Unannounced Care Inspection Report
13 December 2016

Glenview

Type of Service: Nursing Home
Address: 9 Cabragh Road, Dungannon, BT70 3AH
Tel no: 02887767132
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Glenview took place on 13 December 2016 from 09.00 to 15.15 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.

The term 'patients' is used to describe those living in Glenview 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	4	4

The total number of requirements and recommendations above includes one requirement and two recommendations that have been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Veronica McElmurry, 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 estates inspection undertaken on 1 November 2016. 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: Mervyn John Gregg	**Registered manager:** Veronica McElmurry
Person in charge of the home at the time of inspection: Veronica McElmurry	**Date manager registered:** 29 September 2016
Categories of care: RC-I, NH-DE, NH-I, NH-PH, NH-PH(E) A maximum of 4 residential places in category RC-I and 2 places in category RC-I for 2 identified persons. A maximum of 10 patients in category NH-DE.	**Number of registered places:** 45

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

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

A poster was prominently 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 three patients, three care staff, two registered nurses, one domestic staff and four patients' representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- eight patient care records
- staff fire training records from 1 November 2016
- accident and incident records
- complaints received since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- care records audits and audits of restraints.
- a selection of policies and procedures.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 1 November 2016

The most recent inspection of the home was an announced premises inspection. The draft report of this inspection has been issued to the home and the completed QIP is due to be returned to RQIA by 25 December 2016.

Following discussion with the estates inspector for the home, it was agreed that the following areas would be followed up during this inspection:

- staff compliance with mandatory fire drills
- progress made in relation to the development of a plan of refurbishment works contract to replace deteriorated floor and wall surfaces.

A review of the staff training records evidenced that there was a rolling programme in place, to ensure that all staff had attended fire drills. Discussion with the registered manager confirmed that a refurbishment plan was in progress. Following the inspection, the refurbishment plan was submitted, by email on 16 December, to the estates inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 24 May 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 29 (5) (a) **Stated:** Second time	A copy of the regulation 29 monitoring reports must be retained in the home and available for inspection. **Action taken as confirmed during the inspection**: Discussion with the registered 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.	**Met**
Requirement 2 **Ref**: Regulation 20 (1) (a) **Stated:** First time	The registered persons must ensure that at all times staffing levels in the dementia unit are in such numbers as are appropriate for the health and welfare of the patients.	**Met**

	Action taken as confirmed during the inspection: The registered 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 5 December 2016 evidenced that the planned staffing levels were generally adhered to. Refer to section 4.3.1 for further detail.	
Requirement 3 **Ref**: Regulation 14 (5) **Stated:** First time	The registered person must ensure that no patient is subject to restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other patient and there are exceptional circumstances.	**Partially Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of restraint audits confirmed that the home was actively attempting to reduce the amount of restraints that were in use in the home. Although there was evidence that this had been effective in reducing the numbers of patients who had bedrails and lap belts in place, there continued to be some patients who still had lap belts in place. Refer to section 4.3.2 for further detail. This requirement was not fully met and has been stated for the second time.	
Requirement 4 **Ref:** Regulation 15 (2) (a) **Stated:** First time	The registered person must ensure that risk assessments and care plans are completed for each patient who requires the use of a lap belt. Formal consent must be obtained for their use and evidence of consultation with multidisciplinary professionals must be retained within the care record.	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that risk assessments and care plans were in place for each patient who required the use of a lap belt and there was evidence within the care records that care management and other multidisciplinary professionals had been consulted with. Refer to requirement 3 above, for further detail in relation to restraint management.	

Requirement 5 **Ref:** Regulation 17 (1) **Stated:** First time	The registered persons must ensure that an annual quality audit report is completed to ensure that the quality of nursing and other service provision is reviewed. This report must also provide for consultation with patients and their representatives.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the quality of the service provided. Views and comments recorded were analysed and areas for improvement were acted upon.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 32.1 **Stated:** Second time	All policies and procedures should be reviewed to ensure that they are subject to a three yearly review. • A policy on palliative and end of life care should be further developed in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines* and should include the procedure for managing an unexpected death. The policies and guidance documents listed above, should be made readily available to staff.	**Met**
	Action taken as confirmed during the inspection: A review of the above policy confirmed that this recommendation had been met.	
Recommendation 2 **Ref**: Standard 41 **Stated:** First time	The registered person should ensure that the staff duty roster accurately records the hours worked by the activities coordinator, in relation to the hours worked in that role and the hours worked, delivering care to the patients.	**Met**
	Action taken as confirmed during the inspection: A review of the staffing rota for the week commencing 5 December 2016 evidenced that this recommendation had been met.	

