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Unannounced Care Inspection
of
Seapatrick Care Home

02 September 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 02 September 2015 from 10.00 to 16.30.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

For the purposes of this report, the term 'patients' will be used to described those living in Seapatrick Care Home which provides nursing care.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 9 December 2014.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**5**	**2**

The details of the Quality Improvement Plan (QIP) within this report were discussed with the Edel McCaughley, registered manager as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four Seasons Healthcare Maureen Claire Royston	**Registered Manager:** Edel McCaughley
Person in Charge of the Home at the Time of Inspection:	**Date Manager Registered:** 08 March 2015
Categories of Care: NH-PH, NH-I, NH-DE	**Number of Registered Places:** 61
Number of Patients Accommodated on Day of Inspection: 59	**Weekly Tariff at Time of Inspection:** £593

3. Inspection Focus

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

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

4. Methods/Process

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

Prior to inspection the following records were analysed:

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

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with twenty patients, four care staff, one domestic staff, three nursing staff and two patient's visitors/representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP;
- staffing arrangements in the home;
- six patient care records;
- staff training records;
- complaints records;
- regulation 29 monthly monitoring reports;
- policies for communication and end of life care; and
- policies for dying and death and palliative and end of life care.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an announced estates inspection dated 13 January 2015. The completed QIP was returned and approved by the estates inspector.

5.2 Review of Requirements and Recommendations from the last care inspection 9 December 2014

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref: Regulation 20 (1) (c) (i)** **Stated: Third time**	The registered persons shall ensure that the persons employed by the registered person to work at the nursing home receive, appraisal, mandatory training and other training appropriate to the work they are to perform. • All nursing and care staff must receive training and be assessed and deemed competent in continence and bowel management, and nursing staff employed in Seapatrick, must receive training in male/female catheterisation and the management of stoma appliances including the management of an ileostomy.	**Met**
	Action taken as confirmed during the inspection: Training records reviewed evidenced that registered nurses had received training in male and female catheterisation and the management of stoma and ileostomy care. Care staff have received training in continence and bowel care.	

Requirement 2 **Ref: Regulation 20 (3)** **Stated: First time**	The registered person must ensure that a competency and a capability assessment has been completed with any nurse who is given the responsibility of being in charge of the home in the absence of the manager.	**Met**
	Action taken as confirmed during the inspection: Competency and capability assessments have been completed on all registered nursing staff who takes charge of the home in the absence of the registered manager.	
Requirement 3 **Ref: Regulation 16 (1)** **Stated: First time**	The registered person must ensure that a written nursing plan is prepared by a nurse in consultation with the patient or patient's representative as to how the patient's needs in respect of their health and welfare are to be met, and at all times planned care is delivered as prescribed.	**Partially Met**
	Action taken as confirmed during the inspection: Five care records were reviewed; they were not updated to reflect the patient's care needs in keeping with best practice. See section 5.2, 5.3 5.4.2.for details of the findings. This requirement is stated for a second time.	
Requirement 4 **Ref: Regulation 13 (1) (a) (b)** **Stated: First time**	The registered person must ensure that effective systems are in place for meeting the health and welfare needs of patients accommodated in the nursing home at all times.	**Partially Met**
	Action taken as confirmed during the inspection: A review of five care records evidenced that care had not been formally evaluated since May or June 2015. A requirement is made to ensure this issue is addressed.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref: Standard 19.1** **Stated: First time**	The registered person must ensure that where patients require continence management and support, bladder and bowel assessments are completed in full on admission. To enable traceability of bowel function, a consistent record referencing the bristol stool chart should be recorded in the progress record for each patient.	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that continence assessments were completed on admission. The Bristol stool chart was used for each patient.	
Recommendation 2 **Ref: Standard 5.6** **Stated: First time**	The registered person must ensure that contemporaneous records in respect of continence management are further developed to include outcomes for patients.	**Met**
	Action taken as confirmed during the inspection: Contemporaneous records were maintained in respect of continence management.	
Recommendation 3 **Ref: Standard 19.2** **Stated: First time**	The registered person must ensure that Four Seasons Healthcare, catheter care policy is embedded into day to day practice, and the following guidance documents are available to staff and are used on a daily basis: • British Geriatrics Society Continence; • Care in Residential and Nursing Homes; • NICE guidelines on the management of urinary incontinence; • NICE guidelines on the management of faecal incontinence; and • RCN continence care guidelines.	**Met**
	Action taken as confirmed during the inspection: The above guidance documents were available in the home.	

