Unannounced Care Inspection Report
23 June 2016

Chestnut Lodge

Type of Service: Nursing Home
Address: 47 Carrickaness Road, Benburb, BT71 7NH
Tel No: 028 3754 8706
Inspector: Dermot Walsh

1.0 Summary

An unannounced inspection of Chestnut Lodge took place on 23 June 2016 from 09.50 to 17.10.

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

Is care safe?

Safe systems were in place for monitoring the registration status of nursing and care staff. Accidents and incidents were appropriately managed and RQIA was suitably informed of notifications. Staffing levels were adequately maintained. Weaknesses were identified in the delivery of safe care, specifically in relation to compliance with best practice in infection prevention and control (IPC). Weaknesses were also identified with the recruitment process and training on restrictive practice. Three requirements and one recommendation have been made to secure compliance and drive improvement. One recommendation in relation to a system to ensure best practice compliance with infection prevention and control has been stated for a second time.

Is care effective?

Staff were aware of the local arrangements for referral to health professionals. Communications between health professionals were recorded within the patients' care records and recommendations were adhered too. Patients and staff demonstrated confidence and awareness in raising any potential concerns to the relevant people. One recommendation has been made within this domain to ensure that care plans are accurately recorded to reflect the assessed need for the patient.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. Patients and their representatives were very praiseworthy of staff and a number of their comments are included in the report. Activities were observed to be well organised and pleasurable for the patients.

Is the service well led?

Monthly monitoring visits were conducted consistently and corresponding reports were present and available for review. Many compliments had been received by the home in relation to the care and compassion provided to patients/relatives and some of these comments are contained within this report. Appropriate certificates of registration and public liability insurance were on display. Three requirements and two recommendations made above impact on the well led domain. One recommendation made in the previous inspection, as discussed above, will be stated for a second time.

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.

For the purposes of this report, the term 'patients' will be used to describe those living in Chestnut Lodge which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	3	3*

*The total number of recommendations made includes one recommendation that has been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Paul Gildernew, registered manager, 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 care inspection undertaken on 21 January 2016. Other than those actions detailed in the previous QIP there were no further actions required. 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 provider: Four Seasons Health Care (FSHC) Dr Maureen Claire Royston	**Registered manager:** Paul Gildernew
Person in charge of the home at the time of inspection: Paul Gildernew	**Date manager registered:** 17 July 2013
Categories of care: RC-MP(E), NH-PH, RC-I, RC-MP, NH-I, NH-DE Maximum of 20 patients in NH-DE, 17 patients in NH-I, and 2 patients in NH-PH, One regular respite in RC-MP and the home may also provide care on a day basis to 2 persons.	**Number of registered places:** 40

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 previous care inspection report and the returned quality improvement plan (QIP)
- pre inspection assessment audit.

During the inspection we met with nine patients individually and others in small groups, one patient representative, four care staff and one registered nurse.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff not on duty. Nine patient, nine staff and seven patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- three patient care records
- staff training records
- staff induction template
- complaints records
- incidents / accidents records since the last care inspection
- minutes of staff meetings
- a selection of audit documentation
- two recruitment files
- competency and capability assessments for nurse in charge
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- duty rota for the period 13 – 26 June 2016

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 21 January 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 21 January 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 15 (2) (b) **Stated:** First time	It is required that the assessment of patients' needs are revised as required but not less than annually.	**Met**
	Action taken as confirmed during the inspection: Assessment of patients' needs had been revised accordingly in three patient care records reviewed.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 39 **Stated:** Second time	The registered persons should ensure and confirm to RQIA that staff are trained for their roles and responsibilities in: • communication, including the procedure for breaking bad news; • palliative care and end of life training; and • nursing staff using equipment such as a syringe driver, have received training and have received regular updates on their use. The registered manager must ensure that the content of training programmes are maintained in the home at all times and are available for inspection.	**Met**
	Action taken as confirmed during the inspection: Evidence of training completed in the topics listed above was provided on inspection.	
Recommendation 2 **Ref:** Standard 32 **Stated:** Second time	The registered persons should develop a formalised standard operating procedure for obtaining drugs and specialist equipment for patients receiving palliative care/end of life care, and this should be made available to all nursing staff.	**Met**
	Action taken as confirmed during the inspection: A standard operating procedure for obtaining drugs and specialist equipment for patients receiving palliative care/end of life care had been developed and was available to all nursing staff.	

