Unannounced Care Inspection Report
22 August 2016

St Francis

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Inspectors: Donna Rogan and Loretto Fegan

1.0 Summary

An unannounced inspection of St Francis Nursing Home took place on 22 August 2016 from 10:00 hours to 16:00 hours.

The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence of positive outcomes for patients through the competent delivery of safe care. The selection and recruitment information was available for inspection. The induction practices were evidenced to be well managed and there was evidence of appropriate management of staff registration with their various professional bodies. Staffing levels were well maintained and reflected the dependency levels of patients. Staff training was generally well maintained. The environment in the home was welcoming, clean and tidy. Two recommendations were made, one in relation to infection prevention and control and one in relation to the environment.

Is care effective?

There was evidence of good delivery of care with positive outcomes for patients. There was evidence of effective team working and good communication between patients and staff. Care records were recently reviewed; however, improvements are required in relation to the management of supplementary care records, care planning and assessment. One requirement is stated for a second time in relation to pressure ulcer prevention. Four recommendations were made; two are in relation to care records, one in relation to the management of information displayed on notice boards and one in relation to auditing.

Is care compassionate?

There was evidence of good integration between staff and patients. Patients were praiseworthy of staff and a number of their comments are included in the report. Staff interactions with patients were observed to be compassionate, caring and respectful. Patients were afforded choice, privacy, dignity and respect. All patients spoken with were complementary regarding the staffs' attitude and attentiveness to detail. There was evidence of patient, representative and staff consultation. There was a variety of activities available for patient participation; however, it is recommended that the activity programme is reviewed to formalise patient participation and that the records are accurately completed.

Is the service well led?

There was evidence of the home having systems and processes in place to monitor the delivery of care and services within St Francis Nursing Home. Compliance with the requirement and recommendations made in the safe and effective domain and compassionate domains will assist to improve the overall services provided, the experience of service users and leadership within the home.

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	**1***	**8***

*One requirement and one recommendation are made for a second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Laura Lavery, Acting Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was a medicines management inspection undertaken on 15 April 2016. The QIP was returned and validated by the pharmacist inspector. 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. A review of records confirmed that adult safeguarding concerns were managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA have been appropriately notified.

2.0 Service details

Registered organisation/registered person: Mary Bernadette Breen	**Registered manager:** Laura Lavery, acting manager
Person in charge of the home at the time of inspection: Adelaide Hartley, nurse in charge from 10:00 hours to 11:00 hours Laura Lavery, acting manager from 11:00 hours to 16:00 hours	**Date manager registered:** 31 May 2016
Categories of care: NH-PH, NH-I There shall be a maximum of one patient accommodated within category NH-PH	**Number of registered places:** 25

3.0 Methods/processes

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

Prior to inspection we analysed the following information: 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
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspectors also met with approximately 15 patients, four care staff, one registered nurse, two kitchen staff members, one laundry assistant, one domestic, the administrator, the acting manager, one visiting professional and two visiting relatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training records
- accident and incident records
- notifiable events
- audits
- records relating to adult safeguarding
- complaints records

- Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC) registration records
- staff induction, supervision and appraisal records
- minutes of staff, patients' and relatives' meetings
- monthly monitoring reports in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- a selection of policies and procedures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 15 April 2016

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

4.2 Review of requirements and recommendations from the last care inspection dated 17 September 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 16 (1) (2) (b) **Stated:** First time	The registered person must ensure that when a patient is identified as being "at risk" of pressure ulceration a corresponding care plan is prepared to manage this risk and that this is kept under regular review. **Action taken as confirmed during the inspection**: A review of one patient's care record evidenced that there was no care plan in place regarding the prevention of pressure ulcers despite them being identified as being at risk. However, there was evidence that measures were in place regarding care delivery such as the implementation of a repositioning chart and appropriate equipment was in place to manage the risk. The repositioning chart stated that the patient was to be repositioned three hourly, however on occasions the records indicated that this did not occur as frequently and on one occasion a period of 12.5 hours had elapsed without any record of repositioning. On the day of inspection, the record indicated that that a check had taken place regarding the condition of the patient's heels, however staff confirmed that this check had not occurred. This requirement is made for a second time.	**Partially Met**