Recommendation 4 **Ref: Standard 19.4** **Stated: First time**	The registered person must ensure that a copy of the continence training programme is submitted to RQIA.	**Met**
	Action taken as confirmed during the inspection: The continence training programme was forwarded to RQIA.	
Recommendation 5 **Ref: Standard 25.2** **Stated: First time**	The registered person should appoint a continence link nurse(s) within the home and regular audits of the management of incontinence are undertaken and the findings acted upon to enhance standards of care.	**Met**
	Action taken as confirmed during the inspection: There are continence link nurses identified in each of the units in the home. Each link nurse conducts a monthly continence audit and the findings are discussed with the staff.	

5.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating effectively which reflected current best practice. This included the regional guidelines on breaking bad news. Discussion with two registered nursing staff confirmed that they were knowledgeable regarding this policy and procedure.

A sampling of staff training records evidenced that the four registered nurses 10 care staff were scheduled to attend training on Palliative Care on 7 August 2015. This training included the procedure for breaking bad news as relevant to staff roles and responsibilities and communicating effectively with patients and their families/representatives.

A palliative link nurse has been appointed in the home. Two registered nurses and three care staff spoken with were knowledgeable about the important aspects to consider when communicating sensitively with their patients. The importance of good effective communication was included in all staff inductions to the home. It is also included in the competency and capability assessments of all registered nurses taking charge of the home in the manager's absence.

A review of five care records examined evidenced that consultation with patients were conducted in regards to consultation with relatives or their representatives.

Five care records were reviewed and all five had not been evaluated in keeping with best practice. A requirement is made that all care records are updated to ensure they currently reflect the care needs of patients. Please refer to section 5.2, 5.3 and 5.4.2 for further details of the inspection findings.

Is Care Effective? (Quality of Management)

The care records examined evidenced that, patients' individual needs and wishes regarding end of life care had been discussed with their General Practitioner (G.P.). The care plans included reference to the patient's specific communication needs, including sensory impairment and cognitive ability.

A review of care records evidenced that the breaking of bad news was discussed with patients and/or their representatives; options and treatment plans were also discussed, where appropriate. The records evidenced that with patients and/or their representative's consent, information had been shared with the relevant health care professionals.

Three nursing staff consulted with demonstrated their ability to communicate sensitively with patients and/or representatives when breaking bad news by emphasising the need for privacy, have sufficient time and emphasised the importance of good relationships with their patients. Two registered nursing staff consulted demonstrated their ability to communicate sensitively with patients and described to the inspector that when they are breaking bad news that they would sit down by the patient, use a calm voice, speak clearly yet reassuringly, would hold their hands, allow privacy, allow the patient to ask questions, and try to display as much empathy as possible.

There was evidence within four of the care records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

Is Care Compassionate? (Quality of Care)

Having observed the delivery of care and many staff interactions with patients the inspector can confirm that communication is well maintained and patients are observed to be treated with dignity and respect. There were a number of occasions when patients had been assisted to redirect their anxieties by care staff in a professional sensitive way.

The inspection process allowed for consultation with 20 patients. Patients spoken with all stated that they were very happy with the quality of care delivered and with life in Seapatrick Care Home. They confirmed that staff are polite and courteous and that they felt safe in the home. Two patient's relatives/representatives discussed care delivery with the inspector and also confirmed that they were very happy with standards maintained in the home and the level of communication with all grades of staff.

A number of compliment cards were reviewed from past family members. All detailed a positive response in relation to their experiences of how staff communicated in a compassionate and thoughtful way throughout the end of life or palliative care process.

