Unannounced Care Inspection Report
19 April 2016

Sanville

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Inspector: Sharon Loane

1.0 Summary

An unannounced inspection of Sanville took place on 19 April 2016 from 10.15 to 17.30 hours.

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

Is care safe?
The premises and grounds were safe, well maintained and suitable for their stated purpose. Staff assessed risks to patient's safety and developed care plans to manage these appropriately. Staff recruitment was maintained in line with regulation and standards and staff were provided with appropriate induction and training. However, a review of records evidenced that not all staff had completed their mandatory training requirements and there was no system in place to monitor same. A recommendation has been made in this regard.

Is care effective?
Shortfalls have been identified in the delivery of effective care specifically in relation to the management of pressure and /or wound care. Improvements are also required in the recording of repositioning charts in accordance with best practice guidelines. A recommendation stated previously in relation to the management of food and fluids was partially met and has been stated for a second time. One requirement and three recommendations have been made in this domain.

Is care compassionate?
Observations of care and discussions with patients and their representatives evidenced that patients and clients were treated with dignity and respect. There was strong evidence that patients were involved in decisions affecting their treatment, care and support. The ethos of activities delivered was an integral part of the care process, and the activities provided opportunities for patients to participate in meaningful engagements with other patients, staff and community events. The management of activities is commended.

Is the service well led?
At this inspection it was evidenced that the management team had identified the need for additional governance arrangements to assure the safe delivery of quality care within the home. The implementation of these systems and processes will improve the overall services provided, the experience of service users and leadership within the home. One recommendation has been stated in the safe domain and one requirement and three recommendations have been stated within the effective domain. One recommendation has been stated for a second time. One recommendation has been made under the wed-led domain.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	*5

One of the recommendations made includes a recommendation that has been stated for a second time.

Details of the QIP within this report were discussed with Alice McAleer, registered person, Bronwyn Toner, director of human resources and legal services, Claire Reid, acting 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 medicines management inspection undertaken on 28 May 2015. No enforcement or further actions were required other than those detailed in the previous QIP.

The acting manager advised that there was currently an ongoing investigation in relation to the safeguarding of adults which was being managed by the Trust safeguarding team.

2.0 Service details

Registered organisation/registered person: Sanville Alice Mc Aleer	**Registered manager:** The manager is not yet registered with RQIA.
Person in charge of the home at the time of inspection: Claire Reid	**Date manager registered:** Claire Reid– application not yet submitted.
Categories of care: RC-I.NH-I,NH-PH,NH-DE,NH-LD,NH-LD(E), NH-MP(E),NH-MP	**Number of registered places:** 38

3.0 Methods/processes

Prior to inspection the following information was analysed:

- 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 plan (QIP) and the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Seven patients, three care staff, two registered nurses, two ancillary staff and the activities co-ordinator were consulted.

The following records were examined during the inspection:

- validation evidence linked to the previous care inspection QIP
- staffing arrangements in the home
- three patient care records
- staff training records
- two staff personnel records
- NMC and NISCC registration records
- complaints record
- a sample of audits
- accident and incident records
- records relating to prevention and protection of adults at risk
- staff induction, supervision and appraisal records
- records of meetings for staff, patients and patient representatives
- monthly monitoring reports in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- policies and procedure

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector and will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 15 May 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 14 (2) (c) **Stated:** First time	The registered person must ensure that any chemicals used within the home are labelled correctly and stored securely and in accordance with COSHH regulations. This matter was raised in the urgent action report at the conclusion of the inspection.	**Met**
	Action taken as confirmed during the inspection: All chemicals observed were labelled correctly and stored securely. A key pad has been installed for both identified sluices ensuring no access is available other than to authorised staff. Discussion with an ancillary member of staff confirmed that they were knowledgeable in regards to COSHH regulations. This requirement has been met.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 12.3 **Stated:** First time	The registered person should ensure that the nutritional screening of a patient is reviewed following a hospital admission and where patients are at risk of malnutrition an up to date nutritional care plan should be in place.	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that the MUST (Malnutrition Universal Screening Tool) was completed as part of the admission process and was reviewed regularly including any hospital admissions. Care plans were available for the management of nutrition and were in accordance with assessment outcomes. This recommendation has been met.	

