommodated in the general nursing unit were high and that patients required high levels of nursing care.

A review of monthly quality monitoring reports for August and September 2016 indicated that improvements were required in regards to the completion of care records. Furthermore, the findings of this inspection evidenced shortfalls in nursing care records and also in regards to the delivery of safe effective care. This information and evidential evidence was discussed with the regional manager at the inspection, who indicated that the staffing arrangements would be reviewed again to ensure the delivery of safe effective care and the shortfalls identified at this inspection. A requirement has been made.

The registered manager advised that a registered nurse was identified to take charge of the home when the manager was off duty. The registered nurse in charge on day and night duty was clearly identified on the duty rota reviewed. Discussion with the registered nurse that was in charge of the home on the day of the inspection, confirmed that they had been provided with relevant information to undertake the role and demonstrated knowledge regarding managerial responsibilities. The registered nurse confirmed that a competency and capability assessment had been completed recently.

A review of two personnel files evidenced that recruitment processes were in keeping with the Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. The record maintained of Access NI checks was reviewed and evidenced that the necessary information had been reviewed and checked prior to the candidates commencing employment.

Discussion with the registered manager and a review of records evidenced that there were arrangements in place for monitoring the registration status of nursing and care staff with their relevant professional bodies.

Discussion with the registered manager and staff and a review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

The registered manager and staff confirmed that there were systems in place to ensure that staff received support and guidance and to monitor staff performance if required. Staff were coached and mentored through one to one supervision, competency and capability assessments and annual appraisals.

Discussion with staff and a review of the staff training records evidenced that training had been provided in all mandatory areas and this was kept up to date. A review of training records confirmed that staff completed e-learning (electronic learning) modules for mandatory training requirements. Practical training sessions were provided in relation to safe moving and handling and fire safety. The provision of practical training sessions in regards to basic life support was discussed with staff and the registered manager. Staff indicated that they were of the opinion that the current method of training provided in this regard did not provide them with the confidence and competency to complete this skill. The registered manager advised that this matter has been raised with Four Seasons Health Care and was currently being reviewed and addressed. Overall compliance with training was monitored by the registered manager and this information informed the responsible persons' monthly monitoring visit undertaken in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. The registered manager advised that there had been noted improvement in training compliance figures as a result of more robust monitoring and actions taken accordingly. Training compliance was now 92 per cent compared to 52 per cent previously recorded. This is commended.

Staff training records were not reviewed during the inspection in regards to the management of wounds, pressure ulcers and nutrition including the management of weight loss. Observations of care and a review of nursing care records did not provide adequate assurances that staff were appropriately trained and competent to meet the needs of the patients in these areas of nursing care. This had the potential to result in negative outcomes for patient's health and welfare. This has been discussed further in section 4.4.

A recommendation has been made that training should be provided for relevant staff in these areas of practice and systems should be developed and implemented to ensure that the learning has been embedded into practice.

Review of four patient care records evidenced that a range of validated risk assessments were to be completed as part of the admission process and then subsequently reviewed. However evidence was not available to confirm that risk assessments were being reviewed consistently or accurately and on some occasions the risk assessments had not informed the care planning process. This is discussed further in section 4.4.

A review of the accident and incident records confirmed that in general appropriate action had been taken and care management and patients' representatives were notified appropriately. However, prior to the inspection a notification submitted to RQIA retrospectively evidenced some shortfalls in reporting. This has been discussed further in section 4.6 and forms part of the failure to comply notice issued.

A general inspection of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, storage rooms and communal areas. The majority of patients' bedrooms were personalised with photographs, pictures and personal items.

