Unannounced Care Inspection Report
11 December 2019

Sunnyside House

Type of Service: Residential Care Home
Address: 25 Riverwood Vale, High Donaghadee Road, Bangor, BT20 4QE
Tel No: 0289127 0615
Inspector: Heather Sleator

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

1.0 What we look for

2.0 Profile of service

This is a registered residential care home which provides care for up to 45 older persons with a physical disability and persons living with dementia.

3.0 Service details

Organisation/Registered Provider: Presbyterian Council of Social Witness **Responsible Individual:** Lindsay Conway	**Registered Manager and date registered:** Anna McCaffrey – 17 February 2014
Person in charge at the time of inspection: Anna McCaffrey	**Number of registered places:** 45 A maximum of 12 persons in RC-DE category of care. The home is approved to provide care on a day basis only to 3 persons
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** 43

4.0 Inspection summary

An unannounced inspection took place on 11 December 2019 from 10.00 hours to 18.00 hours. The inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

The inspection assessed progress with all areas for improvement identified in the home 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.

Evidence of good practice was found in relation to the culture and ethos of the service, listening to and valuing residents, taking into account their views, choice and preferences. Good practice was demonstrated regarding the provision of therapeutic activities and recreational and spiritual opportunities. Overall there was evidence of governance arrangements; staff training, professional development opportunities, management of accidents/incidents and complaints and effective team working.

Areas for improvement under the regulations were identified regarding the implementing of a robust governance system and the completion of competency and capability assessments for any staff member in charge of the home in the absence of the manager.

Areas for improvement under the care standards were identified regarding the supervision and appraisal of staff, fire safety recommendations, the consultation with residents when completing the annual quality report, evidencing the action taken to suggestions/comments made in the annual satisfaction survey and the updating/review of policy documentation.

Two areas for improvement identified at the previous care inspection of July 2018 have been stated for a second time.

Residents described living in the home as being a good experience and in positive terms. Comments received by residents and their representatives have been included throughout the report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and residents' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	2	*7

*The total number of areas for improvement includes two standards which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Anna McCaffrey, 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.

4.2 Action/enforcement taken following the most recent inspection dated 3 July 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 3 July 2018. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information, and any other written or verbal information received, for example serious adverse incidents.

During our inspection we:

- where possible, speak with residents, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire.

A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff from 17 November to 11 December 2019
- records confirming registration of staff with the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- three resident care records
- three resident supplementary care charts including food and fluid intake charts and reposition charts
- a sample of governance audits/records
- complaints record
- compliments received
- minutes of staff meetings
- minutes of resident and/or relatives meetings
- a sample of reports of the monthly quality monitoring reports from September to December 2019.
- RQIA registration certificate
- Statement of Purpose
- selected policy documentation

Areas for improvement identified at the last inspection were reviewed and assessment of compliance recorded as partially met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the last care inspection dated 3 July 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 23.3 **Stated:** First time	The registered person shall ensure all staff complete COSSH and basic food and hygiene training.	**Partially met**
	Action taken as confirmed during the inspection: The review of the staff training records evidenced that whilst some staff had completed the identified training, a large number of staff had yet to complete basic food hygiene training. **This area for improvement has been partially met and has been stated for a second time.**	
Area for improvement 2 **Ref**: Standard 25.8 **Stated:** First time	The registered person shall ensure staff meetings take place on a regular basis and at least quarterly.	**Partially met**
	Action taken as confirmed during the inspection: The review of the minutes of staff meetings held from January 2019 evidenced that meetings were held in February and June 2019.The desired target, as per the care standards, is that staff meetings are held quarterly. **This area for improvement has been partially met and has been stated for a second time.**	

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to residents and clients from the care, treatment and support that is intended to help them.

Staffing levels within the home were reviewed with the manager. The manager confirmed that staffing levels were planned and kept under review to ensure that the needs of the residents were met. We asked residents about staffing levels and none expressed any concern. Several residents spoke positively about the home to the inspector, including comments such as:

- "Staff are very nice, nothing bothers them."

A review of the staffing rota provided assurance that rostered staffing levels were regularly met and that the staffing skill mix was in keeping with the Residential Care Homes Minimum Standards, August 2011

Discussion with both the manager and staff provided assurance that staff were effectively supported by the manager through informal conversation, handover reports and supervision and appraisal. The review of the supervision and appraisal schedule did not evidence that this process had been completed in accordance with regulation and the care standards. This has been identified as an area for improvement along with the governance arrangements in the home and this is discussed further in 6.6. Five staff were spoken with individually and each one expressed a high level of satisfaction with the support they received from the manager. Feedback from staff also provided assurance that new members of staff undergo a formal, structured period of induction. One such staff member told the inspector that they had been inducted by a senior care assistant and then worked alongside staff and stated this was helpful. Staff comments included:

- "I had induction for a month, it was very good."