Last care inspection recommendations		Validation of compliance
Recommendation 2 **Ref**: Standard 4.9 **Stated:** First time	The registered person should ensure the following actions are taken where patients are at risk of dehydration: • fluid balance charts are accurately completed • the total fluid intake for 24 hours is recorded in the patients'' daily progress notes • when a patient does not met their daily target of fluid intake appropriate action is recorded in the patient's daily progress notes.	
	Action taken as confirmed during the inspection: A review of records pertaining to the management of fluids evidenced that fluid charts recorded details of fluids taken or refused. Fluid targets were identified and appropriate actions had been taken when this was not achieved. A record of total fluid intake for 24 hours was not calculated or recorded in the patients daily progress notes. This was discussed with the acting manager and this element of the recommendation has been stated for a second time.	**Partially met**

4.3 Is care safe?

The acting manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met.

A review of the staffing rota for weeks commencing 11 and 18 April 2016 evidenced that the planned staffing levels were adhered to. Discussion and responses from returned questionnaires for patients and representatives evidenced that there were no concerns regarding staffing levels. Discussion with a sample of staff evidenced that staffing levels were adequate to meet the needs of patients; however a discussion with two staff members, challenged this opinion when they stated that staffing levels were not adequate to meet the needs of the patients. These staff members stated that they felt hurried and rushed and staffing levels were not adequate to provide the necessary supervision for patients, particularly between 18.00 and 20.00 hours. Observations made during the time of this inspection, evidenced that patients' needs were being met by the levels and skill mix of staff on duty. Staff were observed responding to patients requests and needs in a timely and unhurried manner. The negative staff comments were discussed with management during feedback. The acting manager advised that dependency levels of patients were kept under review to determine staffing requirements. The acting manager gave assurances that staffing levels were appropriate to meet the needs of the patients in the home. The management team advised that they would review the staffing arrangements in consideration of the concerns raised and take appropriate actions.

Discussion with the acting manager confirmed that systems were in place to ensure staff are recruited and employed in accordance with relevant statutory employment legislation and mandatory requirements. A review of personnel files evidenced that records were kept of all the documentation relating to the recruitment process. The interview documentation used did not include all relevant information for example, the applicants details, date of interview and signature of interviewer on some of the records examined. In addition, there was no evidence that any gaps in employment had been discussed and recorded. These matters were discussed with the acting manager who agreed to amend the documentation as required.

Discussion with the acting manager and a review of records evidenced that the arrangements for monitoring the registration status of nursing staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC). The acting manager had developed a matrix to record and monitor this information and advised that these are checked monthly. A discussion with the acting manager confirmed that since coming into post, they had identified that the majority of care staff were not registered with the Northern Ireland Social Care Council (NISCC). The acting manager had taken appropriate actions and existing care staff had been given a timescale to complete the registration process. Discussion with care staff and a review of the minutes of staff meetings confirmed these actions. The acting manager advised that staff are advised of their responsibility to register with NISCC as part of the recruitment process. A matrix to record each staff member's registration status has been devised and the acting manager confirmed that this was monitored on a monthly basis.

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. A review of an induction record for one staff member confirmed that it had been completed and recorded appropriately. It was noted that some pages in the induction template did not include the staff member's details. This was discussed with the acting manager as it could impact on the traceability of records should pages become displaced. The acting manager agreed to address this accordingly.

A discussion with the acting manager confirmed that a training schedule was currently being co-ordinated and developed. The acting manager provided evidence of training organised to date. A review of the training matrix for 2015 – 2016 evidenced significant evidence of staff non-compliance. A discussion with management confirmed that previously there had been no system in place to ensure staff attended and completed mandatory training. However, a review of the monthly monitoring reports in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 had identified "training" as an area for improvement and an action plan was available. This matter was discussed further at feedback with management representatives who acknowledged that a system was required to monitor overall compliance with mandatory training. A recommendation has been made.

Discussion with the acting manager and staff confirmed that there were systems in place to monitor staff performance and to ensure staff received support and guidance. Staff advised that they had received regular supervision and annual appraisals. The acting manager advised that a schedule was being developed for staff supervisions and appraisals for 2016.

Discussion with the acting manager and a review of documentation confirmed that any potential safeguarding concerns were managed appropriately. Staff spoken with were knowledgeable about their specific role and responsibility in relation to Adult Safeguarding. A review of the policy on Adult Safeguarding evidenced that the policy had been reviewed in accordance with recent policy and procedures and regional protocols.

A range of validated risk assessments were completed as part of the admission process and were reviewed as required. There was evidence that risk assessments informed the care planning process.

Discussion with the acting manager confirmed that an index of audits had been identified for completion. A review of audits for falls included the following information; the name of the person involved, date, time and details of accident and name of persons or professional bodies notified. However, the audit did not include any information regarding trends and patterns which could further assure the effective safe delivery of care. A recommendation has been made. Refer to section 4.6 for further details.

A review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the last care inspection confirmed that these were appropriately managed.

