Unannounced Care Inspection Report
1 June 2016

Bramblewood Care Centre

Type of Service: Nursing Home
Address: 201 Gransha Road, Bangor, BT19 7RB
Tel No: 028 9145 4357
Inspector: Heather Sleator

1.0 Summary

An unannounced inspection of Bramblewood took place on 1 June 2016 from 09.30 to 17.15 hours.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led. The inspection also incorporated a post registration inspection due to a change of ownership from 5 April 2016 when Burnview Healthcare Ltd the registered organisation and Mrs Briege Kelly, the registered person.

Is care safe?
Following discussion with patients, representatives and staff; and a review of records there was evidence of good delivery of care to patients. Weaknesses were identified specifically in relation to the completion of induction training records and the systems which were in operation to evidence the annual appraisal and supervision of staff and the record of staff training. Two recommendations have been stated.

Is care effective?
Weaknesses have been identified in the delivery of effective care specifically in relation to the assessing, planning and evaluating of care. Improvements are also required in the auditing of patient care records. One requirement and one recommendation have been made.

Is care compassionate?
There was evidence of good communication in the home between staff and patients. Patients were very praiseworthy of staff and a number of their comments are included in the report. Staff interactions with patients were observed to be compassionate, caring and timely. There was good engagement with patients and a varied activities programme.

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

Is the service well led?
There was evidence of systems and processes had been in place to monitor the delivery of care and services within the home. However, these systems had not been maintained from April 2016 when the home came under new ownership. The implementation of governance systems and processes as determined by the new registered person should be viewed as a priority. Requirements and recommendations have been made to seek compliance and drive improvements, as detailed within sections 4.3, 4.4 and 4.6.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Jacqueline Bowen, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was a finance inspection undertaken on 19 February 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered provider: Burnview Healthcare Briege Kelly	**Registered manager:** Jacqueline Bowen
Person in charge of the home at the time of inspection: Jacqueline Bowen	**Date manager registered:** 01/04/2005
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 35

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 plans (QIPs) from inspections undertaken in the previous inspection year
- 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. The inspector also met with 11 patients, three care staff, ancillary staff, one registered nurse and two relatives.

Questionnaires for patients, relatives and staff to complete and return were left for the home manager to distribute. Please refer to section 4.5 for further comment.

The following were examined during the inspection:

- validation evidence linked to the previous QIP
- staff roster
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- staff supervision and appraisal planner
- complaints and compliments records
- incident and accident records
- records of quality audits and
- records of staff, patient and relatives meetings

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 19 February 2016

The most recent inspection of the home was a finance inspection. The completed QIP was returned and approved by the finance inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next finance inspection

4.2 Review of requirements and recommendations from the last care inspection dated 24 September 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 16 (1) **Stated:** First time	The registered person must ensure care plans in respect of palliative/end of life wishes and care must be developed, monitored and evaluated in accordance with the assessed needs of patients. The recommendations of the specialist palliative care team should be reflected in patients' care plans, where applicable. **Ref: Section 5.4**	**Met**
	Action taken as confirmed during the inspection: There were no patients requiring a palliative or end of life care plan in the home at the time of the inspection. Care records in respect of 'Do Not Resuscitate' directives were completed and reviewed in accordance with UK Resuscitation Council guidelines.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 19.1 **Stated:** Second time	It is recommended that the registered manager ensure that a detailed and comprehensive assessment of bowel continence is undertaken. This assessment should include: • The patient's normal bowel pattern in respect of frequency of movements and referencing the Bristol Stool Chart) • The need if any for laxative therapy • The actions to be taken should the normal pattern not be achieved. • The effectiveness of prescribed laxative therapy should be reviewed as required.	**Met**
	Action taken as confirmed during the inspection: The review of four patient care records evidenced that registered nurses had completed a bowel continence assessment which detailed the patient's normal bowel pattern and action to be taken should the normal bowel pattern not be achieved.	
Recommendation 2 **Ref:** Standard 19.1 **Stated:** Second time	It is recommended that a bowel management care plan be established for any patient requiring nursing intervention such as regular or occasional laxative therapy.	**Partially Met**
	Action taken as confirmed during the inspection: As discussed in recommendation 1, a bowel continence assessment had been completed by registered nurses and a corresponding care plan written, where applicable. The review of patient's progress records and the monthly evaluations of the care plan did not evidence that registered nurses were monitoring patients' bowel function using the information recorded by care staff (Bristol Stool Chart). Compliance with this recommendation was not fully met. As this recommendation had been stated for a second time, enforcement action was considered and in discussion with senior management, it was concluded that enforcement action would not be taken at this time. The recommendation has been subsumed into a requirement of the report and the registered person must ensure compliance by the date stated in the QIP.	