Discussion with the manager and a review of records evidenced that competency and capability assessments were not available for all staff identified to be in charge of the home in the absence of the manager. This has been identified as an area for improvement.

A review of governance records provided assurance that all notifiable incidents had been reported to the Regulation and Quality Improvement Authority (RQIA) as required. It was further noted that there were effective arrangements for monitoring and reviewing the registration status of care staff with the Northern Ireland Social Care Council (NISCC).

Staff confirmed that they received regular mandatory training to ensure they knew how to provide the right care. Training is provided to staff by means of either face to face instruction or using online resources. All staff stated that they felt that their mandatory training provided them with the skills and knowledge to effectively care for patients within the home. However, as discussed in 6.1 a number of staff still required to complete training in basic food hygiene. This had been identified at the previous inspection of July 2018 and has been stated for a second time in this report.

Discussion with the manager and review of records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. Following this review an action plan was devised to address any identified deficits.

The management of adult safeguarding within the home was discussed with the manager. It was confirmed that adult safeguarding is an integral component of mandatory training for all staff. Feedback from staff throughout the inspection confirmed that they possessed an effective understanding of how to recognise and respond to potential safeguarding incidents.

We were advised that the use of potential restrictive practices was very limited, for example; the front door is locked and the use of bedrails or alarm/pressure mats when and where there is assessed need. Care records were reviewed regarding the use of a potentially restrictive practice. Evidence was present of risk assessments and care plans to monitor the continued safe use of these types of equipment. Evidence was also present of consultation with the multidisciplinary team in relation to the assessed need for the equipment. The policy in respect of restrictive practice was viewed and following this it was advised that the policy should be reviewed to ensure that it reflects information and/or areas identified at the recent training completed by the manager in respect of the Mental Capacity Act and Deprivation of Liberty Standards

We looked round a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. Patients' bedrooms, lounges and dining rooms were found to be warm, comfortable clean and tidy. It was pleasing to note that several communal areas, including a lounge and dining room appearing bright and welcoming to residents and visitors.

Staff were observed adhering to infection, prevention and control best practice standards throughout the inspection. Gloves and aprons were readily available to staff and used appropriately while they were attending to residents' needs.

We also saw that fire safety measures were in place to ensure residents, staff and visitors to the home were safe. Staff confirmed that the fire detection and warning system was tested weekly and that they were aware of the need to complete fire safety drills/evacuations as part of their training programme, the last fire drill being July 2019. The most recent fire risk assessors report was reviewed and was dated February 2019. Recommendations were made as a result of the assessment however; it was unclear as to whether these had been fully addressed. The manager was advised to identify on the report if any recommendation had either been addressed or were in the process of being addressed. This has been identified as an area for improvement regarding the governance arrangements in the home and is discussed further in 6.6.

In relation to the safe administration and storage of medicines the most recent inspection was 23 April 2018 and there were no areas for improvement identified at this inspection.

Areas of good practice

Examples of good practice found throughout the inspection included: staffing arrangements, staff induction, adult safeguarding and patient and staff engagement.

Areas for improvement

Areas for improvement were identified regarding ensuring that staff who are in charge of the home in the absence of the manager have an up to date competency and capability assessment, ensuring staff receive an annual appraisal and supervision/s and that the action taken to progress any recommendation in the fire risk assessors report is recorded and in evidence.

	Regulations	Standards
Total number of areas for improvement	1	2

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

Feedback from both the manager and staff confirmed that there was a handover meeting at the beginning of each shift; staff stated they were able to discuss and review the ongoing needs of residents during these meetings.

Staff who were spoken with stated that if they had any concerns, they could raise these with the manager. Staff spoke positively about working within the home. Staff commented, “It’s a great home to work in, very friendly and everyone helps each other out.”

There was a records management policy in place which includes the arrangements for the creation, storage, maintenance and disposal of records. Records were stored safely and securely in line with data protection/General Data Protection Regulation (GDPR). A review of three care records confirmed that these were generally maintained in line with the legislation and standards. They included an up to date assessment of needs, life history, risk assessments, care plans and daily/regular statement of health and well-being of the resident. Care needs assessment and risk assessments (e.g. manual handling, nutrition, falls, where appropriate) were reviewed and updated on a regular basis or as changes occurred.