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 13.5 **Stated:** Third and final time	It is recommended that the registered provider offer a structured programme of varied activities and events and enable patients to participate by providing equipment, aids and staff support.	**Met**
	Action taken as confirmed during the inspection: It was evident that a structured and varied activity programme was available. The programme was planned over a four week period. There was a range of equipment and aids available. There is also protected time every day in order to ensure patients are offered and can participate in activities in accordance to their wishes and feelings.	
Recommendation 2 **Ref:** Standard 44 **Stated:** First time	The registered person should ensure that a planned refurbishment programme for the repair/replacement of worn seating is continued to ensure that this meets the required standard.	**Met**
	Action taken as confirmed during the inspection: The acting manager confirmed that there is a refurbishment programme in place to ensure the replacement/repair of worn seating is continued. The inspectors did not observe any seating which was required to be repaired/replaced.	
Recommendation 3 **Ref:** Standard 20 **Stated:** First time	**Carried forward until the next inspection** The registered person should ensure that care records reflect the needs and wishes of patients at the end of life, including their spiritual, religious and cultural needs, where appropriate.	**Partially Met**
	Action taken as confirmed during the inspection: There was insufficient evidence to demonstrate that care records reflected the end of life wishes which includes their spiritual, religious and cultural needs. However, following discussion with patients, staff and a review of information displayed, there was evidence that religious needs of patients were being met. This recommendation is made for a second time.	

Recommendation 4 **Ref:** Standard 4 Criterion 9 **Stated:** First time	The registered provider should ensure that contemporaneous nursing records are kept in relation to the recording of "third party" bed rail checks and that any variances and the actions taken as a result are documented in the care plan.	**Met**
	Action taken as confirmed during the inspection: Patients identified as having 'third party' bed rails in place had a record of checks retained in their bedrooms. The checks were recorded as being completed twice daily. A review of care records evidenced that patients' assessed as requiring bed rails had a care plan in place.	
Recommendation 5 **Ref:** Standard 41 **Stated:** First time	The registered provider should ensure that the number and ratio of staff on duty at all times meets the care needs of the patients and ensure that staff are not working excessive hours which may be detrimental to the quality of the care provided to patients.	**Met**
	Action taken as confirmed during the inspection: Discussion with patients and staff and a review of the duty rotas confirmed that staffing was appropriate to meeting the care needs of patients. A review of the duty rotas and discussion with staff confirmed staff were not working excessive hours.	
Recommendation 6 **Ref:** Standard 41 **Stated:** First time	The registered provider should ensure that the manager has sufficient hours to carry out management duties and that the rota clearly identifies hours worked on the floor and hours worked on management duties.	**Met**
	Action taken as confirmed during the inspection: Following discussion with the acting manager it was confirmed the hours worked on the floor and hours worked on management duties was included in the duty rotas.	

Recommendation 7 **Ref:** Standard 46 **Stated:** First time **To be Completed by:** From the date of inspection	The registered person should ensure that denture pots in shared rooms are labelled and kept clean in accordance with good practice in infection prevention and control. **Ref: Section 5.3.3**	**Met**
	Action taken as confirmed during the inspection: The denture pots in shared bedrooms were observed to be labelled and were observed to be clean.	
Recommendation 8 **Ref:** Standard 46 **Stated:** First time **To be Completed by:** From the date of inspection	The registered person should ensure that an appropriate location is identified in which wound dressings can be carried out in accordance with best practice in infection prevention and control. **Ref: Section 5.3.3**	**Met**
	Action taken as confirmed during the inspection: Registered nursing staff confirmed that patients' dressings are carried out in their own bedrooms.	

4.3 Is care safe?

The acting manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure that the assessed needs of patients were met. An example of the indicators used to evidence that there were sufficient staff to meet the needs of the patients was an assessment of patients' dependency levels.

