Unannounced Care Inspection Report
30 May 2017

Ashbrook Care Home

Type of service: Nursing Home
Address: 50 Moor Road, Coalisland, Dungannon, BT71 4QB
Tel no: 028 87741010
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Ashbrook took place on 30 May 2017 from 09.10 to 17.15 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.

Is care safe?

There were areas of good practice identified throughout the inspection in relation to staff recruitment practices; staff induction, training and development; adult safeguarding arrangements; infection prevention and control practices; and risk management.

No areas for improvement were identified during the inspection.

Is care effective?

There were many examples of good practice found throughout the inspection in relation to the care records, review of care delivery and effective communication systems.

However, areas for improvement were identified in relation to wound care management and pain assessments; the recording of the delivery of mouth care; care plans for acute infections; and patients' and relatives' meetings.

Is care compassionate?

Areas of good practice were found throughout the inspection in relation to the culture and ethos of the home, treating patient with dignity and respect. A number of comments from the consultation process and the returned questionnaires are included in the main body of the report.

No areas for improvement were identified during the inspection.

Is the service well led?

There was evidence of good practice identified in relation to the governance and management arrangements; management of complaints and incidents; quality improvement processes and maintaining good relationships within the home.

No areas for improvement were identified during the inspection.

The term 'patients' is used to describe those living in Ashbrook which provides both nursing and residential care.

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	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Marina McElvogue, deputy manager, and Marcus James Mulgrew, responsible person, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced finance inspection undertaken on 19 January 2017. 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: Ashbrook Home Ltd Marcus James Mulgrew	**Registered manager:** Gillian Larmour
Person in charge of the home at the time of inspection: Marina McElvogue	**Date manager registered:** 26 July 2016
Categories of care: NH-PH, RC-I, NH-DE, NH-I, NH-MP(E) A maximum of 19 patients in category NH-DE, a maximum of 1 patient in category NH-PH and 1 identified patient only in category NH-MP(E). A maximum of 9 residents in category RC-I.	**Number of registered places:** 68

3.0 Methods/processes

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.

A poster was displayed in the home, inviting feedback from patients and their representatives. During the 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 five patients, five care staff, three registered nurses, one kitchen staff, ten patients' representatives and one visiting professional.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- seven patient care records
- staff training records for 2016/2017
- accident and incident records
- audits in relation to care records and falls
- records relating to adult safeguarding
- complaints received since the previous care inspection
- the system for managing urgent communications, safety alerts and notices
- one staff recruitment and selection record
- staff induction, supervision and appraisal records
- records pertaining to NMC and NISCC registration checks
- minutes of staff meetings held since the previous care inspection
- annual quality report
- monthly quality 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 19 January 2017

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

There were no issues required to be followed up during this inspection and any action taken by the registered provider, as recorded in the QIP will be validated at the next finance inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 2 June 2016

There were no requirements or recommendations made as a result of the last care inspection.

4.3 Is care safe?

The deputy manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the week commencing 28 May 2017 evidenced that the planned staffing levels were consistently adhered to. Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. Discussion with patients and staff evidenced that there were no concerns regarding staffing levels. One patients' representative commented that they felt the home was short staffed on the night shift, after the staff member who worked the twilight finished their shift. Through discussion with the responsible person, it was evident that the working arrangements in the home had recently been reviewed in response to the concerns raised. All other patients' representatives were satisfied with the staffing levels provided. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

The deputy manager explained there were currently no staff vacancies and that if an absence occurred, due to illness, this was generally covered by permanent staff working additional hours. Recruitment was ongoing in terms of future workforce planning.

There were safe systems in place for the recruitment and selection of staff. A review of one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Where nurses were employed, their registrations were checked with the Nursing and Midwifery Council (NMC), to ensure that they were suitable for employment. The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI and satisfactory references had been sought, received and reviewed prior to the staff member starting employment.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Staff confirmed that new staff usually received induction over a three week period and that this could be extended, depending on the development of the staff member. One completed induction programme was reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare understanding and competence.

