Unannounced Care Inspection Report
27 June 2016

Dunlarg Care Home

Type of Service: Nursing
Address: 224 Keady Road, Armagh, BT60 3EW
Tel No: 02837530858
Inspector: Sharon Mc Knight

1.0 Summary

An unannounced inspection of Dunlarg Care Home took place on 27 June 2016 from 10:00 to 18:00 hours.

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.

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

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding.

A general inspection of the home was undertaken. One area for improvement was identified to address the poor condition of some vanity units. A recommendation was made.

Is care effective?

Evidenced gathered during this inspection confirmed that there were systems and processes in place to ensure that that the outcome of care delivery was positive for patients. We examined the systems in place to promote effective communication between patients and relatives and were assured that these systems were effective. Patients and staff were of the opinion that the care delivered provided positive outcomes.

Deficits were identified with the standard of record keeping; a requirement was made with regard to the assessment of patient need. Areas for improvements were also identified within the care records and the regularity of staff meetings; three recommendations were made.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully. Staff were also observed to be taking time to reassure patients as was required from time to time. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding issues affecting them. Patients spoken with commented positively in regard to the care they received.

An area of improvement to ensure that issues raised during patients meeting were addressed was identified and a recommendation made.

Is the service well led?

There was a clear organisational structure evidenced within Dunlarg and staff were aware of their roles and responsibilities. A review of care observations confirmed that the home was

operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide.

Staff spoken with were knowledgeable regarding the line management structure within the home and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty.

Systems were in place to monitor the quality of the services delivered, for example a programme of audits and a monthly quality monitoring visits by the regional manager on behalf of the responsible person. However the deficits in the care records had not been identified through these systems. A recommendation was made with regard to the auditing processes.

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 Department of Health, Social Services and Public Health (DHSSPS) Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**1**	**6**

Details of the Quality Improvement Plan (QIP) within this report were discussed with Leena Mary Correa, deputy 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 type e.g. care inspection

The most recent inspection of the home was an unannounced finance inspection undertaken on 15 October 2015. 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 (Bamford) Ltd	**Registered manager:** Patricia Graham
Person in charge of the home at the time of inspection: Leena Mary Correa, deputy manager	**Date manager registered:** 30 May 2012
Categories of care: RC-I, RC-MP(E), NH-LD, NH-PH, NH-PH(E), NH-DE, NH-I	**Number of registered places:** 48

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events 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

During the inspection we met with eleven patients individually and with others in small groups, two registered nurses, five care staff and five patient's visitors/representative.

Ten questionnaires were issued to relatives and staff with a request that they were returned within one week from the date of this inspection.

The following information was examined during the inspection:

- six patient care records
- staff duty roster
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- complaints and compliments records
- incident and accident records
- records of audit
- records of staff meetings
- records of patient meetings
- reports of monthly quality monitoring visits

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 15 October 2015.

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 providers, 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 1 October 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 36.2 **Stated:** First time **To be Completed by:** 12 November 2015	It is recommended that when the updated palliative and end of life care manual is issued by Four Seasons Health Care that staff receive an induction/training on the content to ensure that staff knowledge and care delivery is reflective of best practice in palliative and end of life care. **Action taken as confirmed during the inspection**: The deputy manager confirmed that that updated Palliative Care Manual was available in the nursing office. The two registered nurses, identified as palliative care link nurses for the home, were available to advise and support staff in accordance with the policy and best practise.	**Met**
Recommendation 2 **Ref**: Standard 20.2 **Stated:** First time **To be Completed by:** 12 November 2015	It is recommended that further opportunities, to discuss end of life care, are created by the registered nurses. Any expressed wishes of patients and/or their representatives should be formulated into a care plan. This should include any wishes with regard to the religious, spiritual or cultural need of patients'. **Action taken as confirmed during the inspection**: A review of care records evidenced that opportunities, to discuss end of life care had been provided. Any expressed wishes of patients and/ or their representatives were recorded in the care records.	**Met**

4.3 Is care safe?

The deputy manager confirmed the planned daily staffing levels for the home and advised that these levels were subject to regular review to ensure the assessed needs of the patients were met. Examples were provided of the indicators they used to evidence that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for week commencing 27 June 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff, staffing rosters confirmed that administrative, catering, domestic, laundry and maintenance staff were on duty daily. The staff team also included two personal activity leaders (PAL). Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Patients and relatives spoken with during the inspection commented positively regarding the staff and care delivery.