Recommendation 3 **Ref:** Standard 36 **Stated:** First time	All registered and care staff should be made aware of the homes continence guidelines and policies.	**Met**
	Action taken as confirmed during the inspection: Continence guidelines and policies were available at the nurses' station and staff had been made aware of them. There was evidence of continence training completed in the home for staff.	
Recommendation 4 **Ref:** Standard 39 Criteria (4) **Stated:** First time	Training on catheter management should be sourced and made available to care assistants in the home.	**Met**
	Action taken as confirmed during the inspection: Catheter care training had been conducted in February 2016 for care assistants. The registered manager confirmed further training would be sourced for those staff who had been unable to attend this training session.	
Recommendation 5 **Ref:** Standard 4 Criteria (1) (7) **Stated:** First time	It is recommended that patients' continence assessments and care plans are fully completed and include the specific continence products required by the patient.	**Met**
	Action taken as confirmed during the inspection: Three continence assessments and care plans reviewed made reference to the specific continence products required to meet the continence needs of patients.	
Recommendation 6 **Ref:** Standard 12 Criteria (4) **Stated:** First time	It is recommended that MUST scores should be calculated for each patient, depending on the patients' assessed need and recorded within the patient's care record not less than monthly.	**Met**
	Action taken as confirmed during the inspection: MUST scores had been reviewed monthly in three patient care records reviewed.	

Recommendation 7 **Ref:** Standard 46 Criteria (1) (2) **Stated:** First time	It is recommended that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection.	**Not Met**
	Action taken as confirmed during the inspection: An 'Infection Control Champion' had been nominated and monthly infection control audits had been completed. However, during a review of the environment, there was evidence that compliance with best practice in infection prevention and control had not been achieved. Please see section 4.3 for further clarification. This recommendation has not been met and will be stated for a second time.	
Recommendation 8 **Ref:** Standard 43 Criteria (11) **Stated:** First time	The identified garden area should be developed to make it safe and allow for enhancement of the patient experience in Chestnut Lodge.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager confirmed that plans had been approved by senior FSHC management for the development of the garden area.	
Recommendation 9 **Ref:** Standard 28 Criteria (1) **Stated:** First time	Topical preparations should only be administered to the patient for whom they are prescribed.	**Met**
	Action taken as confirmed during the inspection: Training on topical preparations had been carried out with all care assistants and registered nurses. All topical preparations observed on inspection were in the appropriate patients rooms.	
Recommendation 10 **Ref:** Standard 4 Criteria (9) **Stated:** First time	It is recommended that patient care records should contain documented evidence of skin inspection of pressure areas undertaken.	**Met**
	Action taken as confirmed during the inspection: Five repositioning charts were reviewed on inspection and all charts reviewed had been completed well and appropriately evidenced skin checks.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 13 – 26 June 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

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. Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training. The registered manager would review training records monthly and a monthly report would be submitted to FSHC head office. Compliance with training was also reviewed during the monthly monitoring visits of the home conducted by the regional manager. The majority of training was conducted online. There was evidence of additional face to face training competed on dysphagia; continence management; palliative care; syringe drivers and documentation. Training in restrictive practice was discussed with the registered manager who confirmed that training had not taken place on restraint and/or restrictive practices. As restrictive practices were used within the home, a recommendation was made to ensure this training was completed by all relevant staff.

Records of supervision and appraisals completed with staff were maintained. The registered manager confirmed that 45 out of 49 staff have completed appraisals in 2016. Records of group and individual supervision sessions were evidenced. The registered manager agreed a matrix should be developed to allow for easy identification of staff who have/have not had recorded supervisions during the year.

Competency and capability assessments of the nurse in charge of the home in the absence of the manager had been completed appropriately. The completed assessments had been signed by the registered nurse and verified by the registered manager as successfully completed.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC). NMC and NISCC checks were monitored monthly and evidenced within a file.