Recommendation 3 **Ref**: Standard 12.6 **Stated:** First time	The registered person should review the dining experience in the dementia unit with regard to patient choice and consider the introduction of pictorial menus to assist patients in making their choice of meal.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and observation of the dining experience, evidenced that this recommendation, as stated, was met. However, improvements were still required to be made. A new recommendation has been made in this regard. Refer to section 4.3.3 for further detail.	
Recommendation 4 **Ref**: Standard 25.3 **Stated:** First time	The registered person should ensure that a dementia audit is undertaken, to ensure the quality of care and life afforded to patients in the dementia unit is in accordance with best practice in dementia care.	**Partially Met**
	Action taken as confirmed during the inspection: Although there was evidence that there had been some areas of improvement made in the dementia unit, communal corridors and rooms still required work, to engage and stimulate patients. Refer to section 4.3.3 for further detail. This recommendation was not fully met and has been stated for the second time.	
Recommendation 5 **Ref**: Standard 11 **Stated:** First time	The registered persons should ensure that the provision of activities on the dementia unit are reviewed, to ensure that the needs of patients who do not partake in group activities are taken into account. Records of the level of engagement/enjoyment should be retained within the care record.	**Partially Met**
	Action taken as confirmed during the inspection: Although there was evidence of some records being maintained in the 'activities' section of the patients' care records, this did not evidence activities that had been provided by nursing and care staff. This recommendation has not been fully met and has been stated for the second time.	

Recommendation 6 **Ref**: Standard 11 **Stated:** First time	The registered persons should ensure that a process for auditing patients' care records is further developed to include a review of the supplementary documentation, in addition to the patients' electronic care records. Records of key checks (audits) completed should be maintained and should evidence action taken in response to identified deficits.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of 'key checks' audits confirmed that this recommendation had been met.	

4.3 Inspection Findings

4.3.1 Staffing Arrangements

The registered manager explained that there were currently one registered nurse and two care staff vacancies. These vacancies were being filled by agency staff or permanent staff working additional hours. Some care staff had been recently been recruited and were going through the appropriate checks before starting in post. The registered 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. The dependency levels of patients had been reassessed and staffing levels had been amended where needed.

A review of the staffing rota for the week commencing 5 December 2016 evidenced that the planned staffing levels were not consistently adhered to. However, RQIA were satisfied on this occasion that the occupancy levels of the home had reduced and there remained sufficient staff to meet patients' needs. Discussion with patients and their representatives also evidenced that there were no concerns regarding the staffing levels. Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

4.3.2 Care Practices and Care Records

The home used an electronic system for assessing, planning and evaluating patients' care needs. A review of eight patient care records evidenced that a range of validated risk assessments were completed as part of the admission process.. Risk assessments generally informed the care planning process and both were reviewed as required, although some shortfalls were identified.

Areas for improvement had been identified at the previous care inspection of 24 May 2016 in relation the use of restraint in the home. The registered manager commenced employment in the home approximately eight weeks before the inspection. In this time, they had identified a number of patients who had bedrails and lap belts in place, without the appropriate risk assessments and care plans being in place. These matters had been addressed. Whilst audits

completed by the registered manager evidenced that there had been an evidential reduction in the use of restraint in the home, a number of patients were observed to still use lap belts. The records did not provide adequate rationale for the use of restrictive practices and what alternative measures had been explored. As stated in section 4.2, a requirement has been stated for the second time in this regard. This will be monitored during future inspection. Further non-compliance will lead to enforcement action.