Systems were in place to regularly record residents’ weights and any significant changes in weight were responded to appropriately. There were arrangements in place to refer residents to dietitians and speech and language therapists (SALT) as required. However, the review of one resident’s care records evidenced that a referral had not been made to the relevant professional regarding the resident’s weight. This was discussed with the manager who stated that this would be addressed immediately. A robust system of the auditing of care records should be in evidence so as any issue pertaining to the wellbeing of residents is addressed in a timely manner. Refer to 6.6

The care records also reflected the multi-professional input into the residents’ health and social care needs and were found to be updated regularly to reflect the changing needs of the individual residents. Residents and/or their representatives were encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate. Care records reviewed were observed to be signed by the resident and/or their representative.

An individual agreement setting out the terms of residency was in place and appropriately signed.

Discussion with the manager and staff confirmed that wound care was managed by community nursing services. Staff advised that they were able to recognise and respond to pressure area damage. Referrals were made to the multi-professional team regarding any areas of concern identified in a timely manner.

Discussion with staff confirmed that a person centred approach underpinned practice. Staff were able to describe in detail how the needs, choices and preferences of individual residents were met within the home. For example, at the time of the inspection a resident was going out for lunch with friends.

A varied and nutritious diet was provided which met the individual and recorded dietary needs and preferences of the residents. The dining rooms were warm bright and well ventilated. Condiments and place settings were appropriately set and the environment was pleasant for residents to eat their meals. There was a wide range of choices available for residents to choose from, portion size was good and the meals were well presented. The day's menu was displayed on each dining table and staff were observed as being attentive to residents' needs during the meal service. One resident commented, "They're (staff) very nice here and I like the meals."

The manager advised that systems were in place to ensure effective communication with residents, their representatives and other key stakeholders. These included pre-admission information, multi-professional team reviews, residents' meetings, staff meetings and staff shift handovers. Minutes of staff meetings and resident and/or their representative meetings were reviewed during the inspection and as discussed in 6.1 the frequency of staff meetings had not increased in line with the care standards. This standard has been stated for a second time in this report.

Observation of practice evidenced that staff were able to communicate effectively with residents. Discussion with the registered manager and staff confirmed that management operated an open door policy in regard to communication within the home.

There were also systems in place to ensure openness and transparency of communication, for example, the visits by registered provider reports ,latest RQIA inspection report , resident meeting minutes and resident newsletter were on display or available on request for residents, their representatives and any other interested parties to read.

The manager reported that arrangements were in place, in line with the legislation, to support and advocate for residents. Information regarding advocacy services was available and displayed in the home.

Three completed questionnaires were returned to RQIA from residents' representatives. Respondents described their level of satisfaction with this aspect of care as very satisfied or satisfied.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care records and reviews, communication between residents and other interested parties.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We arrived in the home at 10.00 hours and were met immediately by staff who offered us assistance. Residents were present in the lounge, dining room or in their bedroom, as was their personal preference. Observations of interactions throughout the day demonstrated that patients relating positively to staff and to each other. Residents were engaged by staff with respect and encouragement at all times. One resident commented, “Staff would do anything for you.”

Activities, such as art, music, quizzes, crafts and board games were part of the weekly programme. Residents have the opportunity to worship as there are services held in the home and there are daily devotional readings. Residents also have the opportunity to go out with staff to the many local attractions. The home has a ‘shop’ where residents can purchase items such as toiletries, biscuits and sweets if they wish to. There was also a newsletter available and displayed for residents and relatives to enjoy. Residents were keen to discuss how helpful the newsletter was stating it kept them up to date with what was happening and what was planned for the future.

The systems in place to ensure that the views and opinions of residents were sought and taken into account included residents and relatives meetings, an annual quality survey of residents and relatives and events which include the relatives, for example there is an established ‘Friends of Sunnyside’ group who organise many fundraising activities during the year. The review of the annual quality report and the residents/relatives satisfaction questionnaires identified two areas for improvement. A satisfaction survey had been undertaken with residents and relatives in March 2019. The review of the survey evidenced that there had been suggestions made by the residents. Any action taken regarding these suggestions had not been shared with residents, for example, via ‘You said, we did’ information being displayed so as residents knew that their opinions and/or suggestions had been acknowledged. The review of the annual quality report did not reflect the involvement and opinion of the residents, for example the outcome of the resident satisfaction survey. These two areas have been identified as areas for improvement in this report.

During each monthly monitoring visit the views of a sample of residents were sought and their views were reflected in good detail in all three of the monthly monitoring reports that were reviewed. Staff members’ comments and actions, along with observation of practice and the views expressed by residents and confirmed that compassionate care was being provided consistently in Sunnyside House.