A review of the home's environment was undertaken which included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, fresh smelling and recent areas that had been refurbished were completed to a high standard. The home had a very calm and relaxed environment with areas allocated to meet a range of patients' individual needs and preferences. Staff, patients and their representatives spoken with were complimentary in respect of the home's environment.

Infection prevention and control measures were generally in accordance with best practice guidance. However, in one identified bathroom the seal around the shower tray and toilet area was damaged and the hand rail in the shower was rusted and therefore could not be cleaned effectively. Management representatives advised that there were plans in place to refurbish facilities on the first floor however, given the identified hygiene risks to patients it was agreed that interim repair measures would be undertaken to this bathroom immediately. Post inspection, an email correspondence was received by RQIA confirming that the issues identified in relation to the identified bathroom at inspection have been actioned.

Fire exits and corridors were observed to be clear of clutter and obstruction. A discussion and a review of records evidenced that PEEPS (personal emergency evacuation plans) were in place and reviewed on a regular basis.

Areas for improvement

It is recommended that a system is developed and monitored to ensure that staff attends training and mandatory trainings requirements are met.

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

4.4 Is care effective?

A review of three patient care records evidenced that a range of validated risk assessments and care plans were commenced on the day of admission and completed within five days of admission to the home. There was evidence of ongoing re-assessment and that risk assessments informed the care planning process. There was also evidence that the care planning process included input from patients and/or their representatives, where appropriate. There was evidence of regular communication with representatives within the care records reviewed.

A review of nursing records provided evidence of nursing interventions, activities and procedures carried out. Records examined were in accordance with NMC guidelines.

Supplementary care charts for example; repositioning records and food and fluid intake records evidenced that some areas were not maintained in accordance with best practice guidance, care standards and legislative requirements. A recommendation previously stated in regards to the management of fluid intake records has been stated for a second time, refer to section 4.2. A review sample of repositioning records evidenced that repositioning was not in accordance with the plan of care and staff were not recording the actual positional change and comments on the condition of the patient's skin at the time of repositioning. However, records did evidence that pressure areas were being checked and recorded twice daily. Two recommendations have been made refer to section 5.3 for further details.

A review of care records in respect of one identified patient was examined and shortfalls were identified in relation to pressure and /or wound care management. A review of the care record evidenced that two care plans were available with two different plans of care and treatment. The acting manager advised that there had been a change to the initial plan of care for a period of seven days; however the previous care plan had not been discontinued. A review of wound care records evidenced that the dressings were not carried out in accordance with the prescribed frequency and on some occasions the dressings had not been renewed in seven and / or eight days. This was very concerning given that the treatment plan advised that the dressing (s) were to be renewed on alternate days. In addition there were inconsistencies in regards to the recording of information. There was evidence that registered nurses were recording information regarding the wound dressing change either in the wound chart and /or the evaluation notes which again were not reflective of the interventions / treatment required . These concerns were discussed with the home manager as the identified shortfalls have a direct impact on the delivery of safe and effective care. A requirement has been made.

Discussion with staff and a review of the duty rota evidenced that registered nurses and care staff team leaders were required to attend a handover meeting at the beginning of each shift. The acting manager advised that information is then disseminated to staff according to their role and responsibility. A written handover template was completed at each shift and was made available to staff and included relevant information on each patient's condition. There were also communication books available for each staff department which enabled staff to share with their colleagues any relevant information in regards to the patient's wellbeing. Discussion with staff confirmed that the systems available provided the necessary information regarding the patient's condition.

Discussion with the acting manager confirmed that staff meetings would be held every eight weeks initially, until they became more established in their role as acting manager. Records were available to evidence staff meetings that had been held 15 and 22 March 2016 included an agenda and a list of attendees. Staff stated that there was effective teamwork; each staff member was knowledgeable regarding their role and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the manager.

Discussion with the acting manager and a review of records evidenced that a patients and /or relatives meeting had been held since the acting manager came into post March 2016. The minutes of the meeting were available and an action plan was included. There was evidence that some of these actions had been addressed during a staff meeting. Discussion with patients and one patient representative confirmed that they knew the acting manager and felt that they could approach them with any concerns. However, three questionnaires returned by patients following the inspection, indicated that they did not know the acting manager as there had been recent changes and some responses indicated they never saw the acting manager. This information was shared with the management team post inspection who agreed to address the comments made.

Areas for improvement

The acting manager must ensure that the treatment and care provided to each patient meets their identified assessed needs and reflects their plan of care in relation to the management of pressure and / or wounds. A requirement has been made.

It is recommended that repositioning charts are completed to reflect the care delivered / not delivered in accordance with best practice guidelines.