A review of two patients' care charts did not evidence that records were maintained in relation to regular release and reposition of their lap belts, throughout the day. Discussion with staff evidenced that the reasons for using the lap belts were to 'prevent them from falling'. Using a lap belt is not a safe or effective means of preventing falls and it was concerning that the staff consulted with did not recognise that a lap belt was a form of restraint. This was discussed with the registered manager, who acknowledged that the use of lap belts and bedrails had been commonplace throughout the home and that they were in the process of engaging with patients' representatives, care management and other multidisciplinary professionals, to ensure that the patients' safety in the home was maintained, whilst reviewing alternate means of falls prevention. A requirement has been made to ensure that where lap belts are deemed necessary, records of regular release and repositioning are maintained. A recommendation has also been made that the staff receive training on restraint management.

Shortfalls were also identified in relation to the oversight registered nurses had of patients' total food and fluid intakes and the monitoring of patients' weights. A review of one patient's food and fluid intake records evidenced that records were not accurately completed and there was no evidence of oversight by registered nurses regarding the patient's food and fluid intake. For example, food intake charts were not completed on six days out of the 12 days reviewed. A review of the fluid intake charts identified that the patient had eaten small amounts of foods on these days; however, foods such as porridge, yoghurts and soups were recorded on the fluid intake charts, yet were not recorded on the food intake charts. Whilst we acknowledged that staff were observed assisting patients with food and fluid intake during this inspection, a requirement has been made in relation to the overall management of food and fluids.

A number of patients were identified as being at risk of losing weight due to a poor appetite or being unable to eat independently. The registered nurse explained that patients were generally weighed regularly according to the guidance in their care plans. These weight records were meant to be audited regularly to ensure that any loss of weight was identified and action was taken to address the concern. However, a review of one identified patient's care record identified that in September 2016, the patient's weight was 50.8kgs. On the 11 November 2016 this was 46.5kgs and on 4 December 2016, the patient weighed 44.3kgs. Each time the patient had been weighed during that period of time they has lost weight.

There was no care plan in place in relation to poor appetite or the potential for weight loss. There was also no evidence within the care record that a referral had been made to the relevant health care professionals, such as GPs, dieticians and speech and language therapists (SALT) for advice and guidance to help identify the cause of the patient's poor nutritional intake. This matter was discussed with the registered manager during feedback at the end of the inspection. A review of the key checks audits undertaken by the registered manager had identified that the patient had lost greater than ten percent of their body weight in the previous three months; however, the electronic system had only identified this on the day before the inspection.
It was concerning that the named nurse, who had the responsibility for updating this patient's care record, had not identified the weight loss sooner and taken the necessary action to have the patient reassessed. Following the inspection, the registered manager confirmed to RQIA,

by email on 15 December 2016, that the identified patient had been referred to SALT and to the dietician. A requirement was made in this regard.

A review of repositioning records evidenced that they were generally well maintained; however, there was evidence of some gaps in completion. If patients are not re-positioned, there is a greatly increased risk that they will develop pressure sores. The records evidenced that over a 24 hour period, one patient had been repositioned after 16 hours and on another day, there was a gap in repositioning of up to eight hours. Given that the patient's pressure areas were intact, RQIA were satisfied that this was most likely to be an error in record keeping, rather than the care not been delivered. A recommendation has been made in this regard.

There was some evidence of good practice in regards to many care records. For example, 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. Where a patient had been prescribed an antibiotic to treat an acute infection, this information was included in their care plan. Patients who were identified as requiring a modified diet, had the relevant choke risk and malnutrition risk assessments completed and this information was reflected in their care plan.

Where a patient had a wound, there was evidence of regular wound assessments and review of the care plan regarding the progress of the wound. A review of the daily progress notes, evidenced that the dressing had been changed according to the care plan. Patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

4.3.3 Dementia Environment

As discussed in section 4.2, a recommendation that had been made in relation to the dementia unit had not been met and has been stated for the second time. A dementia audit had not been undertaken. RQIA acknowledges that improvements had been made to the environment, for example, a 'Hollywood' themed area provided reminiscence opportunities for patients and there was evidence that the activities coordinator had created a memory box for patients. However, many areas of the dementia unit noted for improvement were still in need of attention. Particular reference was made to the future development of the dining room in the dementia unit, where improvements to the décor were required.