Discussion with the deputy manager and staff confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, undertook competency and capability assessments and completed annual appraisals. Competency and capability assessments were also completed with all registered nurses who were given the responsibility of being in charge of the home.

Individual supervisions were also conducted with staff in response to learning that was identified from incidents. For example, where a patient's fall was reviewed, there was evidence that supervision had been undertaken with staff, to promote learning and prevent recurrence. Recommendations from serious adverse incidents that occurred in other organisations were also shared with staff. This is good practice and is commended.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and records were kept up to date. A review of staff training records confirmed that staff completed modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. There were gaps on the matrix in key areas such as adult safeguarding. The deputy manager acknowledged this and confirmed that plans were in place to address this. Following the inspection, the registered manager confirmed to RQIA, by email on 5 June 2017, that all staff will have completed this training by 26 June 2017. Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

Discussion with the deputy manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff were appropriately managed in accordance with the NMC. Similar arrangements were also in place to ensure that care staff were registered with the Northern Ireland Social Care Council (NISCC).

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The staff understood what abuse was and how they should report any concerns that they had. Discussion also evidenced that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures.

The registered manager had been identified as the safeguarding champion for the home; and had attended specific training to undertake this role. Following the inspection, the registered manager confirmed to RQIA, by email on 5 June 2017, that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice

Review of patient care records evidenced that a range of validated risk assessments were generally completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were generally completed following each incident, care management and patients' representatives were notified appropriately. Sensor mats which were linked to the call bell system were utilised to help prevent falls. A falls' safety calendar was also used to draw the staffs' attention to patients who had recently fallen.

A number of patients required a pressure relieving mattress on their bed due to the risk of developing pressure damage to their skin. Each mattress had a notice, directing the staff on the correct mattress setting, according to the patients' weights.

Where bedrails were required, there was evidence that staff had undertaken risk assessments for their use and this information was included in the care plans. Similar systems were in place for patients who required the use of lap belts; and there was evidence within the care records that the lap belts had been released and repositioned in keeping with the care plan.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, the dining room and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients/representatives/staff spoken with were complimentary in respect of the home's environment. Fire exits and corridors were observed to be clear of clutter and obstruction.

Infection prevention and control measures were adhered to and equipment was appropriately stored. The home also used 'I am clean' stickers, to indicate that the commodes had been cleaned and by whom; this is good practice and is commended.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.4 Is care effective?

Review of the patient care records evidenced that a range of validated risk assessments were generally completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Although there were some areas for improvement identified, there were also many areas of good practice noted. For example, patients who were identified as requiring a modified diet, had the relevant assessments completed. The prescribed modified diet was included in the care plans, together with recommended strategies for ensuring correct feeding techniques were utilised or maintaining optimum posture.

The care records evidenced that the staff adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

Where patients were unable to eat orally and required feeding by percutaneous endoscopic gastrostomy (PEG) tube, there was evidence that the care of the PEG tube was appropriately managed. A review of the records confirmed that the placement of the tube was regularly checked and that any equipment used, was changed regularly in line with best practice.

Patients who required urinary catheters had care plans in place, to ensure that they were managed in keeping with best practice guidance. The care plan included detail on the hygiene care of the catheter; the frequency of tube change; actions to take in case of blockage; and monitoring of fluid intake and output.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored. Discussion with the deputy manager also confirmed that the patients' fluid intakes were reviewed by the registered nurses twice daily; and were totalled by the registered nurses every day. There was also a system in place, to ensure that the patients' bowel records were monitored by the registered nurses.

Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day. Referrals were made to relevant health care professionals, such as GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of the patient's poor nutritional intake. Improvements were identified in relation to the auditing of patients' weight; refer to section 4.6 for further detail.

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.