Discussion with ancillary staff such as those in the laundry, domestic and kitchen staff stated that nursing staff communicated regularly with them where needed regarding patients' needs. All stated that they were kept informed where required if patients' conditions were deteriorating. All staff spoken with felt that communication was exceptional regarding the theme of this inspection.

Areas for Improvement

There were no recommendations made in relation to this standard. One requirement was made in relation to ensuring care records are up dated to reflect their current condition.

Number of Requirements:	**1**	**Number of Recommendations**:	**0**

5.3 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

Policies and procedures on the management of palliative and end of life care and death and dying were available in the home. These documents reflected best practice guidance such as the Gain Palliative Care Guidelines, November 2013, and included guidance on the management of the deceased person's belongings and personal effects.

Training records evidenced that staff were scheduled to attend training in the management of palliative care on 7 August 2015 and the management of death, dying and bereavement. Registered nursing staff and care staff spoken with were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

Discussion with two registered nursing staff confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the registered manager, registered nursing staff evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

A protocol for timely access to any specialist equipment or drugs was in place and discussion with registered nursing staff confirmed their knowledge of the protocol.

Registered nursing staff confirmed that there are currently no patients requiring the use of specialist equipment, such as a syringe driver. Training records evidence that three registered nursing staff have received training in the management of a syringe driver.

A palliative care link nurse has been identified in the home to provide support and advice when required.

Is Care Effective? (Quality of Management)

Five care records were reviewed. One patient had been identified as currently requiring palliative care. This patient's care record was reviewed. There was evidence that patients' needs for palliative and end of life care were assessed. However the care record was not reviewed or updated in keeping with best practice or the GAIN guidelines. The care record had not been evaluated since May 2015 and there was no care plan in place to manage the patient's current care needs. The management of hydration and nutrition, pain management and symptom management was not updated to reflect the patient's current needs. There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered. However this information was not updated since May 2015. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements. However as previously stated this should be regularly reviewed as patients' care needs change in terms of palliative care management.

A key worker/named nurse was identified for each patient approaching end of life care. There was evidence that referrals had been made to the specialist palliative care team and where instructions had been provided, these were evidently adhered to.

Discussion with the registered manager, registered nursing staff evidenced that environmental factors had been considered. Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying.

A review of notifications of death to RQIA during the previous inspection year evidenced that they were appropriately reported.

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of five care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences regarding end of life care. Registered nursing staff consulted with demonstrated an awareness of patient's expressed wishes and needs as identified in their care plan.

Arrangements were in place in the home to facilitate, as far as possible, in accordance with the persons wishes, for family/friends to spend as much time as they wish with the person. For example there were facilities where families can stay overnight. Catering and snack arrangements are in place where necessary.

From discussion with the registered manager and registered nursing staff and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives during this time. There was evidence within compliments/records that relatives had commended the management and staff for their efforts towards the family and patient.

Discussion with the manager and a review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

All staff consulted with confirmed that they were given an opportunity to pay their respects after a patient's death.

From discussion with the manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included bereavement support; staff meetings, one to one counselling.

Information regarding support services was available and accessible for staff, patients and their relatives. This information was displayed on various notice boards throughout the home.

Areas for Improvement

A requirement is made that when patients are identified as requiring palliative care that the care record is updated to reflect their care needs and is regularly evaluated.

Number of Requirements:	**1**	**Number of Recommendations:**	**0**

5.4 Additional Areas Examined

5.4.1. Meal and meal times

A review of the lunch time meal was reviewed in both units of the home. The lunch served was chicken soup and a variety of sandwiches. The main meal of the day is served in the evenings. Patients requiring pureed meals were served soup and potato for lunch. There are two units in the Dementia unit, side 1 and side 2. Both units were observed during the serving of the lunch time meal. The overall management of the meal in Side 1 was well organised and there was a calm atmosphere observed. The registered nurse was observed to assist with the serving of the meals in this unit. Side 2 was observed to be less organised and the registered nurse could not participate or direct staff as they were assisting patients being seen by their General Practitioner (GP).