A review of the recruitment process evidenced areas for improvement. Relevant checks on NMC registration; Access NI; relevant references and an interview had been conducted prior to the staff member commencing in post. However, reasons for leaving previous employment; exploration of employment gaps and evidence of qualification had not been established. A requirement was made to ensure all relevant information has been obtained and reviewed prior to any staff member commencing in post.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Discussion with the registered manger confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures.

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

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since 21 January 2016 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. Rooms and communal areas were clean and spacious. Fire exits and corridors were observed to be clear of clutter and obstruction.

The following issues were identified which were not managed in accordance with best practice guidelines in infection prevention and control (IPC):

- inappropriate storage in identified rooms
- cracked toilet cistern lid
- pull cords in use without appropriate covering
- commode/shower chairs not effectively cleaned after use
- identified commode seat ripped
- personal protective equipment stored within communal toilets.

The above issues were discussed with the registered manager and a requirement was made. An assurance was provided by the registered manager that these areas would be addressed with staff and measures taken to prevent recurrence. A recommendation was made in the previous QIP that management systems are put in place to ensure compliance with best practice in infection prevention and control. This recommendation has been stated for a second time.

During a review of the environment we observed eight bedrooms which did not have nurse call facilities for patients to alert staff if they required assistance. It was not clear from a review of the care records why the nurse call provision had been removed. This was discussed with the registered manager and a requirement was made to ensure all patients within the home are provided with appropriate communication facilities to alert staff if they require assistance when in their bedrooms.

A refurbishment programme was in progress in the home. The main dining room had been redecorated. Planning had been approved for improvement works to the garden area and plans were in place to extend the laundry room. RQIA had been notified accordingly and appropriate records had been completed.

Areas for improvement

It is required that the recruitment process is reviewed to ensure that all necessary information has been obtained and reviewed prior to the staff member commencing in post.

It is required that the registered person ensures the infection control issues identified on inspection are managed to minimise the risk and spread of infection.

It is required that all patients within the home have a nurse call provision in their bedroom to summon help if needed.

It is recommended that training on restraint be arranged for all relevant staff to attend.

Number of requirements	3	Number of recommendations:	1

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 reviewed as required. There was evidence that risk assessments informed the care planning process. Care plans had been reviewed monthly. However, one care plan did not reflect the actual care need of the patient. The care plan drafted in July 2015 discussed a cast and sling in place for a patient with a left arm fracture. The care plan was last reviewed in June 2016 and a documented statement 'care plan relevant and continues' was included within the review. Discussion with staff and the registered manager confirmed the cast and sling were removed 'months ago'. A recommendation was made to ensure care plans are updated to reflect the assessed needs of the patients.

Supplementary care charts such as repositioning and bowel management records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements.

Staff demonstrated an awareness of patient confidentiality in relation to the storage of records. Records are stored securely in lockable cabinets at the nursing stations.

Registered nurses were aware of the local arrangements and referral process to access other relevant professionals, for example General Practitioner's (GP), speech and language therapists (SALT), dieticians and tissue viability nurses (TVN). Care records reviewed reflected recommendations prescribed by other healthcare professionals.

Discussion with the registered manager confirmed that general staff meetings were generally conducted quarterly. There was evidence of meetings having occurred on 16 March 2016 and 15 October 2015. Minutes of the meetings were available and maintained within a file. Minutes included details of attendees, dates, topics discussed and decisions made. A notice displaying details of the meeting date and agenda was also contained in the file.

The registered manager confirmed that quarterly patient/relative meetings were conducted by the Personal Activity Leader (PAL) in the home. The registered manager and the PAL would meet and discuss topics for inclusion in the patient/relative meetings. Notices of scheduled dates for these meetings would be on display at the front entrance to the home and on noticeboards within the home. A notice was on display informing of a patient/relative meeting on 30 June 2016. Records of the meetings were maintained by the PAL. Minutes of these meetings were not readily available for review by patients/relatives unable to attend the meeting. This was discussed with the registered manager who agreed to develop a system to enable patients/relatives to review the minutes of the meetings if they so wished.