Concerns were identified in regards to the hygiene of toileting aids within communal bathrooms. This was particularly concerning given the recent facility visit undertaken by the Public Health Agency during July 2016. Some of the recommendations made were reviewed at this inspection, and it was evidenced that appropriate actions had not been implemented. For example; a recommendation made in regards to the cleanliness and decontamination of toileting equipment continued not to be met. Observations made evidenced that raised toilet seats were unclean and soiled underneath. Discussion with the registered manager and staff indicated a lack of awareness and that appropriate measures had not been implemented in response to this shortfall previously raised. This is not in keeping with infection prevention and control and has the potential to impact negatively on patients' health and welfare. A requirement has been made.

Fire exits and corridors were observed to be clear of clutter and obstruction.

A discussion was held with the registered manager regarding an ongoing variation that had been submitted to RQIA in May 2016. Additional information was provided by the registered manager in regards to same and the care inspector provided further clarification in relation to some matters discussed. This information has been shared with the estates inspector at RQIA for further review and follow up actions.

Areas for improvement

Two requirements and one recommendation were made, in relation to staffing arrangements, infection prevention and control and training in specified areas of practice.

Number of requirements	2	**Number of recommendations**	1

4.4 Is care effective?

A review of six care records was undertaken; four in the general nursing unit and two in the nursing dementia unit.

Nursing Dementia Unit

Care records reviewed in the nursing dementia unit evidenced that risk assessments were completed as part of the admission process and were reviewed and updated regularly.

One care record reviewed evidenced that initial plans of care were based on the pre-admission assessment and referral information. A comprehensive, holistic assessment was commenced on the day of admission and completed within five days of admission to the home.

A second care record was reviewed in regards to the management of weight loss. There was evidenced that nutritional screening was carried out in accordance with best practice guidelines and an appropriate nutritional care plan was in place. There was evidence that the care plan had been reviewed and evaluated at regular intervals and that entries made accurately reflected the patient's needs.

There was evidence that the patient's weight was monitored in accordance with the best practice guidance and appropriate actions had been taken including the involvement of other health and/or medical professionals.

A review of food and fluid intake charts evidenced that these were being completed accurately and a discussion with the registered nurse and a review of records evidenced that these were being monitored by registered nurses on a daily basis. Information recorded in the patient's daily progress notes was consistent with the information recorded in the food and fluid charts and fluid intakes were reconciled and recorded in the patients daily evaluation notes.

No concerns were raised in the review of records or delivery of care within this unit.

General Nursing Unit

Care records examined within the general nursing unit were identified as requiring improvements and they were not sufficiently detailed to reflect the assessed needs of patients. Significant concerns were identified regarding the quality of care delivered within this unit. There was a lack of evidence to demonstrate that safe and effective care and treatment was being delivered consistently, in regards to the management of wounds, nutrition and weight loss. Care records examined did not evidence a systematic approach to assessing, planning and evaluating care.

As discussed in section 4.3, the review of four patient care records did not evidence that risk assessments were accurately and consistently completed and reviewed in accordance with changes in the patient's condition. Care plans were either not in place, or not sufficiently reviewed in response to the changing needs of patients. Discrepancies were also identified in relation to some of the information recorded.

The following issues were identified in the named care records provided to the registered manager and the regional manager.

There was insufficient evidence within the care records reviewed that patient weight loss was being identified and appropriately managed. The Malnutrition Universal Screening Tool (MUST) used by the home, had not been completed consistently and significant gaps were noted of up to and including a period of five calendar months, despite patients having significant weight loss. Care plans for the management of weight loss were not in place for all three identified patients.

Food and fluid charts were inconsistently recorded with evidence of long gaps between entries and in some cases no entries were recorded. Fluid charts were not always reconciled and the information was not consistently recorded in the daily evaluation notes. A comparison of information recorded within food and fluid charts and daily progress notes for individual patients identified inconsistencies and inaccuracies. For example, one registered nurse had recorded "intake good" when the food and fluid chart indicated that the patient had "refused all meals except a small supper". There were other examples of similar inaccuracies. Entries in the progress notes were often vague and meaningless, for example, "satisfactory intake, diet tolerated well", with no indication if this was accurate. Registered nurses did not make any record of the action they had taken when food and /or fluid intake was inadequate.