The pureed meal served appeared unappetising, bowls were overflowing. Patients' clothing was observed to be heavily stained with food. One patient was observed to eat from another patient's plate. Specialised equipment such as place guards to assist patients eating and drinking were not observed to be in use. The filling in the sandwiches was quite creamy and patients were observed to be having difficulty in eating them in a dignified way. Two patients were observed to require assistance from staff this was not always carried out in a timely way. Menus were available on the tables of the meal being served. However, staff assisting with the meal were not aware of what flavour the soup was or what the fillings in the sandwiches were. The dining room was also overcrowded.

The meal time experience in the frail elderly unit was well organised.

The meal time experience was discussed with the registered manager during feedback. It was agreed that the above issues be addressed and mealtimes would be reviewed and re-organised to ensure meals are served in keeping with best practice guidelines. A requirement is made in this regard.

5.4.2. Care records

Five care records were reviewed throughout all the units in the home. They were not maintained in keeping with best practice and had not been reviewed for several months. The registered manager stated that they were aware that the care records required to be reviewed as recent audits had identified that they were not being maintained in accordance with policies and procedures and required to be updated to reflect patients' changing needs. The following issues were identified and are required to be addressed as a priority;

- do not resuscitate orders should be regularly reviewed in keeping with Resuscitation Council (UK) guidelines;
- dependency levels should be updated at least monthly;
- best interest decision records should always be kept up to date;
- care plans should be updated to ensure pain relief is appropriate to meet the needs of patients;
- The Malnutrition Universal Screening Tool (MUST) should be updated to reflect patients changing needs;
- when a patients is at risk of malnutrition or has had significant weight loss a food and fluid chart should be maintained in keeping with best practice;
- care planning in relation to distressed reactions should always be kept up to date and should include trigger factors and how the reactions are presented;
- where specialised equipment is in use this should be included in the care planning process such as the use of 'crash mats';
- wound care is required to be reviewed for those patients identified as having a wound or pressure ulcer to ensure that the records are being maintained in keeping with best practice;
- records of wounds/pressure ulcers should always accurately reflect the current status the specifics of the condition of the wound/pressure ulcers should be recorded. The term, "dressing changed" is not specific enough to inform the reader of the current condition of the wound/pressure ulcer;
- when a patient's condition deteriorates the care plan should be totally reviewed to ensure it is up to date and reflective of their condition and care plans are in place to meet their specific needs; and
- ensure care records are regularly evaluated in keeping with best practice.

During feedback the registered manager informed the inspector that all care plans will be reviewed within the next four weeks and provided assurances that they will all be reflective of patients care needs. This issue will be reviewed by RQIA during subsequent inspections to the home. It is recommended that the registered manager informs RQIA when the process of reviewing all the care records is complete.

5.4.3 Comments by staff, patients and patient representatives

As part of the inspection process patients, their representatives and staff were consulted and questionnaires issued. Some comments received are detailed below:

Staff

Staff spoken with were positive regarding services the home and the management. They raised no concerns during discussions. Six staff members completed questionnaires and all were satisfied with the services provided in the home in relation to end of life and palliative care. One staff member expressed that they felt that some staff required support in completing their e-learning. This member of staff also felt that, "nursing staff should listen to care staff". Another member of staff stated, "with the exception of e-learning, that no further training is provided". A recommendation is made that the above issues are considered and where possible implemented.

Other comments returned in the questionnaires included the following:

"The manager Edel is very approachable and great at what she does."
"Seapatrick is so welcoming and it feels like home for the residents."
"Very satisfied that patients are afforded privacy, dignity and respect at all times."
"Very satisfied that patients are well supported and enabled to have a dignified death."
"Very satisfied that there are arrangements in place to manage patient's pain."

Patients

There were no returned questionnaires from patients. However patients spoken with stated the following:

"I feel really safe in the home."
"I feel we are all well looked after."
"I am happy here, the staff are kind."
"I cannot complain about a thing."
"The food is good."