A review of the staffing rotas for weeks commencing 15 August 2016 and 22 August 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff rotas it was confirmed that administrative, maintenance, catering, domestic and laundry staff were on duty daily. Staff spoken with, were satisfied that there were sufficient staff to meet the needs of the patients. Relatives and patients spoken with commented positively regarding the staff and care delivery.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Two completed induction programmes were reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. Staff spoken with stated they were well supported and well directed during their induction period.

Review of two records and discussion with the registered manager confirmed that a competency and capability assessment was completed with all registered nurses who were given the responsibility of being in charge of the home.

Training was provided via an electronic learning system. There were systems in place to monitor staff compliance with training. Review of staff training records evidenced that the compliance levels with adult safeguarding, fire awareness and moving and handling was high. A review of staff meeting minutes evidenced that training was discussed with staff. Following discussion with the acting manager it was confirmed that a management system was in place to ensure that staff required to complete training were identified and reminded to complete their training.

Discussion with the acting manager, staff on duty and a review of records confirmed that there were systems in place to ensure that staff received supervision and appraisal. Appraisals of staff were currently being reviewed for the previous year. Discussion with the acting manager and review of records evidenced that the monitoring of the registration status of nursing and care staff was appropriately managed.

The acting manager confirmed that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. A review of two staff personnel files evidenced that selection and recruitment processes were in keeping with the above regulation.

A review of documentation confirmed that adult safeguarding concerns were being managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA had been appropriately notified. The acting manager described the systems in place to monitor the progress of safeguarding issues should they be reported with the local health and social care trust or the Police Service of Northern Ireland (PSNI).

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk and inform the patient's individual care plans. See section 4.4 for comments regarding the management of care records.

Discussion with the acting manager and review of records also evidenced that systems were in place to ensure that notifiable events were reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that these had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. The acting manager completed a monthly analysis of falls to identify any trends or patterns.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The vast majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home smelt fresh, clean and was appropriately heated. Fire exits and corridors were observed to be clear of clutter and obstruction. A programme of redecoration was in place and the administrator confirmed work completed so far this year.

It is recommended that the following issues are addressed:

- sluice rooms should be reorganised, tidied and appropriately cleaned, there were inappropriate items stored in this area
- bedpans and commode pots should be appropriately cleaned and when cleaned appropriately stacked and stored
- the maintenance room should be kept locked when not in use
- ensure toilet seats are appropriately cleaned after use
- ensure broken handles to wardrobes and drawers are repaired/replaced

Areas for improvement

Two recommendations are made. One is in relation to the environment and one is made in relation to the management and control of infection.

Number of requirements	0	Number of recommendations:	2

4.4 Is care effective?

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and that they were reviewed. There was evidence that registered nurses, assess, plan, evaluate and review care in accordance with the nursing process. Risk assessments informed the care planning process. However, the review evidenced that care records did not always accurately reflect the assessed needs of patients. For example, one patient's care plan did not have a care plan in place regarding the prevention of pressure ulcers despite being identified as being at risk. A requirement was made in this regard following the previous inspection; this requirement is stated for a second time following this inspection. The Braden Scale had not been completed from 29 February 2016 to 6 July 2016 and the care plan should also contain more detail, for example in relation to the frequency of repositioning the patient and the specific type of cushion or mattress in use. Information in the patients' assessment, daily progress notes or care management reviews for example in relation to social activities or skin care needs should be supported with a care plan. The acting manager agreed to ensure that issues identified in relation to care records would be addressed in accordance with patient need. A recommendation is made in this regard. A recommendation is also made that all entries to care records includes the year of entry. It is also recommended that progress reports reflect the outcome or result of care delivery.

Supplementary care charts such as food and fluid intake evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. However as previously stated repositioning charts should accurately reflect the identified patient's condition. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

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. Care records were subject to regular auditing. However, there was no evidence that an action plan was in place to address issues identified and there was no evidence that the outcome of the audit had been shared with the named nurse. A recommendation is made in this regard.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and that the handover provided the necessary information regarding changes in patients' condition. Staff also confirmed that communication between all staff grades was effective. Discussion with the registered manager confirmed that 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 registered nurses' meeting was held on 5 May 2016. The most recent care assistant meeting was held on 20 October 2015.