A review of care records found insufficient evidence that patient's weight loss was being identified and appropriately managed.

The failure to accurately record food and fluid intake for patients identified as being at risk of malnutrition and dehydration could have potentially serious consequences for patients.

A review of wound care records for an identified patient evidenced significant gaps in the delivery of care. Wounds that required dressings to be renewed on alternate days had not been changed for up to and including one week. In addition the care plan in place for wound management had not been reviewed and updated in four months.

Repositioning charts were not being recorded accurately and repositioning was not carried out in accordance with the patients care plan. The care plan indicated that the patient required two hourly positioning however a review sample of records evidenced gaps of up to and including five hours between positional changes. There was no evidence that these records were being monitored and reviewed by registered nurses and corrective actions taken.

There was, therefore, potential for nursing staff to fail to prevent, identify or manage pressure care and/or pressure ulcers appropriately.

Given the identified concerns within this domain and the potential impact to patients' health and welfare, it was considered that the matters be addressed through a failure to comply notice in respect of Regulation 12 (1) (a) and (b) of the Nursing Homes Regulations (Northern Ireland) 2005. Further inspection will be undertaken to ensure that compliance with regulations is achieved.

In addition, a recommendation has been made under the safe domain that training must be provided for staff relevant to their roles and responsibilities in the areas aforementioned including the nursing process.

Discussion with the registered manager and staff evidenced that nursing staff were required to attend a handover meeting at the beginning of each shift.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained. The registered manager advised that regular meetings were held across teams and also a general staff meeting was held twice annually. A review of the minutes of some meetings held evidenced the accuracy of this information.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager.

Discussion with the registered manager and information displayed in the foyer of the home evidenced that patient and/or relatives meetings were held quarterly. Minutes were available.

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. Patients and representatives were aware of who their named nurse was and knew the registered manager.

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

Areas for improvement

The matters identified were concerning and had the potential to impact negatively on patients' health and welfare. Actions to address the identified shortfalls in regards to the quality of nursing care and other services provided have been included in a failure to comply notice issued under Regulation 12 (1) (a) and (b) of the Nursing Homes Regulations (Northern Ireland) 2005.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to patients' needs. Staff were observed responding to patients' needs and requests in a timely and cheerful manner. Staff spoken with were knowledgeable regarding patient's personal preferences.

Patients spoken with commented positively in regard to the care they received and were generally happy in their surroundings.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. Nine patients were observed being nursed in bed within the general nursing unit. Discussion with a registered nurse and a review sample of care records evidenced the rationale for this care intervention. Observations of care delivery confirmed that patients were assisted appropriately, with dignity and respect with the exception of the issues referred to in section 4.4.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

During this inspection, the home was having a party to celebrate "Halloween". Music and refreshments were provided and it was evident from the patients' engagement and participation that they were enjoying the activity. Some family members were also present and there was evidence of good relationships and interactions between patients, relatives and staff.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. One patient representative spoken with at the inspection advised that they were satisfied with the care that their relative received and were confident that if they raised a concern or query with the registered manager or staff, appropriate actions would be taken.

During the inspection, four patients were consulted on an individual basis and the majority of others in smaller groups, two registered nurses, three care staff; two catering staff and one ancillary staff member were also consulted.

All comments received from patients were positive, some of which included;

“The care is very good.”
“I am happy living in the home.”
“No complaints, issues are dealt with.”

In addition to speaking with patients, their representatives and staff, questionnaires were provided by RQIA for distribution and a request was made that these would be returned within an identified timeframe.

At the time of writing this report, no questionnaires were returned from any identified groups.

Areas for improvement

No specific areas for improvement have been made under this domain as identified improvements during this inspection were made under the other three domains.