We also sought staff opinion on staffing via questionnaires; four were returned following the inspection. All of the respondents indicated that there were sufficient staff to meet the needs of the patients. However one staff included the following comments:

"There are sufficient staff to care for the basic needs of the residents but not enough time to do a little extra i.e. go for a walk, chat too.

"…in this care setting, which is a very busy home, I find it difficult to keep up with the record keeping…"

The comments received were discussed with the registered manager.

The deputy manager, registered nurses and staff spoken with were aware that a nurse was identified to be in charge of the home when the registered manager was off duty. The nurse in charge was clearly identified on the staffing roster.

A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the registered manager. The assessments were signed by the registered manager to confirm that the assessment process has been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home.

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. The record maintained of Access NI checks included the unique identification number of the certificate. The records evidenced that the certificate had been received and checked prior to the candidate commencing employment.

Discussion with the deputy manager and a review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed.

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. One completed induction programme was reviewed. The 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 registered manager signed the record to confirm that the induction process had been satisfactorily completed.

Training was available via an e learning system and internal face to face training arranged by Four Seasons Health Care (FSHC). Training opportunities were also provided by the local health and social care trust. The registered manager had systems in place to monitor staff attendance and compliance with training. These systems included a print out of which staff had completed an e learning training and signing in sheets to evidence which staff had attended face to face training in the home. We did not review the compliance figures for mandatory training but requested a sample of compliance figures to be e mailed following the inspection. An e mail was received on 1 July 2016 and confirmed that in the past 12 months 98% of staff have completed safeguarding training, 95% infection prevention and control and 90% moving and handling.

The deputy manager confirmed that systems were in place for staff supervision. Records of supervision were not reviewed.

Review of six patient care records evidenced that validated risk assessments were completed. However, for those patients admitted to the home regularly for respite the risk assessment were not review on each admission. Care records are further discussed in section 4.4.

Discussion with the deputy manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that there was appropriate notification to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. The registered manager completed a monthly analysis of accidents 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 majority of patients' bedrooms were personalised with photographs, pictures and personal items. A number of bedrooms had recently been redecorated and new bedroom furniture provided. The décor was bright, fresh and tastefully completed.

A number of bedrooms had fitted vanity units which were in a poor state of repair with the veneer worn. In one identified bedroom the basin of the vanity unit was extensively cracked presenting a potential infection prevention and control risk. It was agreed that this basin would be replaced as a priority. The deputy manager confirmed that the need to replace the damaged vanity units had been identified and costing requested by the registered manager. A rolling programme should be implemented to replace the vanity units which are in a poor state of repair; those units which are extensively worn should be prioritised. A recommendation was made.

There were two damaged windows in one area of the home, one of which had been broken two weeks prior to the inspection. The deputy manager explained that repairs were due to be completed during the week of the inspection but no date had been confirmed. We asked that the deputy manager contact FSHC estates officer and inform us of the date the repairs will be completed. We were informed of the scheduled date for the repairs on 1 July 2016 and received confirmation on 7 July 2016 that both windows had been repaired. The importance of ensuring that repairs are made in a timely manner was discussed with the deputy manager.

The home was clean and appropriately heated. With the exception of one area the home was fresh smelling. The management of odours in the identified area was discussed with a deputy manager who confirmed that the flooring was due to be renewed. There was no timescale identified for the replacement flooring. The deputy manager agreed to review the situation and consider how the malodour would be managed until the flooring was replaced. Confirmation of the action taken to ensure the malodour was not impacting on patient care was received on 1 July 2016.

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

Areas for improvement

A rolling programme should be implemented to replace the vanity units which are in a poor state of repair. The identified damaged basin should be replaced as a priority.

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

4.4 Is care effective?

We reviewed six patients' care records; five for patients receiving nursing care and one receiving residential care. Three of the five patients were in the home for short term respite care. We reviewed the admission process and the management of wound care. The day to day maintenance of care records was also considered for each patient.

We were informed by a registered nurse that, for patients who received regular respite, their assessments would be reviewed on each admission to the home to ensure any changes to the their condition were recorded and that the assessments accurately identified the patient's needs. Care plans would then be reviewed and updated as required. The care records reviewed did not reflect this practice. In one care record the patient's needs assessment had been completed in June 2014; risk assessments were dated October 2014. There was no evidence to confirm that these assessments had been reviewed from the date they were completed. The care plans in place were last reviewed in October 2014. Discussion with the patient and staff confirmed that the assessments and care plans did not accurately reflect the patient's need or the care they currently required. Care records of two other patients admitted for respite also contained a completed needs assessment, risk assessments and care plans but they contained no evidence of any review being completed on admissions to the home. The assessment of patient need must be kept under review and revised no less than annually. A requirement was made. It is recommended that the care records of patients admitted for respite care are reviewed at the time of each admission to the home to ensure that accurately reflect the needs of the patients.