Although the recommendation made in regards to the dining experience in the dementia unit had been met, as stated, there was still areas noted for improvement. For example, there was an absence of table cloths or place mats and the dining room lacked stimulation for the patients. This was discussed with the registered manager, who agreed to specifically include the dining room, as part of the dementia audit.

4.3.4 Consultation

During the inspection, we met with three patients, three care staff, two registered nurses, one domestic staff and four patients' representatives. Some comments received are detailed below:

Staff

"It is very good here".
"The care is excellent, a lot of the staff have placed their own relatives here, it says a lot".
"No concerns, the care is spot on".
"Everything is very good, the patients are well look after very well".
"The care is very good, the patients are well looked after".

Patients

"I like it alright".
"It is clean and tidy, I get everything I need".
"It is good alright".

Patients' representatives

"It is good, the staff can be under pressure at times".
"Brilliant, couldn't get better care, it is known to be the best home around".
Very good, excellent, would put you in mind, to book yourself in".
"The staff are always happy, smiling and friendly".

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. One staff and one relative Both questionnaires indicated that the respondents were either 'very satisfied' or 'satisfied' that the care was safe, effective and compassionate; and that the home was well-led. No written comments were received.

4.3.5 Environment

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to warm, clean and tidy. Management advised of a number of environmental improvements and refurbishments completed since the last estates inspection undertaken on 1 November 2016 and a programme of refurbishment works which is ongoing. RQIA were satisfied on this occasion that the registered persons were proactively managing this however, RQIA will continue to monitor the progress of the planned improvements in accordance with the timescales identified during subsequent inspections.

There was an absence of storage facilities/vanity units in some of the ensuite toilets, which meant that patients' toiletries and other items were placed on the floor. The toilet brushes used throughout the home were also not consistent with regional infection control guidance. These matters were discussed with management at feedback who advised these matters would be attended to as part of the ongoing refurbishment plan. This will be monitored at future inspection.

Fire exits and corridors were maintained clear from clutter and obstruction.

4.3.6 Governance and Management Arrangements

The registered manager commenced employment in the home approximately eight weeks prior to the inspection. 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.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. All those consulted with described the registered manager in positive terms and stated that she was 'very approachable'.

There was evidence that the registered manager had taken action to improve the effectiveness of the care; however, as discussed in section 4.2, a number of requirements and recommendations were not met and have been stated for the second time.

Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. The home had a condition on its registration certificate, in regards to two identified patients who had been accommodated under the residential care (RC-I) category. Given that some of the patients had been re-categorised as requiring 'nursing' care, advice was given in relation to having this condition removed from the registration. A certificate of public liability insurance was current and displayed.

Discussion with two staff members, evidenced that they were not clear on the home's whistleblowing procedures. The policy on whistleblowing was undated, therefore we were unable to establish when it had been developed. The review of the policy also identified that it did not include any contact details for the relevant health and social care trusts' adult safeguarding teams, the Patient Client Council or the RQIA. The registered manager was aware that many of the policies and procedures for the home were due to be updated and that it is intended that the policies will be made available through the electronic learning system (Evo learning). Following the inspection, the registered manager confirmed to RQIA by email on 16 December, that updated policies on adult safeguarding and whistleblowing had been developed and were displayed on staff notice boards.

Areas for improvement

A requirement has been made that where a patient is subject to restraint, there is evidence within the care records of regular release and repositioning of the restraint. This refers particularly, but is not limited to, the use of lap belts.

A recommendation has been made that all staff, as appropriate, receive training in relation to the management of restraint and that the effectiveness of this training is monitored, to ensure that learning has been embedded into practice.
A requirement has been made that patients who are identified as being at risk of dehydration and/or malnutrition; and require their total food and fluid intake to be monitored, should have accurate records maintained. The registered nurses must have oversight of these records and be able to demonstrate evidence of action taken in relation to identified shortfalls.

A requirement has been made that where patients are identified as losing weight, registered nurses must ensure that timely referrals are made to the relevant healthcare professionals, such as GPs, dieticians and speech and language therapists (SALT) for advice and guidance to help identify the cause of the patient's poor nutritional intake.

A recommendation has been made that contemporaneous records are maintained of all nursing interventions, activities and procedures carried out in relation to each resident. This relates specifically to the repositioning needs of patients.