There were numerous thank you cards and compliments available regarding the home, comments included:

- "To all the staff, thank you for all your love and kindness to me." – respite resident December 2019
- "Just a note of appreciation for the reception at Sunnyside last week, it was a pleasure to be present in such a happy and contented home." - visiting clergy December 2019

We spoke to residents during the inspection and comments included:

- ''Staff are very kind, always ask if there's anything I would like."
- "Staff are very nice, very pleasant."
- "Couldn't be better, staff so kind."
- "Staff are very nice, nothing bothers them."
- "If you need them (staff), they help all they can."
- "Staff always come quickly when I need them."
- "Staff would do anything for you."
- "It's (Sunnyside) fantastic, staff are fantastic and the food is fantastic."
- "I would recommend this home a thousand times."
- "It's my lifeline here; I'd lost confidence which is why I came here."

There were three questionnaires returned from residents' representatives. All the respondents were either satisfied or very satisfied that the care afforded in Sunnyside House was safe, compassionate and effective and that the service was well led. An additional comment was made which was; "Sunnyside provides a good level of care, staff treat residents with compassion."

We also spoke to staff during the inspection and comments included:

- "It's the standard of care in here that makes it a special place to work."
- "Teamwork, the seniors will listen to you if you have a suggestion."
- "I like it here, good staff."

There were no questionnaires completed and returned to RQIA from staff.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the centre, listening to and valuing residents.

Areas for improvement

Areas for improvement were identified regarding the sharing of the outcome and action taken to suggestions made by residents in the resident satisfaction survey and the annual quality report should evidence the consultation with residents and/or their representatives.

	Regulations	Standards
Total number of areas for improvement	0	2

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The manager, Anna McCaffrey, facilitated the inspection and demonstrated a good understanding of The Residential Homes Regulations, care standards and the systems and process in place for the daily management of the home. A wide range of documentary evidence to inform the inspection's findings, including minutes of staff meetings, residents meetings, monitoring reports, audit records, work rotas, residents care records, staffing information and written policies and procedures were made available. Feedback and discussion took place at the conclusion of the inspection with the manager and areas of good practice and areas for improvement were identified.

A range of policies and procedures was in place to guide and inform staff. Policies were centrally indexed and retained in a manner which was easily accessible by staff. The manager stated that policies and procedures were systematically reviewed every three years or more frequently as changes occurred. However, the review of the organisations whistleblowing policy evidenced that this policy had not been reviewed from 2014. This should be addressed.

The home's statement of purpose was not dated and therefore we were unable to assess as to whether this document was reviewed in accordance with legislative requirements. This has been identified as an area for improvement.

There was a system to ensure safety bulletins; serious adverse incident alerts and staffing alerts were appropriately reviewed and actioned.

There was a complaints policy and procedure in place which was in accordance with the legislation and Department of Health (DOH) guidance on complaints handling. Residents and/or their relatives were made aware of how to make a complaint by way of meetings, residents guide and the complaints procedure was displayed on notice boards in the home and trust information leaflets were also displayed. The review of records evidenced that complaints received had been fully investigated and resolved to the complainant's satisfaction.

The manager advised that there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to residents at appropriate intervals. Audits of risk assessments, care plans, accidents and incidents (including falls, outbreaks), complaints and the environment were available. The need for a more robust governance system was identified as an area for improvement regarding for example, care records, the supervision and appraisal of staff and staff training. These areas and others, have been discussed in the 6.3, 6.4 and 6.5 of this report

There was an accident/incident/notifiable events policy and procedure in place which included reporting arrangements to RQIA. A review of accidents/incidents/notifiable events confirmed that these were effectively documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures. A regular audit of accidents and incidents was undertaken and was reviewed as part of the inspection process.

A monthly monitoring visit was undertaken in accordance with Regulation 29. Records of the past three months were reviewed, the reports showed the visits were both announced and unannounced, provided a view regarding the conduct of the setting, included outcomes/action plans and qualitatively reflected service users and staff views and opinions. However, it is the expectation that the areas identified for improvement in this report should have been identified and discussed in the monthly quality monitoring reports.

Discussion with staff confirmed that there were good working relationships within the home and that management were responsive to suggestions and/or concerns raised. There were open and transparent methods of working and effective working relationships with internal and external stakeholders. Residents were aware of who the manager was and that management, in general, were very approachable. One resident commented;

- "Think the manager is called Anna, she's very nice."

