Unannounced Care Inspection Report
13 September 2016

Lisnisky

Type of Service: Nursing Home
16 Lisnisky Lane, Portadown, Craigavon
BT63 5RB
Tel no: 028 38 339153
Inspector: Sharon McKnight

1.0 Summary

An unannounced inspection of Lisnisky took place on 13 September 2016 from 09:30 hours to 17:15 hours.

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

Is care safe?

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.

Concerns were identified in the delivery of safe care, specifically in relation to the recruitment processes and the procedure to confirm, and regularly monitor, the registration status of care assistants with the Northern Ireland Social Care Council (NISCC). Two requirements have been made. One recommendation, stated for a second time following the previous inspection has not been fully complied with. Following discussion with a senior inspector in RQIA it was agreed that, as there had been progress since the previous inspection and given that a date had now been identified for the work to commence; this recommendation would be stated for a third and final time.

Is care effective?

Evidenced gathered 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.

A review of care records confirmed that patients were assessed and care plans were created to manage and direct the care required. One area for improvement was identified regarding the care records in the residential unit and a recommendation was made. There were arrangements in place to monitor and review the effectiveness of care delivery. We examined the systems in place to promote effective communication between staff and were assured that these systems were effective. Relatives and staff were of the opinion that the care delivered was effective.

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 living in the home.

There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

There was a clear organisational structure evidenced within Lisnisky 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. One area for improvement was identified with regard to the auditing processes and a recommendation was made.

The term 'patients' is used to describe those living in Lisnisky 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	**2**	**4***

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

Details of the Quality Improvement Plan (QIP) within this report were discussed with Edith Harrison, 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 care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 2 March 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: Four Seasons healthcare/ Dr Maureen Claire Royston	**Registered manager:** Edith Harrison
Person in charge of the home at the time of inspection: Edith Harrison	**Date manager registered:** 2 March 2016
Categories of care: NH-DE, RC-I, RC-MP(E), RC-PH, RC-LD(E), NH-I, NH-TI 47 Nursing : 16 Residential Of the 47 residents accommodated in the nursing category there shall be a maximum of 14 assessed as DE. The home is approved to provide care on a day basis only to 9 persons.	**Number of registered places:** 63

3.0 Methods/processes

Prior to inspection we analysed the following records:

- notifiable events 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 plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection the inspector met with 14 patients individually and with others in small groups, the deputy manager, nursing sister, two registered nurses, one senior care assistant, three care staff and four patient's visitors/ representative.

Ten questionnaires were also 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:

- three patient care records
- staff duty roster for the week commencing 12 September 2016
- staff training records
- staff induction records
- staff recruitment records
- records of staff NMC/NISCC registration
- complaints and compliments records
- incident and accident records
- records of audit
- records of staff meetings
- reports of monthly quality monitoring visits

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 2 March 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 was validated during this inspection. Refer to section below for details.

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

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 44 **Stated:** Second time	It is recommended that a future phase of refurbishment should consider the replacement of vanity units whose surfaces or structure are damaged.	**Partially Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that an assessment of the vanity units had been completed and that costings had been received for those which require to be replaced. No timescale had been agreed for the completion of the work. Prior to the conclusion of the inspection the registered manager confirmed that the work would commence by 12 October 2016. Given that this recommendation has been stated twice the action taken to comply with this recommendation was discussed with a senior inspector in RQIA. It was agreed that, as there had been progress since the previous inspection and given that a date had now been identified for the work to commence this recommendation would be stated for a third and final time.	