Number of requirements	3	**Number of recommendations**	2

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Veronica McElmurry, 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/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 nursing.team@rqia.org.uk 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 14 (5) **Stated:** Second time **To be completed by:** 10 February 2017	The registered persons must ensure that no patient is subject to restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other patient and there are exceptional circumstances. **Ref: Section 4.2 and 4.3.2**
	Response by registered provider detailing the actions taken: Any measures of restraint in use are currently under review awaiting trust review meetings with relatives or OT input. This is ongoing.
Requirement 2 **Ref:** Regulation 19 (1)(a) **Stated:** First time **To be completed by:** 10 February 2017	The registered persons must ensure that where a patient is subject to restraint, there is evidence within the care records of regular release and repositioning of the restraint. This refers particularly, but is not limited to, the use of lap belts. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: Manual Charts of Release and Repositioning of any lap belts in use commenced immediately post inspection and are checked during each shift by nurse in charge and regularly by Manager/Deputy. Staff responsibility has been reinforced at meetings.
Requirement 3 **Ref:** Regulation 13 (1) (a) **Stated:** First time **To be completed by:** 10 February 2017	The registered persons must ensure that patients who are identified as being at risk of dehydration and/or malnutrition; and require their total food and fluid intake to be monitored, should have accurate records maintained. The registered nurses must have oversight of these records and be able to demonstrate evidence of action taken in relation to identified shortfalls, within the patients' care records. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: Manual food and fluid charts were commenced immediately post inspection. These are checked during each shift by nurse-in-charge and regularly by Manager/Deputy. Staff responsibility has been reinforced at meetings any concerns and shortfalls idientified by nursing staff is highlighted to staff at the time and brought to manager's attention.

Requirement 4 **Ref:** Regulation 12 (1)(a)(b) **Stated:** First time **To be completed by:** 10 February 2017	The registered persons must ensure that the treatment provided to each patient meets their individual needs and reflects current best practice. This refers specifically to where patients are identified as losing weight, registered nurses make timely referrals to the relevant healthcare professionals, such as GPs, dieticians and speech and language therapists (SALT) for advice and guidance to help identify the cause of the patient's poor nutritional intake. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: All of the patients with recorded weight loss have been reviewed and where necessary brought to the attention of dietician. Staff Nurses responsibility in this area has been highlighted at staff meeting and follow-up auditing continues.
Recommendations	
Recommendation 1 **Ref**: Standard 25.3 **Stated:** Second time **To be completed by:** 10 February 2017	The registered persons should ensure that a dementia audit is undertaken, to ensure the quality of care and life afforded to patients in the dementia unit is in accordance with best practice in dementia care. **Ref: Section 4.2 and 4.3.3**
	Response by registered provider detailing the actions taken: Sterling University Dementia Audit completed by myself on 5th January 2017, report available with outcomes and intended actions clear. Work ongoing.
Recommendation 2 **Ref**: Standard 11 **Stated:** Second time **To be completed by:** 10 February 2017	The registered persons should ensure that the provision of activities on the dementia unit are reviewed, to ensure that the needs of patients who do not partake in group activities are taken into account. Records of the level of engagement/enjoyment should be retained within the care record. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Activities within the Dementia Unit have been reviewed and revised taking into account group and individual interests, abilities and level of participation. This has also been reinforced at staff meetings. Review of records continues. Meaningful activites training in place.

Recommendation 3 **Ref**: Standard 19.4 **Stated:** First time **To be completed by:** 10 February 2017	A recommendation has been made that all staff, as appropriate, receive training in relation to the management of restraint and that the effectiveness of this training is monitored, to ensure that learning has been embedded into practice. Evidence of the training and monitoring, should be retained in the home. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: Restraint training is now in place, completion is being monitored. Application of this training is now being reinforced into practice.
Recommendation 4 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 10 February 2017	A recommendation has been made that contemporaneous records are maintained of all nursing interventions, activities and procedures carried out in relation to each resident. This relates specifically to the repositioning needs of patients. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: The importance of contemporonerous record keeping for all patients' records has been reinforced. For ease of completion manual repositioning and release charts have been introduced. These are regularly reviewed.

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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