The registered manager confirmed that they operate an open door policy to allow relatives and patients to meet with them at any time. The registered manager also confirmed that they would undertake a daily, recorded walk around the home and would avail of the opportunity to engage with patients and relatives at this time.

A 'Quality of Life' (QOL) feedback system was available at the entrance to the home. The registered manager confirmed that the home aimed to achieve service feedback from a variety of staff, visiting professionals, patients and patient representatives. However, it was also acknowledged that the same representatives respond the majority of the time. Further details of the QOL can be found in section 4.5.

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 were confident in raising any concerns they may have with the staff and/or management.

Information leaflets were available to staff, patients and/or representatives at the entrance to the home. These included information on the quality of life programme (QOL), advice on person centred care; your rights – your information; stroke; diabetes; learning and physical disability services; hearing and bereavement.

Areas for improvement

It is recommended that care plans are updated to accurately reflect the assessed needs of the patients.

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

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. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent. Nine staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. Two of the questionnaires were returned within the timescale for inclusion in the report. On inspection one registered nurse and four carers were consulted to ascertain their views of life in Chestnut Lodge.

Some staff comments were as follows:
'This is a good place to work.'
'The work here is enjoyable and rewarding.'
'You feel good at the end of the day because you know you have helped the patients.'
'I like to work here.'

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives, and staff on the running of the home. A 'Quality of Life' feedback system was available at the reception area. This is an iPad which allows patients, relatives/representatives, visiting professionals and/or staff to provide feedback on their experience of Chestnut Lodge. A portable iPad is also available to record feedback from patients. This feedback is ongoing and is shared with the regional manager. Anyone completing the feedback has the option to remain anonymous or leave their name. Management have the option to contact people who leave their contact details to gain further clarification on the feedback received.

All feedback reports are acknowledged by the registered manager. Any actions taken as a result of the feedback is submitted to FSHC head office. Views and comments recorded were subsequently analysed and an action plan was developed and shared with staff, patients and representatives through staff and relative meetings. Any urgent feedback would be communicated with staff through the 'care blox' system; a multi-functional electronic communication system available within the home. The registered manager confirmed the results and any actions taken would also be included within the annual quality report.

Patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Consultation with nine patients individually, and with others in smaller groups, confirmed that the care was safe, effective, compassionate and well led. Nine patient questionnaires were left in the home for completion. Nine patient questionnaires were returned within the timeframe. Responses from the patients would indicate a high level of satisfaction with this service.

Some patient comments were as follows:
'I'm very happy. There is nothing wrong here.'
'I like living here.'
'They (the staff) are lovely people. Everybody is happy.'
'They do their best here.'
'I like it alright.'

One patient representative was consulted on the day of inspection. The representative commented positively on the care provided to their loved one. Seven relative questionnaires were left in the home for completion. No relative questionnaires were returned within the timescale for inclusion in the report.

A programme of activities was available at the entrance to the home. Ten patients were observed enjoying art and music during the inspection. Games had been planned for the afternoon session. Four day trips were planned to take place within the next two months. The PAL discussed plans to utilise the garden space outside once the planned improvements to this area have been completed.

Areas for improvement

No areas for improvement were identified during the inspection under the compassionate domain.

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

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities.

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

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

Policies and procedures were maintained electronically. Staff had 24 hour access to online facilities within the home.

A record of compliments was maintained. Some examples of compliments received were as follows:

'Many thanks for all your help and support with my husband … over the past few years.'
'I've had a very enjoyable and positive experience here as a student nurse. … this was a valuable experience.'
'We would like to express our gratitude and appreciation to you all.'

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, monthly audits were completed in accordance with best practice guidance in relation to wound analysis, care records, infection prevention and control, falls, medicines management, complaints, restraint, bed rails, hand hygiene, personal protective equipment, hoists/slings, health and safety and incidents/accidents.