Recommendation 3 **Ref:** Standard 32.1 **Stated:** First time	End of life arrangements for patients should be discussed and documented as appropriate and include patients' wishes in relation to their religious, spiritual and cultural need. Arrangements for breaking bad news with patients and/or their representatives should also be discussed and documented as appropriate.	**Met**
	Action taken as confirmed during the inspection: Care records evidenced that that, as far as possible, registered nurses had discussed end of life wishes/spirituality with patients and/or their representatives.	
Recommendation 4 **Ref:** Standard 32.1 **Stated:** First time	The following policies and guidance documents should be developed and made readily available to staff: • A policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.* • A policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines which* should include the out of hours procedure for accessing specialist equipment and medication, referral procedure for specialist palliative care nurses and the management of shared rooms. • A policy on death and dying in line with current best practice, such as DHSSPSNI (2010) *Living Matters: Dying Matters* which should include the procedure for dealing with patients' belongings after a death.	**Met**
	Action taken as confirmed during the inspection: The recommended policy documentation as listed above was present.	

Recommendation 5 **Ref:** Standard 32.1 **Stated:** First time	Management should implement a system to evidence staff have read newly developed policy documentation in relation to Communicating Effectively, Palliative and End of Life Care and Death and Dying as referenced in recommendation 4.	
	Action taken as confirmed during the inspection: The registered manager had established a system to evidence newly developed policy documentation had been read by staff. However, due to a change in ownership the documentation had been sent back to the previous owner. New policy documentation supplied by the new owner/provider was present and a system was in place to verify staff had read the new policy documentation.	**Met**
Recommendation 6 **Ref:** Standard 32 **Stated:** First time	Staff should complete training in; • communicating effectively • palliative and end of life care	
	Action taken as confirmed during the inspection: The registered manager stated that this training had been undertaken by the majority of staff and as previously stated the information had been returned to the previous owners of the home. The registered manager stated the training has been included in the training schedule for staff for the 2016/2017 year.	**Met**

4.3 Is care safe?

The registered 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 week commencing 30 May 2016 evidenced that the planned staffing levels were adhered to. The registered manager stated that five registered nurses had commenced employment in the home from January 2016. The registered manager was very positive in respect of securing the staff as the use of agency nursing staff had greatly reduced. It was also stated that the last few months had been a time of change for the home with the advent of new ownership and new nursing staff. The registered manager recognised that it would take time for new staff to be fully inducted into the home and for all staff to implement any new processes directed by the registered person. Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels. Relatives commented positively regarding the staff and care delivery.

A review of three personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005, Regulation 21, schedule 2.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of registered nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

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. Three completed induction programmes were reviewed. The programmes included a written record of the areas completed. Inductions records did not evidence a consistent approach to validating that induction had been completed. The induction period and training for one staff member was still on-going however the remaining two induction training records did not evidence that the employee and the inductor signed the record to confirm completion and to declare understanding and competence. The registered manager had not signed the record to confirm that the induction process had been satisfactorily completed. A recommendation has been made that induction training records evidence it was been signed and dated by all parties to verify agreement on conclusion.

Training was previously completed via an e learning system, internal face to face training arranged by management and training provided by the local health and social care trust. The registered manager stated staff training statistics for the year 2015/2016 were no longer available as this information had been returned to the previous owner, on request. The registered manager informed that staff training would no longer be via an e learning system and would be delivered in the home by face to face training. External training opportunities would continue to be available for staff. There was a lack of availability of other required documentation including; records of staff annual appraisal and supervision. Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Observation of the delivery of care evidenced that training had been embedded into practice. Comments received from patients included; ‘staff are excellent’ and ‘they’re the best.’