Recommendation 2 **Ref**: Standard 20.2 **Stated:** First time	It is recommended that further opportunities, to discuss end of life care, are created by registered nurses. Any expressed wishes of patients and/ or their representatives should be formulated into a care plan for end of life care. This should include any wishes with regard to the religious, spiritual or cultural needs of patients.	**Met**
	Action taken as confirmed during the inspection: Care records evidenced that palliative and end of life care needs were included in the assessment of need completed on admission to the home. The registered nurses spoken with confirmed that if a patient expressed wishes these would be formulated into a care plan. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 4.8 **Stated:** First time	It is recommended that the identified patients care is reviewed to ensure that infection prevention and control measures are not compromised and that the patients' dignity is preserved.	**Met**
	Action taken as confirmed during the inspection: The identified patient was no longer resident in the home. The delivery of care was observed to be in keeping with good infection prevention and control measures and supported patient dignity. This recommendation has been met.	
Recommendation 4 **Ref**: Standard 44 **Stated:** First time	It is recommended that an update on the refurbishment of the identified bathroom, with a completion date when it will be operational, is provided to RQIA by 30 March 2016.	**Met**
	Action taken as confirmed during the inspection: RQIA were informed on 3 March 2016 that the required work was complete and that the bathroom was operational. This recommendation has been met.	

4.3 Is care safe?

The registered manager confirmed the current occupancy of the home and the planned daily staffing levels. They advised that these levels were subject to regular review to ensure the assessed needs of the patients were met. The registered manager provided examples of the indicators used to evidence that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for week commencing 12 September 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. There was also a personal activity leader (PAL) to provide activities for the patients. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Patients commented positively regarding the staff and care delivery.

We also sought staff opinion on staffing via questionnaires; nine were returned following the inspection. Eight of the respondents indicated that, in their opinion, there was sufficient staff to meet the needs of the patients. One staff member commented that the staffing in one unit did not reflect the dependency of the patients accommodated. This opinion was contrary to the opinion of staff spoken with and observations made during the inspection

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 of the home was clearly identified on the staffing roster in each unit.

The recruitment procedures were discussed with the registered manager and two personnel files were reviewed. The first personal file contained only one reference. There were documents to evidence that a second reference had been requested. The completed application form in the second file did not contain an employment history; that section of the form was blank. There was no information recorded in the interview notes to evidence if any discussion had taken place to confirm if the applicant had previously worked. All other information required under regulation was available in the two files. All information required in regard to the selection and recruitment of staff must be obtained prior to the commencement of employment. A requirement was made.

The record maintained of Access NI checks was reviewed. The records included the date the certificate was issued, the registration number of the certificate and that date the certificate was checked by the home. Records evidenced that the outcome of the Access NI check had been confirmed prior to the candidate commencing employment.

Discussion with the registered manager and staff and a 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.

The arrangements in place to confirm and monitor the registration status of registered nurses with the Nursing and Midwifery council (NMC) and care staff registration with the Northern Ireland Social Care Council (NISCC) were discussed with the registered manager.
A review of records evidenced that the arrangements for monitoring the registration status of registered nurses were appropriately managed.

At the time of the inspection there were nine care staff working in the home with no records to evidence their registration status with the NISCC. This issue was highlighted by the registered manager in February 2016 during the monthly monitoring visit undertaken on behalf of the registered provider. The reports of the monthly monitoring visits from February to August 2016 evidenced that the issue had been reviewed at each visit but no confirmation of registration had been received. We requested that the registered manager, as a matter of urgency, provide confirmation of the NISCC registration status of the nine identified care assistants employed in the home. Confirmation that the registration process had been commenced for the identified care assistants was provided by the registered manager on 14 September 2016. The registered person must ensure that they have systems in place to check that staff, where appropriate, are registered with a professional regulatory body. Records must be maintained to evidence registration. A requirement was made.

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. A review of the print out of mandatory training evidenced good compliance with mandatory training; for example in the past 12 months 97% of staff had completed basic life support, 97% infection prevention and control and 91% adult safeguarding training. The registered manager explained that training was ongoing to ensure all staff completed the required areas. Compliance with mandatory training was also monitored as part of the monthly monitoring visit undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

The registered manager confirmed that systems were in place for staff supervision. Currently staff supervision was delivered in a group setting. Staff should also receive individual, formal supervision. A recommendation was made. Records to evidence the frequency at which supervision took place and the areas/topics were available; the content was not reviewed.