In two care records of patients admitted for long term care a comprehensive assessment of patient need and risk assessment were not completed at the time of admission to the home. A comprehensive, holistic assessment should be commenced on the day of admission and completed within five days of admission to the home. A recommendation was made. The importance of recording as assessment of patients' skin condition on admission was discussed with the deputy manager.

The care records of a patient receiving residential care were reviewed. These records contained good detail of the patient's individual wishes and preferences. There was evidence that these records had been reviewed.

Wound management in respect of one patient was reviewed. Details of the wounds and frequency with which they required to be re-dressed were recorded in patient's care records. The care record contained an initial wound assessment and an assessment of the wound following each dressing renewal. Review of completed wound assessment records evidenced that prescribed dressing regimes were adhered to. The registered nurses spoken with were knowledgeable regarding the patient's wound, dressing regime and the progress of the wounds.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. There was evidence within the care records of regular, ongoing communication with relatives. Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Discussion with the deputy manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication.

The deputy manager confirmed that staff meetings were held regularly with all staff teams. In 2016 meetings were held with the registered nurses on 27 April, care staff on 17 May and housekeeping staff on 15 January. Minutes of these meeting detailing staff attendance and the areas discussed were available. Prior to these meetings there was no record of meetings taking place since May 2015. Staff meetings should take place regularly and at a minimum quarterly in accordance with DHSSPS Care Standards for Nursing Homes (April 2015). A recommendation was made.

Staff advised that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff also confirmed that if they had any concerns, they would raise these with the registered or deputy manager.

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. The deputy manager explained that both they and the registered manager had regular, daily contact with the patients and visitors and were available, throughout the day, to meet with both on a one to one basis if needed. Patients and relatives spoken with confirmed that they knew who the registered manager was, that she was regularly available in the home to speak with and that they were confident in raising any concerns they may have with the staff and/or management.

Areas for improvement

The assessment of patient need must be kept under review and revised no less than annually.

The care records of patients admitted for respite care should be reviewed at the time of each admission to the home to ensure that accurately reflect the needs of the patients.

A comprehensive, holistic assessment should be commenced on the day of admission and completed within five days of admission to the home.

Staff meetings should take place regularly and at a minimum quarterly.

Number of requirements	**1**	**Number of recommendations**:	**3**

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. We observed numerous occasions when staff offered patients' choice and took time to find out what the patients wanted when it was not always apparent and patients were unable to express their wishes clearly. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding patients likes and dislikes and individual preferences.

Patients spoken with commented positively in regard to the care they received and were happy in their surroundings. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner.

Patients meeting were held quarterly; the most recent took place on 12 May 2016. These meetings were facilitated by the PAL. A record of issues raised by the patients was recorded; there was no record of the action taken in response to the issues raised. We noted that over the past three meetings similar issues were being raised by the patients. For example in the meeting held in September 2015 patients raised issues with the breakfast trolley, these issues were raised again during the meeting in February 2016. The idea of a portable shop was first suggested in September 2015 and was raised at the two subsequent meetings. We discussed with the deputy manager the importance of ensuring that issues raised during patient meetings are addressed and the outcome discussed at the next meeting and included in the record of the meeting. A recommendation was made.

We spoke with the relatives of three patients who all commented positively with regard to the standard of care, the attentiveness of staff and communication in the home.

They confirmed that they were made to feel welcome into the home by all staff and were confident that if they raised a concern or query with the registered manager or staff, their concern would be addressed appropriately. The following comments were provided:

"I am very happy with the care given to dad."
"Communication from staff is excellent, they tell me everything."
"The care is excellent. They have tried so hard to improve mum's appetite."
"The girls are great."

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 was an iPad which allowed relatives/ representatives, visiting professionals and/or staff to provide feedback on their experience of Dunlarg. A portable iPad was also available to record feedback from patients. 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. Any complaints received via the "Quality of Life" system would also be recorded in the record of complaints and addressed through the complaints process.

Ten relative questionnaires were issued; none were returned prior to the issue of this report. There were no relatives visiting during the inspection.