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 acting manager. The -acting manager confirmed that they operated an open door policy and were available for patients and their representatives.

There was a relatives meeting planned for 2 September 2016. The acting manager stated that minutes of the meeting will be made available for those relatives who do not attend. The acting manager stated that it was their intention to ensure a meeting with relatives was held every six months. There were various compliment cards and records displayed on notice boards throughout the home. A recommendation is also made that notice boards are kept up to date with relevant information regarding evidenced based practice and that patients' personal information should not be displayed on notice boards.
The lunchtime meal was observed to be served in an organised manner. Patients were observed to receive their meal in a timely way and were provided with a range of choices. Kitchen staff were familiar with patients' wishes and feelings and their likes and dislikes. The meal provided appeared nutritious and patients spoken with stated that they enjoyed the food and felt their needs were well attended to during meal times.

Areas for improvement

There was one requirement and four recommendations made.

Number of requirements	**1**	**Number of recommendations**:	**4**

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with approximately 15 patients individually and with others in smaller groups, confirmed that they were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care and that they were offered choices at mealtimes and throughout the day.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Patients identified as being unable to verbalise their feelings, were communicated effectively with and if additional support was required, they would get this from the registered nursing staff.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Arrangements were in place to structure patients' day. Staff supported patients to maintain friendships and socialise within the home. Discussion with staff also confirmed that there were opportunities for patients to attend external activities. Patients and staff stated that they had recently enjoyed an outing to 'Oxford Island' and a Barbeque. There was evidence of a variety of activities in the home and discussion with patients confirmed that they were given a choice with regard to what they wanted to participate in. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. However more formal arrangements should be put in place in order to evidence activities in the home and records should be maintained of patient participation in a more structured and meaningful way. A recommendation is made in this regard.

Patients and their representatives confirmed that if they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Review of the compliments records evidenced that the staff cared for patients and their relatives in a kindly and compassionate manner. There have been no recent complaints recorded.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. Nine staff, three relatives and three patients returned questionnaires to RQIA within the specified timeframe.

Comments on the returned questionnaires were mainly positive, four of the nine staff questionnaires indicated dissatisfaction with staffing in the home stating that an activity co-ordinator should be employed to ease the "pressure of care staff in the afternoons". Some comments received during the inspection and in the returned questionnaires are detailed below:

Staff comments included:

- "we have a good team here we all work together"
- "we have plenty of training"
- "I believe we are well trained to do our job"
- "patients now need more care and attention, which need two people so other residents are losing out"
- "an extra staff member to mind the day room could be needed, we get so busy at times"
- "I think the care is excellent here"
- "I wouldn't hesitate to go to the new manager"
- "I like working here"

Discussions were held with approximately 15 patients both individually and in groups. Patients spoken with were positive regarding the care they were receiving; all were complementary of the staff and were complementary regarding the food served. There were no issues raised during the inspection by patients. Some comments were made by patients as follows:

Patients' comments included

- "I think we are well looked after"
- "There is plenty to do, we are kept entertained, I love watching the television"
- "I have no complaints"
- "The food is very good, there are a range of choices"
- "Staff are so pleasant and helpful"
- "I would have no hesitation to ask for help"
- "staff are quick to come if I need them"
- "It is not home, but I'm happy enough"

During the inspection two relatives were spoken with, they were very positive regarding all aspects of care. There were no issues raised. Some comments were made by relatives during the inspection and in the three returned questionnaires were as follows:

Patients' representatives' comments included;

- "staff are attentive and kind"
- " I would recommend it"
- "my ….. is happy"
- "I would give the home the maximum amount of gold stars"
- "I can't speak highly enough about the care my ….. is receiving"

One visiting professional spoke highly of the home, stating that staff always made timely referrals. They confirmed that their instructions were always actioned and that staff communicated effectively with them in a professional and knowledgeable manner.

Areas for improvement

There was one recommendation made in this domain.