We recognised that new management systems were in the process of being established in the home, however it is recommended that the following systems are establishes as a matter of priority;

- staff training matrix and records
- staff annual appraisal and supervision planner

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. The registered manager confirmed that 65 percent of staff had undertaken safeguarding training in the past 12 months. The registered manager stated that newly recruited staff had not undertaking training in adult safeguarding yet and that they had read the policy documentation. Annual refresher training was considered mandatory by the home. A review of documentation confirmed that any safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home’s policies and procedures. RQIA were notified appropriately. The registered manager had robust systems in place to monitor the progress of safeguarding issues with the local health and social care trust.

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 since the previous inspection 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 accident, incidents and of falls to identify any trends or patterns. The last audit of audit and analysis completed was April 2016; refer to section 4.6 for further detail.

An inspection of the general environment of the home was undertaken and included 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 found to be warm, well decorated, fresh smelling and clean throughout. Patients, representatives and staff spoken with were complimentary in respect of the home's environment. The garden and patio areas of the home had recently been enhanced with the purchase of new garden furniture. Patients had benefitted from this and were able to sit outside and enjoy the 'good weather.'

Areas for improvement

The establishment of the new systems in relation to staff training and staff annual appraisal and supervision should be viewed as a priority.

Staff induction training records should evidence a consistent approach regarding the completion of records. Induction training records should evidence the signature of the staff member, the inductor and the signature of the registered manager to validate the completion of the induction training programme.

Number of requirements	**0**	**Number of recommendations**:	**2**

4.4 Is care effective?

As stated in section 1.1 the home came under the new ownership and management of Burnview Healthcare Ltd, on 5 April 2016. Prior to this care records had been completed using the previous owners documentation. At the time of the inspection the deputy manager had commenced re-writing patient care records using Burnview Healthcare's nursing process documentation. The registered manager was advised to ensure this process was completed as quickly as possible as it may or can lead to confusion for registered nursing staff and the delivery of effective patient care.

Review of four patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Care record reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. However, the review of the care planning process did not evidence that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines and a requirement has been made. The review of patient care records did not evidence a consistent approach by registered nursing staff to completing documentation. As discussed in section 4.2, recommendation 2, there was a lack of evidence in patients' progress records that registered nurses had recorded patients' actual response to planned care on a daily basis. For example, progress records did not evidence that registered nursing staff were making an

assessment of patients' bowel function based on the detailed recording maintained by care staff. Progress records included statements referring to 'incontinence care given' or 'continence needs met.' There was no evidence in the monthly evaluation of the care plan that the specific care intervention had been completed or reviewed.

The manager completes audits of patient care records, on a rotational basis, however as was evidenced by the review of patient care records it was recommended that a robust system regarding the auditing of care records was established until such times as a consistent approach by registered nurses is in evidence. There was evidence that the care planning process included input from patients and/or their representatives, as far as possible. Five relatives' responded via questionnaire and confirmed they were kept up to date about the care and treatment afforded by staff to their relative.

Supplementary care charts, for example, repositioning and food and fluid intake records evidenced that records were generally maintained in accordance with best practice guidance, care standards and legislative requirements

Discussion with the registered manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication. Staff spoken with confirmed that the shift handover provided the necessary information regarding any changes in patients' condition. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff confirmed that staff meeting were held every three to four months and that the minutes were made available.

The serving of the midday meal was observed. Tables were attractively set with cutlery, condiments and napkins. Meals were plated at the time of serving by a catering assistant. This was good practice and afforded nursing and care staff time to assist the patients. Those patients who had their lunch in the lounge or their own bedroom were served their meal on a tray which was set with cutlery and condiments and the food was covered prior to leaving the dining room. The meals were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch. Catering staff were very positive about the change of ownership and stated 'any changes that have been made have been for the better, the quality of any change has been an improvement.'

Areas for improvement

The care planning process must evidence that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines.

A robust system regarding the auditing of care records should be established until such times as a consistent approach by registered nurses is in evidence.

Number of requirements	**1**	**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. We observed numerous occasions when staff took time to find out what the patients wanted when it was not always apparent and patients were unable to express their wishes clearly. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. We observed the activities coordinator spending individual time with patients in the lounge and it was evident there was a good rapport between the staff member and patients.