The registered manager and staff clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. The registered nurses and care staff were aware of whom to report concerns to within the home. Annual refresher training was considered mandatory by the home.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk and inform the patient's individual care plans. Assessment of patient need is further discussed in section 4.4.

Discussion with the registered 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 in August 2016 evidenced that accidents and incidents had been appropriately notified 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. The home was fresh smelling, clean and appropriately heated. As discussed in section 4.1 an assessment of the vanity units

had been completed and costings have been received for those which require to be replaced. Confirmation was provided that the work would commence by 12 October 2016.

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

There were no issues identified with infection prevention and control practice.

Areas for improvement
All information required in regard to the selection and recruitment of staff must be obtained prior to the commencement of employment.

The registered person must ensure that they have systems in place to check that staff, where appropriate, are registered with a professional regulatory body.

Staff should receive individual, formal supervision.

Number of requirements	2	Number of recommendations	1

4.4 Is care effective?

We reviewed three patient care records. The care records of two patients receiving residential care evidenced that a pre admission assessment had been completed. An assessment of patients' needs was commenced at the time of admission to the home and initial plans of care generated. In addition to the assessment of need a wide range of risk assessments were also completed. We identified that the range of risk assessments completed for those patients in receipt of nursing care and residential care were the same. In addition there was some duplication with the risk assessments in place in the residential unit. We observed that one patient had two different pain assessments completed; the outcome of one indicated the patient had no pain whilst the outcome of the other indicated moderate pain. The social needs of the patients in the residential unit had not been assessed. The care plans in place were generally to meet the patients' physical needs. The care plan for medication referenced the Nursing and Midwifery Council (NMC) which is not the regulatory body of the staff working in the residential unit. Following discussion with the registered manager it was agreed that the assessment and care planning processes for patients in receipt of residential care would be reviewed to ensure their needs are appropriately and accurately assessed and care plans generated to meet all of their needs. A recommendation was made.

A review of one patient's care record receiving nursing care evidenced that a comprehensive, holistic assessment of nursing needs was commenced at the time of admission to the home.

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. Care records were regularly reviewed and updated, as required, in response to patient need. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.
There was evidence in the care records of regular communication with relatives. Registered nurses and senior care staff 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 registered manager and staff advised 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. Staff spoken with confirmed that the shift handover provided the necessary information regarding any changes in patients' condition. A written report was completed for the registered manager at the end of each 24 hour period.

The registered manager confirmed that staff meetings were held approximately every three months and that records of these meeting were maintained. The record of each meeting was sent to the relevant head of department and a copy displayed in the home to inform staff.

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 manager.

Patients spoken with commented positively in regard to the care they received. The following comments were provided:

"Staff know me and how I like things done."
"Nice atmosphere…"

We spoke with the relatives of four patients who commented positively regarding staffing, communication, activities and the general care and atmosphere in the home.

Areas for improvement

The assessment and care planning process for patients in receipt of residential care should be reviewed to ensure their needs are appropriately assessed with care plans generated to meet identified needs.

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

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. 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.

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

Numerous compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

"…the care, attention, kindness, patience and understanding that was given to her was second to none."

"…we always wanted the best care for …and it was a comfort knowing she was in great hands."

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. The system was entitled 'Quality of Life' (QOL) and was a feedback system which was available in the reception area and throughout the home. The system works via a computerised tablet which allowed relatives/ representatives, visiting professionals and/ or staff to provide feedback on their experience of Lisnisky. A portable computer tablet was also available to record feedback from patients. The registered manager explained that when feedback was received via this system an automatic email is sent to management who then must respond to any comments made. Anyone completing the feedback has the option to remain anonymous or leave their name. If an expression of dissatisfaction or a complaint was made through the QOL the registered manager explained it was recorded as a complaint and addressed through the complaints process.

The registered manager explained that they were currently working with the Personal Activity Leader (PAL) to create a newsletter to inform the patients and relatives about events in the home. The aim would be to produce the newsletter quarterly.

Ten relative questionnaires were issued; one was returned prior to the issue of this report. The relative was very satisfied with the care provided and commented that they were "very happy with both the care and carers" and that "the manager is very approachable and caring."