Ten questionnaires were issued to nursing, care and ancillary staff; four were returned prior to the issue of this report. Comments provided regarding staffing are discussed within the domain of safe care in section 4.3.

Areas for improvement

Issues raised during the patients meeting should be addressed, the outcome discussed at the next meeting and included in the record of the meeting**.**

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

4.6 Is the service well led?

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

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

Staff spoken with were knowledgeable regarding line management and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Discussions with staff also confirmed that there was good team work and the registered manager was responsive to any suggestions or concerns raised.

Patients and relatives spoken with confirmed that they knew who to make a complaint to and were confident that staff and/or management would address any concern raised by them appropriately. A record of complaints was maintained. The record included the date the complaint was received, the nature of the complaint, details of the investigation and a copy of the letter sent to the complainant. The record also indicated if the complaint was closed. There were numerous thank you cards and letters received from former patients and relative displayed in the home.

The deputy manager discussed the systems in place to monitor the quality of the services delivered. These systems included a programme of audits which were completed on a monthly basis. However the deficits in the care records had not been identified through these audits. There was no evidence in the audit records that the areas for improvement had been re-audited to check compliance. The completion of the audit cycle to ensure areas for improvement were complied with was discussed. The registered manager should increase the frequency with which care records are audited and ensure that the audit process includes a re-audit of the areas for improvement to check compliance has been achieved.
A recommendation was made.

There were arrangements in place to receive and act on health and safety information, urgent communications, safety alerts and notices; for example from the Northern Ireland Adverse Incident Centre (NIAIC).

The unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. An action plan was generated to address any identified areas for improvement.

Areas for improvement

The registered manager should increase the frequency with which care records are audited and ensure that the audit process includes a re-audit of the areas for improvement to check compliance has been achieved.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Leena Mary Correa, Deputy 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 (Insert Service Type). 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 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)(b) **Stated:** First time **To be completed by:** 27 July 2016	The registered provider must ensure that the assessment of patient need is kept under review and revised no less than annually. **Ref section 4.3**
	Response by registered provider detailing the actions taken: Registered manager and Registered staff have conducted a review of each patient need ensuring each have been updated to meet the annual requirement.
Recommendations	
Recommendation 1 **Ref**: Standard 44.1 **Stated:** First time **To be completed by:** 27 July 2016	It is recommended that a rolling programme is implemented to replace the vanity units which are in a poor state of repair. The identified damaged basin should be replaced as a priority. **Ref section 4.3**
	Response by registered provider detailing the actions taken: A refurbishment programme commenced with fifteen vanity units authorised. Each bedroom has been reviewed and those identified will be prioritised and completed first.
Recommendation 2 **Ref**: Standard 4.7 **Stated:** First time **To be completed by:** 27 July 2016	It is recommended that the care records of patients admitted for respite care are reviewed at the time of each admission to the home to ensure that accurately reflect the needs of the patients. **Ref section 4.4**
	Response by registered provider detailing the actions taken: Registered manager has discussed with Registered nurses that all respite documentation is fully reviewed on day of admission and reflects current status.
Recommendation 3 **Ref**: Standard 4.1 **Stated:** First time **To be completed by:** 27 July 2016	It is recommended that a comprehensive, holistic assessment should be commenced on the day of admission and completed within five days admission to the home. **Ref section 4.4**
	Response by registered provider detailing the actions taken: Registered manager has discussed with Registered nurses to commence the admission assessment upon admission and complete within five days.This will be monitored by the Home Manager.

Recommendation 4 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 24 August 2016	It is recommended that staff meetings take place regularly and at a minimum quarterly in accordance with DHSSPS Care Standards for Nursing Homes (April 2015). **Ref section 4.4**
	Response by registered provider detailing the actions taken: All meetings have been held at least quarterly, and there are records to evidence this.
Recommendation 5 **Ref**: Standard 7.2 **Stated:** First time **To be completed by:** 10 August	It is recommended that issues raised during patient meeting should be addressed, the outcome discussed at the next meeting and included in the record of the meeting**.** **Ref section 4.5**
	Response by registered provider detailing the actions taken: Issues raised have now been addressed and discussed at residents meeting held 12/08/16
Recommendation 6 **Ref**: Standard 35.4 **Stated:** First time **To be completed by:** 27 July 2016	It is recommended that the registered manager should increase the frequency with which care records are audited and ensure that the audit process includes a re-audit of the areas for improvement to check compliance has been achieved. **Ref section 4.6**
	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 areas of non compliance which are completed by named nurse within one week, then reaudited to ensure full compliance has been achieved.

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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