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

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home’s certificate of public liability insurance were appropriately displayed in the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and the Patient Guide were displayed and available in the reception area of the home.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

A copy of the complaints procedure was displayed in the home. Discussion with the registered manager and review of the home’s complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

It could not be validated that effective quality monitoring and governance systems were in place to ensure the safe and effective delivery of care to patients; this had the potential to place patients at risk of harm.

It was of significant concern that the quality assurance and governance systems failed to identify or address the deficits in management of wounds, weight loss and nutrition. There was also an inconsistent approach to the auditing process for example; the last audits completed for nutrition and weight loss were July 2016.

There was also a lack of evidence that the care planning process was accurate and reliable and that the recommendations of other health care professionals were adhered to at all times. In addition, audits that had been undertaken of patient care records were of no intrinsic value to the monitoring of the standard of care planning and care documentation.

It was of further concern that the issues identified at this inspection, had not been identified during the completion of the monthly monitoring reports; as required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Prior to this inspection, RQIA had not been notified in a timely manner regarding incidents which had occurred in the home as per Regulation 30 of the Nursing Homes Regulations (Northern Ireland), 2005. Furthermore, at this inspection it was identified that the home had not notified RQIA that a registered nurses employment had been terminated and referral in this regard had been made to the Nursing Midwifery Council (NMC).

These deficits in senior management oversight had the potential to impact negatively on patients' health and welfare. The concerns identified formed part of the intention meeting on 2 November 2016, to issue a failure to comply notice. As a consequence of the meeting a failure to comply notice was served in respect of Regulation 10 (1) of the Nursing Homes Regulations (Northern Ireland) 2005. Further inspection will be scheduled as detailed above to validate compliance with this breach in Regulations.

Areas for improvement

The improvements required have been included in the two failure to comply notices issued under Regulation 10 (1) and Regulation 12 (1) (a) and (b) of the Nursing Homes Regulations (Northern Ireland) 2005.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed as part of the inspection process. The timescales commence from the date of inspection.

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

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

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to the web portal for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 20 (1) (a) **Stated:** First time **To be completed by:** 30 November 2016	The registered provider must ensure that the number and skill mix of staff working in the home over a 24 hour period is adequate to ensure the delivery of safe effective care. Evidence of decision making information should be retained. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Staffing has been reviewed by the Home Manager and Regional Manager ;the number of staff and the skill mix meets the assessed needs of the current resident group and will be kept under review
Requirement 2 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** 30 November 2016	The registered provider must minimise the risk of infection and the spread of infection between patients and staff. This requirement is made specifically in relation to the cleaning and decontamination of toileting aids including raised toilet seats. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Housekeeping Team ensure that raised toilet seats are included in their daily tasks. Care Staff decontamination files have been updated and staff are completing daily Current Infection Control e learning percentage is 98% Infection control audits are completed and actions addressed as identified

Recommendations	
Recommendation 1 **Ref**: Standard 39 Criteria 4 **Stated:** First time **To be completed by:** 30 December 2016	The registered provider should provide training for staff in relation to their roles and responsibilities in the following identified areas; • the management of wounds and pressure care • the management of nutrition including weight loss • the nursing process including record keeping A system should be developed and implemented to ensure that the learning has been embedded into practice. **Ref: Section 4.3 & 4.4**
	Response by registered provider detailing the actions taken: All Care & Nursing Staff have received training in Care Documentation and Supplementary Charts – records are retained Nursing staff have completed Competencies in Wound Care Further training in Use of Thickeners has been requested and is due to take place on 11th January 2017 Supervisions have been completed in respect of Nutrition/Fluid management . The areas of practice which were identified as requiring training and support to improve practice have been discussed at the staff meetings held on 10.11.16 and 1.12.16 notes of these meetings are held on record A tool has been devised which supports the Registered Manager / senior staff complete spot checks of staff knowledge on the subject of wounds, pressure care and nutrition. The tool affords the opportunity for feedback and further discussion with staff.

Please ensure this document is completed in full and returned to the web portal

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