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the approach and attitude of staff, the accessibility of management and of maintaining good working relationships.

Areas for improvement

The following area was identified for improvement in relation to implementing robust governance systems in the home, and ensuring policy documentation is reviewed in accordance with legislative requirements.

	Regulations	Standards
Total number of areas for improvement	1	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Anna McCaffrey, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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 residential care 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 20 (3) **Stated:** First time **To be completed by:** 1 February 2020	The registered person shall ensure that a current competency and capability assessment is present for any staff member who is in charge of the home in the absence of the manger Ref: 6.3
	Response by registered person detailing the actions taken: Dates have been set to carryout competancy assessments for Deputy Manager, Senior Care Staff and Care Staff who act up in the managers absence.
Area for improvement 2 **Ref:** Regulation 17 (1) **Stated:** First time **To be completed by:** 1 February 2020	The registered person shall ensure that a robust governance system is operational in the home which assures the quality of services and care available in the home. Ref: 6.4
	Response by registered person detailing the actions taken: Review of operational systems ongoing to ensure that quality of service is undertaken within the correct timescales and action plans commenced if required.
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 23.3 **Stated:** Second time **To be completed by:** 1 February 2020	The registered person shall ensure all staff complete COSSH and basic food and hygiene training. Ref: 6.1
	Response by registered person detailing the actions taken: Basic Food Hygiene training provided by outside provider on 20.01.12 for staff who did not attend in 2019. Further date to be arranged later in the year for New Staff. Date arranged for March 2020 for COSHH Training and further date to be arranged later in the year by company who provide chemicals.
Area for improvement 2 **Ref**: Standard 25.8 **Stated:** Second time **To be completed by:** Immediate	The registered person shall ensure staff meetings take place on a regular basis and at least quarterly. Ref: 6.1
	Response by registered person detailing the actions taken: Dates have been arranged for all grades of staff to attend staff meetings quarterly and displayed for all staff.

Area for improvement 3 **Ref**: Standard 24 **Stated:** First time **To be completed by:** 1 March 2020	The registered person shall ensure that staff receive an annual appraisal and supervision/s as per the requirements of the care standards Ref: 6.3
	Response by registered person detailing the actions taken: Organisational chart for home staffing levels have been reviewed and to be discussed at senior care staff meeting. Senior staff have been identified to undertake appraisial / supervision for keygroups. Supervision (1) January - April, supervision (2) September - December and Appraisial May - August.
Area for improvement 4 **Ref**: Standard 29.1 **Stated:** First time **To be completed by:** 10 January 2020	The registered person shall ensure that any recommendations stated in the fire risk assessors report for the home evidence the date of and action taken to progress the recommendations Ref: 6.3
	Response by registered person detailing the actions taken: Yearly Fire Risk assessment by Landlord and Provider have been undertaken. Awaiting final report from both parties. Any issues raised will be raised with Landlord for completion as soon as possible.
Area for improvement 5 **Ref**: Standard 20.12 **Stated:** First time **To be completed by:** 31 March 2020	The registered person shall ensure that the quality of services provided is evaluated on at least an annual basis and follow-up action taken. Key stakeholders are involved in this process. Ref: 6.5
	Response by registered person detailing the actions taken: Quality of services are audited through monthly reports to provider and unannounced monthly inspections, along with regular audits of accident & incidents, complaints & compliments. When an issue is raised an action plan will be commenced.
Area for improvement 6 **Ref**: Standard 1.7 **Stated:** First time **To be completed by:** 1 March 2020	The registered person shall ensure that a report is prepared that identifies the methods used to obtain the views and opinions of residents and their representatives and this incorporates the comments made, issues raised and any actions to be taken for Improvement. A copy of this report is provided to residents and their representatives. Ref: 6.5
	Response by registered person detailing the actions taken: Quality Assurance questionnaire for 2019 currently being reviewed to ensure that all areas / concerns raised are relayed to staff, residents and relatives. Report will be displayed on notice board and copy available to view.

Area for improvement 7 **Ref**: Standards 20.6, 21.4 and 21.5 **Stated:** First time **To be completed by:** 28 February 2020	The registered person shall ensure that policy documentation is reviewed and or revised on a three yearly basis and that the home's statement of purpose is dated and similarly reviewed and revised as necessary. Ref: 6.6
	Response by registered person detailing the actions taken: Policy folder has been reviewed and requests made to provider for policy's to be update and re-issued. Statement of Purpose has been updated and date of reviewed inserted.

Please ensure this document is completed in full and returned via Web Portal

The Regulation and Quality Improvement Authority

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