Online 'TRaCA' audits are conducted on housekeeping, daily/weekly medications management, health and safety, resident care, weight loss and the homes governance arrangements. All TRaCA audits demand an 'actions taken' section to be completed for every audit even if the audit had achieved 100 percent compliance. The action taken could be confirmation that the information was shared with staff. All actions taken are documented online by the registered manager. The system would notify the registered manager of any audit that had not been actioned.

A care record audit was reviewed. The audit had been completed by the registered manager who, following the audit had developed an action plan to address shortfalls identified within the audit. The action plan was given the named nurse responsible for the care record who would then address the actions and sign the action plan as completed. The registered manager would verify the actions as completed with a signature. The registered manager confirmed that audit results would be discussed at staff meetings. More urgent findings would be communicated through the 'care blox' system.

Urgent communications, safety alerts and notices were reviewed by the registered manager on receipt and, where appropriate, were shared with staff. A system was in place to ensure that all relevant staff had read the communication or had been notified about it. A safety alert folder was maintained at the nurses' station.

Discussion with the registered manager and review of records evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. An action plan was generated within the report to address any areas for improvement and a review of the previous action plan was included within the report. Copies of the reports were available for patients, their representatives, staff and trust representatives.

Discussions with staff confirmed that there were good working relationships within the home and that management were responsive to any suggestions or concerns raised.

As previously discussed issues were identified with the management of infection prevention and control practices, review of care plans, recruitment process and the provision of a nurse call system in a number of patients' bedrooms. Three requirements and two recommendations were made within two of the other domains, and one recommendation has been stated for the second time.

Areas for improvement

No areas for improvement were identified during the inspection under the well led domain.

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 this QIP were discussed with Paul Gildernew, registered manager, 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 may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for review 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 21(1) (b) **Stated:** First time **To be completed by:** 30 June 2016	The registered provider must ensure the recruitment process is reviewed to make sure that all relevant information has been obtained and/or reviewed prior to a staff member commencing in post. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The recruitment process will include reviewing of appliction forms and where there are noted gaps in applicants previous employment this will be discussed and reasons recorded.
Requirement 2 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** 14 July 2016	The registered person must ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Registered person has completed an infection control audit and areas identified during inspection process are addressed. Registered Manager will continue to monitor compliance. Inappropriate storage of wheelchairs in bathrooms as well as cleaning of commode and shower chairs after use has been discussed/recorded with staff. The cracked toilet cistern lid has been replaced. Pull cords have all been sheathed for ease of cleaning. The identified ripped commode is now replaced. A further four Dani Centres purchased and placed throughout home to promote effective infection prevention and control.
Requirement 3 **Ref:** Regulation 18 (2)(a) **Stated:** First time **To be completed by:** 14 July 2016	The registered person must ensure that all patients within the home have a nurse call provision in their bedroom to summon help if needed. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Registered manager reviewed the number of nurse call leads required and these are now provided to residents. Where there is an identified risk following consultaion and agreement with MDT a care plan will be implemented expalining the reasons for call bell not insitu. Registered manager will continue to monitor this.

Recommendations	
Recommendation 1 **Ref:** Standard 46 Criteria (1) (2) **Stated:** Second time **To be completed by:** 30 July 2016	It is recommended that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. **Ref: Section 4.2, 4.3**
	Response by registered provider detailing the actions taken: FSHC infection control audits will be carried out monthly and areas of non compliance will be detailed in an action plan, discussed with staff and reviewed again to close the loop. An infection control champion has been put in place under the supervision of the Registered Manager.
Recommendation 2 **Ref:** Standard 18 Criteria (10) **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that all relevant staff receive training on restraint/restrictive practices. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Training on restraint was conducted 8th July 2016 for Nursing and Care staff.
Recommendation 3 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 31 July 2016	The registered provider should ensure that care plans accurately reflect the assessed needs of the patients. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Registered Manager or delegated person completes a weekly care plan TRaCA via Qol - Qulaity of Life Programme and records this completion on a care plan audit matrix. The TRaCA highlights any care plans that may not accurately reflect the residents assessed needs; these care plans are rectified by named nurse within one week, then reaudited to ensure full compliance.

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

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