Despite these areas of good practice, some areas for improvement were identified. For example, in relation to wound care management, the review of the care records evidenced that wound assessments and pressure risk assessments were not consistently completed when a patient developed skin damage; there was also little use of wound photography, in keeping with the National Institute of Clinical Excellence (NICE) guidelines. This was discussed with the deputy manager; a requirement has been made in this regard.

Patients who were prescribed regular analgesia did not consistently have validated pain assessments completed. This was discussed with the deputy manager; a requirement has already been made in this regard.

Oral hygiene assessments were not in place and care plans were not consistently developed for patients who had had particular needs in relation to mouth care. Although there was evidence that the patients' oral hygiene needs were being attended to; improvements were identified in relation to the recording of this aspect of care delivery. A recommendation has been made in this regard.

Where patients were prescribed antibiotic therapy for the treatment of acute infections, care plans had not been consistently reviewed to reflect this. A recommendation has been made in this regard.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005. The patient register was checked on a regular basis by the registered manager and was correct on the day of the inspection

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition. There was also a communication book which staff described as being very valuable to them, particularly when returning to work, after a period of leave.

Staff meetings were held on a regular basis and records were maintained for those who were unable to attend. 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. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Patients 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. Through discussion, it was evident that the management team in the home made themselves available to all patients and their representatives on a daily basis; however, discussion with the deputy manager and a review of records confirmed that patients' and relatives' meetings had not been held in some time. A recommendation has been made in this regard.

Areas for improvement

Areas for improvement were identified in relation to wound care management and pain assessments; the recording of the delivery of mouth care; care plans for acute infections; and patients' and relatives' meetings.

Number of requirements	1	Number of recommendations	3

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. 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.

Two dedicated staff members were employed to provide activities in the home. Patients consulted with stated that there were always different activities they could participate in. There was evidence of a variety of activities in the home and discussion with patients confirmed that they were given a choice with regards to what they wanted to participate in. There were various photographs displayed around the home of patients' participation in recent activities. Hairdressing services were provided up to three times each week.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. The home had a chapel, where patients could sit and watch mass from a local church, which was streamed live to the home every morning.

We observed the lunch time meal in the dining room. We saw that the atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set with tablecloths and patients were assisted to eat as required. The lunch served appeared very appetising and patients spoken with stated that it was always very nice. Discussion took place with the responsible person regarding the provision of condiment sachets; as these were difficult for the patients to open. Assurances were provided that this would be addressed.

Discussion with the deputy manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. The annual quality report was reviewed and evidenced that the views and comments recorded were analysed and areas for improvement were acted upon.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the deputy manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. We read

some recent feedback from patients' representatives. One comment included praise for the care given when a patient was receiving end of life care, describing 'the amazing care and attention' given during this time.

The care plans detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for the patients, as appropriate. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met. There was also a system in place which directed staff on what they should do and who they should contact, in the event of an unexpected death.

During the inspection, we met with five patients, five care staff, three registered nurses, one kitchen staff, ten patients' representatives and one visiting professional. Some comments received are detailed below:

Staff

"The care is very good, we all help the patients get what they need'.
'The care is excellent'.
'The care is good, we are dedicated and do our best to see that everyone is happy'.
'The care is very good'.
'I have no concerns'.

Patients

"I am well pleased with the treatment I get'.
'You couldn't be treated better'.
'I get what I need surely; the staff are very polite'.
'All is ok here'.
'I am treated like a lord, you could not beat it'.

Patients' representatives

'It is absolutely brilliant, five stars'.
'I can't praise them enough'.
'Perfect'
'We are happy enough'.
'It is perfect, I could not even knit pick at anything, I have peace of mind and can go home content'.
'I have no concerns'.
'The place is fantastic, they are very attentive'.

One patients' representative commented in relation to the staffing levels on the night shift; this comment was relayed to the responsible person during the inspection; and is discussed in section 4.3.

Visiting professional

'I have no concerns'.