Number of requirements	**0**	**Number of recommendations**:	**1**

4.6 Is the service well led?

Discussion with the acting manager and staff evidenced that there was a clear organisational structure within the home. The acting manager had recently commenced employment on 31 May 2016. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the acting manager. The acting manager's working hours were included on the duty rota.

Discussion with the acting manager and observation evidenced that the home was operating within its' registered categories of care. The acting manager was aware of her responsibility to keep this under review. The registration certificate was displayed appropriately. A valid certificate of public liability insurance was displayed.

The policies and procedures for the home were systematically reviewed at least on a three yearly basis or before if there were changes. Staff confirmed that they had access to the home's policies and procedures.

Discussion with the acting 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. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately.

There was evidence that systems were in place to monitor and report on the quality of nursing and other services provided. For example, there was evidence that the acting manager completed the following audits:

- accidents/incidents
- care records
- infection prevention and control
- environment audits
- complaints

As previously stated in section 4.4, there was no evidence that the outcome of audits had been shared with the named nurse or an action plan formulated. A recommendation has been made in this regard. A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately.

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 person and review of records evidenced that Regulation 29, of the Nursing Homes Regulations (Northern Ireland) 2005, monthly monitoring visits were completed in accordance with the regulations and/or care standards and copies of the reports were available for patients, their representatives, staff and trust representatives.

Areas for improvement

No areas for improvement were identified during the inspection

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

5.0 Quality improvement plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Laura Lavery, Acting 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the acting 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 by the acting manager. Once fully completed, the QIP will be returned to nursing team email address 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 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 person/manager 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 person/manager 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 16 (1) (2) (b) **Stated:** Second time **To be completed by:** 30 September 2016	The registered provider must ensure that when a patient is identified as being “at risk” of pressure ulceration a corresponding care plan is prepared to manage this risk and that this is kept under regular review. **Ref: Section 4.2 (Previous requirement)** **Response by registered person detailing the actions taken:**
Recommendations	
Recommendation 1 **Ref**: Standard 43 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should; • ensure the maintenance room is kept locked when not in use • ensure toilet seats are appropriately cleaned after use • ensure broken handles to wardrobes and drawers are repaired/replaced **Ref: Section 4.3** **Response by registered provider detailing the actions taken:**
Recommendation 2 **Ref:** Standard 46 **Stated:** First time **To be completed by:** 30 September 2016	The registered should; • ensure sluice rooms are reorganised, tidied and appropriately cleaned, as there were inappropriate items stored in this area • ensure bedpans and commode pots are appropriately cleaned and when cleaned appropriately stacked and store **Ref: Section 4.3** **Response by registered person detailing the actions taken:**
Recommendation 3 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that the identified care record issues are addressed in accordance with patient need. **Ref: Section 4.4** **Response by registered person detailing the actions taken:**

Recommendation 4 **Ref:** Standard 21 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure entries to care records include the year of entry and the progress reports should include the outcome of care delivery. **Ref: Section 4.4** **Response by registered person detailing the actions taken:**
Recommendation 5 **Ref:** Standard 7 **Stated:** First time **To be completed by:** 30 October 2016	The registered provider should ensure that notice boards are kept up to date with relevant information and patient personal information should not be displayed. **Ref: Section 4.4** **Response by registered person detailing the actions taken:**
Recommendation 6 **Ref:** Standard 11 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that more formal arrangements are put in place in order to evidence activities in the home. Records should be maintained of patient participation in a more structured and meaningful way. **Ref: Section 4.4** **Response by registered person detailing the actions taken:**
Recommendation 7 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 30 October 2016	The registered provider should ensure that all audits should formulate an action plan and there should be evidence of follow up of the action plans to ensure there are no outstanding issues. **Ref: Section 4.4** **Response by registered person detailing the actions taken:**
Recommendation 8 **Ref:** Standard 20 **Stated:** Second time **To be completed by:** 30 October 2016	The registered person should ensure that care records reflect the needs and wishes of patients at the end of life, including their spiritual, religious and cultural needs, where appropriate. **Ref: Section 4.2 (Previous recommendation)** **Response by registered person detailing the actions taken:**

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the

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