It is recommended that training is provided for staff in relation to the prevention of pressure damage based on best practice guidelines.

Number of requirements	**1**	**Number of recommendations**:	**2**

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with patients and observation of care delivery and /or practices confirmed that patients were afforded choice, privacy, dignity and respect.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

The lunch time meal was observed and was noted to be well managed. Tables were well presented, meals smelt and looked appetising. A registered nurse, care staff team leader and hospitality assistant were available to direct the meal service and all staff appeared confident in their roles and responsibilities. Staff were observed in offering patients choice and were kind and respectful in their interactions. Staff demonstrated a good knowledge of patients' particular preferences and assessed needs. Timely assistance was offered as required and aids including adapted cutlery were available to encourage and promote independence. The acting manager

advised that the menu had recently been reviewed and patients had been included in this review. This information was confirmed by staff and patients. Pictorial and table size menus were currently being developed to enable patients to make better informed choices. This improvement is commended.

Patients spoken with confirmed that they were afforded many opportunities to maintain contact with their families, friends and members of their community. There was a programme of events and activities displayed and discussion with patients confirmed that the activities provided were enjoyable, positive, and meaningful and considered their physical, emotional needs and interests. A discussion with the activities co-ordinator and a review of information evidenced that activities were well managed and the home embraced activities as an integral part of the care process. A review of photographs evidenced patients actively participating and sharing their life experiences with staff and members of the community. For example the patients and local students had planted beds and planters, the ladies had shared their knowledge of "how to bake the best apple tart" with a group of students. The home is commended for their efforts to embrace this element of the care process.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. The activities co-ordinator advised that various clergy visit the home on a monthly basis and patients are afforded an opportunity to attend.

Discussion with the acting manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. Views and comments recorded were analysed and an action plan was developed and shared with staff, patients and representatives. A copy of the annual quality report for 2015-2016 was available and displayed at the main reception for consultation.

As part of the inspection process, questionnaires were issued to staff (ten), patients (five) and their representatives (ten). At time of writing this report the following questionnaires have been returned; Patients (five), Patient representatives (seven) and staff (one). Some comments received are detailed below:

Staff
One questionnaire was returned with a very positive response in all domains.

Patients
Five questionnaires were returned and in general the responses were positive.

One response indicated some negative comments and three stated that they were unfamiliar with the registered manager.
This information was discussed with the management team. Refer to section 4.4 for further information.

Patient Representatives
All responses made were very positive. The well led domain generated a number of positive comments as detailed below;
"I love this home, second to none; - every aspect of care is excellent I could not recommend any room for improvement. All staff must be hand-picked"
"all three managers in my time in the home (2.5 years) have been excellent"
"my uncle has been here for 2.5 years – couldn't be happier, I'm here daily and appreciate the care and commitment shown. Truly happy in all aspects".

Areas for improvement
No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0

4.6 Is the service well led?

Discussion with the acting manager and staff evidenced that there was a clear organisational structure within the home. The home had experienced a recent turnover in regards to the registered manager position; however this had been effectively managed. The current manager had only recently been appointed as acting manager, March 2016 and was in the process of completing their induction. There was a system in place to identify the person in charge of the home, in the absence of the acting manager. Staff consulted advised they had received a job description and were knowledgeable of their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home, however some patient's responses (previously referred to in section 4.5) indicated that they did not know who the acting manager was as there had been recent changes, and this information was shared with the senior management team who gave assurances that this would be addressed.

The registration certificate and the certificate of public liability insurance were current and displayed in the main entrance to the home.

Discussion with the acting manager and observations evidenced that the home was operating within its registered categories of care. The home is registered for NH-DE (nursing dementia) category of care and patients accommodated under this category of care were evidenced to be cared for in the general nursing unit. A discussion with the acting manager advised that this arrangement was currently effective and that all patients' needs were being appropriately met. A discussion with some care staff felt that at times it was difficult to meet the patients' needs cared for in the NH-DE category of care within the general nursing environment for example if a patient became distressed. However, observations made during this inspection observed staff responding to patients' needs appropriately and effectively with minimal impact on the needs of other patients. This information was discussed with management at feedback who gave assurances that this arrangement was being effectively managed to meet the needs of patients accommodated. No other concerns and / complaints were registered by patients, their representatives and others. Post inspection, this matter was discussed with senior management at RQIA and a decision was made that this arrangement would be followed–up with the registered person as a separate correspondence.

The senior management team and acting manager confirmed that a system was in place to review all policies and procedures for the home in line with Care Standards for Nursing Homes, April 2015. A review of policies and procedures confirmed the implementation of this process. Staff confirmed that they knew how to access policies and procedures to guide them in their practice.