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

Patients: respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. Written comments included, 'I feel safe and secure, there is a friendly atmosphere here' and 'the staff are extremely friendly and helpful'. One patient commented further that they did not feel fully involved in making decisions about their care; and another patient wrote that the staff do not always apply the patient's incontinence pad correctly. Following the inspection, these comments were relayed to the registered manager to address.

Relatives: respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. Written comments included, 'we are delighted regarding the care (our relative) is receiving', 'the staff do a wonderful job in the time they have available'. Two respondents commented in relation to the staffing levels. Following the inspection, these comments were relayed to the registered manager to address.

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

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

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.6 Is the service well led?

Discussion with the deputy manager and observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

All those consulted with knew who the registered manager and other members of the senior management team were and stated that they were available at any time if the need arose. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. All those consulted with described the registered manager in positive terms; comments included 'she is very approachable' and 'very good'. Staff described how they felt confident that the registered manager would respond positively to any concerns/suggestions raised.

Discussion with the deputy manager and staff evidenced that there was a clear organisational structure within the home. 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 registered manager.

Discussion with the deputy 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. A copy of the complaints procedure was displayed in each patients' bedroom. The responsible individual confirmed that the policy had recently been updated to reflect the DHSSPS Care Standards for Nursing Homes 2015.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous inspection, confirmed that these were appropriately managed.

There were systems in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

However, through discussion and the review of records, it was evident that patients' weights were not included in the auditing processes. As discussed in section 4.4, there was evidence that patients' weights were being monitored on a monthly or weekly basis, as appropriate to the needs of the patients; however, one patient was identified as losing weight every time they were weighed. The lack of a weights auditing process was discussed with the responsible person, who advised that plans were in place to record the patients' weights in graph format, which would help in identifying upward or downward trajectories. RQIA was satisfied that this system would provide registered nurses with greater oversight of any weight loss/increase over a period of time.

Review of management audits for falls confirmed that on a monthly basis the number, type, and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. Advice was given in relation to identifying the location of falls within the home on the falls audit.

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 deputy manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. An action plan was generated to address any areas for improvement; discussion with the manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Marina McElvogue, deputy manager, and Marcus James Mulgrew, responsible person, 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 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 15 (2) (a) and (b) **Stated:** First time **To be completed by:** 27 August 2017	The registered persons must ensure that risk assessments are reviewed in response to patients' changing needs. This refers specifically to pressure risk assessments, which must be reviewed when skin damage has been reported; and in relation to pain assessments. **Ref: section 4.4**
	Response by registered provider detailing the actions taken: All staff have been reminded to include up to date risk assessments in relation to pressure risk and to ensure all skin damage/ wound care records are completed. Audit in place to ensure this continues. Staff reminded regarding the use of photography to assist in documentation of wounds. All registered staff reminded to ensure that pain assessments are completed and reviewed for all residents.
Recommendations	
Recommendation 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 27 August 2017	The registered persons should review the system for recording the delivery of oral hygiene to patients, to ensure that it is delivered in keeping with the care plan. This refers particularly to patients who are nil by mouth and require specialist care intervention. **Ref: section 4.4**
	Response by registered provider detailing the actions taken: All staff have been reminded to ensure that they document in the resident's daily evaluation notes that mouth care has been given in addition to signing for particular mouth care medications in the medication administration records. Care plan has been enhanced to include specific directions in relation to nil-by-mouth resident.
Recommendation 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 27 August 2017	The registered persons should ensure that care plans are developed and reviewed in response to acute infections. **Ref: section 4.4**
	Response by registered provider detailing the actions taken: All staff have been reminded to ensure that care plans are in place for residents who have an acute infection. Audit undertaken to ensure this is the case.
Recommendation 3 **Ref**: Standard 7 **Stated:** First time **To be completed by:** 27 August 2017	The registered persons should ensure that patients' and relatives' meetings are carried out on a regular basis. **Ref: section 4.4**
	Response by registered provider detailing the actions taken: Resident's meeting scheduled for 10th July 2017. Relatives meeting date to be confirmed.

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