Patients' representatives

Two visiting relatives/representatives stated in discussion that they could not ask for better from staff and that they were always available. The following comments were made by relatives/representatives in six returned questionnaires:

"Very satisfied that my relative can be as independent as possible."
"We all have a high opinion of the care of our father is receiving is all that we expect and more, staff are very caring, food is first class."
"…… is relating well to staff."
"Mother is well looked after."
"Satisfied that my relative has privacy in the home."
"The staff at Seapatrick are very friendly, approachable and knowledgeable, 100% well done."

6. Quality Improvement Plan

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

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

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

6.1 Statutory Requirements

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

6.2 Recommendations

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

6.3 Actions Taken by the Registered Manager/Registered Person

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

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref: Regulation 16** **Stated: Second time**	The registered person must ensure that a written nursing plan is prepared by a nurse in consultation with the patient or patient's representative as to how the patient's needs in respect of their health and welfare are to be met, and at all times planned care is delivered as prescribed.
To be Completed by: **14 October 2015**	**Response by Registered Person(s) Detailing the Actions Taken:** All care plans have been rewritten and evaluated. Care plans are patient specific and will be updated as needs change.
Requirement 2 **Ref: Regulation 15**	The registered persons must ensure that all care records are reviewed to ensure they are up to date and reflective of the current care needs of the patients.
Stated: First time **To be Completed by:** **28 October 2015**	**Response by Registered Person(s) Detailing the Actions Taken:** A schedule has been implemented to ensure that a monthly review is carried out for each resident in the home. New staff have received support and training in the completion of care plans and this will be ongoing as required.
Requirement 3 **Ref: Regulation 15**	The registered persons must ensure that when patients are identified as requiring palliative care that the care record is updated to reflect their care needs and is regularly evaluated.
Stated: First time **To be Completed by:** **14 October 2015**	**Response by Registered Person(s) Detailing the Actions Taken:** Patients requiring palliative care will have their needs assessed weekly or more often if their condition changes. Next of kin will be notified and informed at all stages of treatment.
Requirement 4 **Ref: Regulation 12 (4)**	The registered persons must ensure that the issues identified in section 5.4.1 shall be addressed and mealtimes are reviewed and re-organised to ensure meals are served in keeping with best practice guidelines.
Stated: First time **To be Completed by:** **14 October 2015**	**Response by Registered Person(s) Detailing the Actions Taken:** Meal times have been reviewed on the Bannview Unit and some residents are now receiving their meals in the lounge where they can be assisted by a dedicated member of staff. Plate guards and adaptive cutlery are available for use.

Requirement 5 **Ref: Regulation 15** **Stated: First time** **To be Completed by: 14 October 2015**	The registered persons must ensure that all the issues raised in relation to the management of care records as listed in section 5.4.2 are addressed as a priority. **Response by Registered Person(s) Detailing the Actions Taken:** All care files have now been updated and a schedule for maintaining these files has been implemented. Patients are all assigned to a named nurse who is responsible for maintaining the files each month. All nurses are aware that good documentation is an NMC requirement and have been given extra time to complete.
Recommendations	
Recommendation 1 **Ref: Standard 35** **Stated: First time** **To be Completed by: 28 October 2015**	The registered manager shall inform RQIA when the process of reviewing all the care records is complete. **Response by Registered Person(s) Detailing the Actions Taken:** The files are complete as of 21.09.15
Recommendation 2 **Ref: Standard 7** **Stated: First time** **To be Completed by: 28 October 2015**	The registered person shall review the comments made by the staff member and where appropriate ensure the comments are addressed as stated in section 5.4.3 of the report. **Response by Registered Person(s) Detailing the Actions Taken:** Staff received training in CPR, Diabetes, Continence, Palliative care and Dementia care during the month of August. This was in addition to the e learning that staff had to complete. All staff were made aware of the training available and further dates are to be scheduled for those who were unable to attend previous sessions. With regards to Nursing staff not listening to care staff this matter will be raised at the next staff meeting, ensuring that all staff are aware of the importance of listening to all staff views.

Registered Manager Completing QIP	Edel McCaughley	**Date Completed**	22.09.15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	25.09.15
RQIA Inspector Assessing Response	**Donna Rogan**	**Date Approved**	**29.09.15**

Please ensure the QIP is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address