Discussion with the acting manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Discussion with the senior management team and acting manager confirmed that the home had systems in place to monitor and report on the quality of nursing and other services provided. These systems have recently been reviewed and developed to further enhance and assure the safe delivery of quality care. For example, the following audits were identified to be completed in accordance with best practice guidance:

- infection prevention and control
- care records
- accidents and incidents
- health and safety
- complaints
- wound management
- nutritional / weight management
- training
- recruitment.

The acting manager advised that decisions were being made as to which audits were to be completed initially, to ensure safe effective quality care. A review of the accident audit for March 2016, identified areas for further development, to ensure any patterns, trends or shortfalls were identified and to be assured that the necessary improvements required were embedded into practice. A recommendation has been made.

Discussion with the acting manager and a review of records evidenced that Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, monthly monitoring visits were completed in accordance with the regulations and care standards and copies of the reports were available for patients, their representatives, staff and trust representatives. The reports reviewed highlighted areas for improvement which had also been identified at this inspection and an action plan was generated to address same. The senior management team advised that the new quality assurance framework would inform the monthly monitoring visits.

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

At this inspection it was evidenced that the management team had identified the need for additional governance arrangements to assure the safe delivery of quality care within the home. The implementation of these systems and processes will improve the overall services provided, the experience of service users and leadership within the home. Areas for improvement were identified in the previous domains of safe and effective care.

Areas for improvement

The monthly accident/incident analysis should be further developed to ensure any patterns, trends or shortfalls are identified and to be assured that the necessary improvements required are embedded into practice.

Number of requirements	0	Number of recommendations:	1

5.0 Quality improvement plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed as part of the inspection process. The timescales commence from the date of inspection.

The registered person 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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the 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 person/s meets legislative requirements based on 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered person to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed 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 person/manager 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 person/manager 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 12(1)(a)(b) **Stated:** First time **To be completed by:** 30 May 2016	The registered person must ensure that the treatment and care provided to each patient meets their identified assessed needs and reflects their plan of care in relation to the management of pressure and / or wounds. **Ref Section 4.4** **Response by registered person detailing the actions taken:** Wound Care risk assessment templates have been revised in accordance with TVN guidance. Weekly management of this continues to ensure all staff are clear on this assessment.
Recommendations	
Recommendation 1 **Ref**: Standard 4.9 **Stated:** Second time To be completed by: 30 May 2016	The registered person should ensure the following actions are taken where patients are at risk of dehydration: • the total fluid intake for 24 hours is recorded in the patients'' daily progress notes **Ref Section:4.2** **Response by registered person detailing the actions taken:** Patients daily progress notes over 24 hours now accurately record total fulid intake. Weekly management of this continues to ensure all staff are clear on this assessment.
Recommendation 2 **Ref**: Standard 39 **Stated:** First time **To be completed by:** **30 May 2016**	It is recommended that a system is developed and monitored to ensure that staff attend training and mandatory trainings requirements are met. **Ref Section: 4.3** **Response by registered person detailing the actions taken:** Training Policy has been effectively implemented to ensure staff are aware of mandatory training requirments. We have implemented two mandatory training sessions every quarter and carry out a quarterly review to ensure best practice is provided.
Recommendation 3 **Ref**: Standard 23 **Stated:** First time **To be completed by:** 30 May 2016	It is recommended that repositioning charts should contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning and the actual positional change is recorded. Records should reflect the care delivered and /or not delivered. **Ref Section: 4.4** **Response by registered person detailing the actions taken:** Reposition charts have been revised and now clearly identify left or right re-positioning; care records reflect this.

Recommendations	
Recommendation 4 **Ref**: Standard 39 **Stated:** First time **To be completed by:** 30 June 2016	It is recommended that training is provided for staff in relation to the prevention and care of pressure damage and /or wound care based on best practice guidelines, training should include the recording of repositioning charts. **Ref Section: 4.4**
	Response by registered person detailing the actions taken: Training is now complete with regards to the recording of the resposition charts. Wound Care training is scheduled for care team.
Recommendation 5 **Ref**: Standard 22.10 **Stated:** First time **To be completed by:** 30 June 2016	It is recommended that the monthly accident/incident analysis is further developed to ensure any patterns, trends or shortfalls are identified and to be assured that the necessary improvements required are embedded into practice. **Ref Section: 4.3 & 4.6**
	Response by registered person detailing the actions taken: All action points succeeding from patterns, trends / shortfalls from the monthly accident / incident audits are now in place on the actual audit plan and are applied into practice.

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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