Ten questionnaires were issued to nursing, care and ancillary staff; nine were returned prior to the issue of this report. All of the respondents indicated that they were satisfied or very satisfied with the care delivery in the home. Two staff expressed dissatisfaction with the information received prior to admission of patients into one identified unit. Their comments were discussed with the registered manager who agreed to address the issue. Other comments regarding staffing are discussed within the domain of safe care in section 4.3.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.6 Is the service well led?

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

Patients and representatives spoken with confirmed that they were aware of how to make a complaint and were confident that staff and /or management would address any concern raised by them appropriately. Patients were aware of who the registered manager was.

A record of complaints was maintained. The record included the date the complaint was received, the nature of the complaint and details of the investigation. The registered manager reviewed recorded complaints on a monthly basis.

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, audits were completed in relation to incidents/ accidents, management of alarm mats and lap belts and infection prevention and control practices. We reviewed a completed environmental infection control audit. There was no evidence in the audit records that the areas for improvement had been re-audited to check for compliance. The completion of the audit cycle to ensure quality improvement was discussed with the registered manager and a recommendation 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 and reviewed during the next visit.

Areas for improvement

Areas for improvement identified during audit should be re-audited to ensure the required improvements have been made and compliance is 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 the QIP were discussed with Edith Harrison, 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 21(1)(b) **Stated:** First time **To be completed by:** 11 October 2016	The registered provider must ensure that all information required in regard to the selection and recruitment of staff is obtained prior to the commencement of employment. **Ref section 4.3**
	Response by registered provider detailing the actions taken: The selection and recruitment process will be followed. This will include gaps noted in employment being scoped out at interview and a comment recorded. All personnel files for recently commenced staff have been checked ensuring two references are in place.
Requirement 2 **Ref**: Regulation 21(1)(b) **Stated:** First time **To be completed by:** 11 October 2016	The registered provider must ensure that they have systems in place to check that staff, where appropriate, are registered with a professional regulatory body. Records must be maintained to evidence registration. **Ref section 4.3**
	Response by registered provider detailing the actions taken: Systems are in place to check that staff are registered with a professional regulatory body.Checks are completed monthly and recorded on a log. Staff have been made aware of the importance of registration and renewal.
Recommendations	
Recommendation 1 **Ref**: Standard 44 **Stated:** Third time and final time **To be completed by:** 15 November 2016	It is recommended that a future phase of refurbishment should consider the replacement of vanity units whose surfaces or structure are damaged. **Section 4.2**
	Response by registered provider detailing the actions taken: The vanity units identified have been replaced,the remaining units have been costed and the need for replacement/repair will be monitored.
Recommendation 2 **Ref**: Standard 40 **Stated:** First time **To be completed by:** 15 November 2016	It is recommended that staff should receive individual, formal supervision according to the home's procedures and no less than every six months for staff who are performing satisfactorily. **Ref section 4.3**
	Response by registered provider detailing the actions taken: At present staff are receiving group and individual supervision. A plan is in place to ensure all staff receive individual supervision at least twice a year.

Recommendation 3 **Ref**: Standard 4.1 **Stated:** First time **To be completed by:** 15 November 2016	It is recommended that the assessment and care planning process for patients in receipt of residential care should be reviewed to ensure their needs are appropriately assessed and care plans generated to meet identified needs. **Ref section 4.4**
	Response by registered provider detailing the actions taken: Care plans have been reviewed to include social needs. This will be discussed further during Care plan training scheduled for 4th November and will be monitored through use of QoI.
Recommendation 4 **Ref**: Standard 35.16 **Stated:** First time **To be completed by:** 15 November 2016	It is recommended that areas for improvement identified during audit should be re-audited to ensure the required improvements have been made and compliance is achieved. **Ref section 4.6**
	Response by registered provider detailing the actions taken: QoI identifies areas needing improvement in audits, findings are notified to named nurse who have five days to address the issues. The audit will be reaudited using QoI to ensure compliance is fully 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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