The activities coordinators in the home were very enthusiastic and dedicated. One of the coordinators stated the starting point for their activities programmes was 'knowing their likes and dislikes, hobbies and interests and having a good knowledge of their needs and abilities.' A patients meeting and coffee morning is held every month and is greatly enjoyed as the patients 'love to get together and discuss home life.' The activities coordinator stated that recently a cream tea was organised in celebration of the Queen's 90th Birthday and, even though it was a cardboard cut-out, the patients all enjoyed getting their photograph taken with the Queen. In discussion patients confirmed that the activities provided in the home were very good. The activities programme is displayed on a notice board in the entrance foyer of the home.

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. Patients meet monthly and the most recent patient satisfaction survey was completed in October 2015. Views and comments recorded were analysed and an action plan was developed and displayed on a notice board in the entrance foyer for the information of staff, patients and representatives. A relatives meeting was held in April 2016 and was chaired by the new registered person, Mrs Briege Kelly. Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. One relative commented that 'the manager is very pleasant and helpful.'

The following are some comments we received from patients:
'They're (staff) the best.'
'Staff are excellent.'
'Staff are excellent, best there is.'
'Sometimes it takes a bit of time to answer the call bell but that's understandable.'
'Staff are good although it varies.'

We met with two relatives during the inspection who stated:
'Manager is very pleasant and helpful.'
'The home seems to meet my (relative's) needs.'

Comments received from staff included:
'Very good home.'
'Everyone very friendly.'
'We work well as a team.'
'The manager is very approachable.'

Questionnaires

As part of the inspection process we issued questionnaires to staff, patients and patients' representatives. The returned questionnaires were generally positive regarding the quality of nursing and other services provided by the home. Specific comments are detailed below:

The following comments were provided by patient representatives:
'With extra staff I feel the home would produce an excellent level of care'

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 registered manager and staff evidenced that there was a clear organisational structure within the home following the new ownership of the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. The Statement of Purpose and Patient's Guide were being revised to reflect the recent changes in the home and will be displayed, once again, in the entrance lobby when the revision has been completed.

Staff confirmed that they had access to the home's policies and procedures. However, policy documentation was also in the process of being revised due to the new ownership of the home. The registered manager stated that a system has been established to verify staff have read and adhere to the new policy documentation.

Discussion with the registered 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.

Staff spoken with confirmed that they were aware of the home's complaints procedure and that they were confident that staff/management would manage any concern raised by them appropriately.

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 RQIA or other relevant bodies appropriately.

Discussion with the registered manager and review of records evidenced that systems had been in place to monitor and report on the quality of nursing and other services provided. However audits had not been completed from April 2016. The registered manager stated this was due to the templates for completing any audit had been returned to the previous provider and she was waiting for guidance from the new provider. The re-establishment of the regular

monitoring of the quality of nursing and other services provided by the home should be viewed as a priority and a recommendation has been made.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

Discussion with the registered manager and review of records evidenced that monthly quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and Trust representatives. Following the review of the monthly quality monitoring reports it is suggested that the registered person view the template for completing the report available on RQIA's website at www.rqia.org.uk as this may provide a more fulsome account of the conduct of the home than the current template in use.

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Areas for improvement
The re-establishment of the regular monitoring of the quality of nursing and other services provided by the home and governance systems should be viewed as a priority.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Jacqueline Bowen, 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 Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to Nursing.Team@rqia.org.uk by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 13 (1) (a) **Stated:** First time **To be completed by:** 30 September 2016	The registered provider must ensure that registered nurses are competent in respect of the assessing, planning and evaluating of patient care and do so in accordance with NMC guidelines. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: nurses attended care plan documentation training on the 22.06.16. One to one follow up is planned to ensure that all nurses are familiar with the new documentation. Care files are audited following transfer of old files to new files to ensure compliance. An action plan is in place to address any issues. A nurse meeting is palnned for the the end of August
Recommendations	
Recommendation 1 **Ref**: Standard 39 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that staff induction training records evidence a consistent approach regarding the completion of records. Induction training records should evidence the signature of the staff member, the inductor and the signature of the registered manager to validate the completion of the induction training programme. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Staff induction records are in place for each new staff member starting. Name and start date is recorded and each entry is dated and signed by both the staff member being inducted and the person doing the induction. This is retained in the staff member's personnel file
Recommendation 2 **Ref**: Standard 39 and standard 40 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that the establishment of the new systems in relation to staff training and staff annual appraisal and supervision are viewed as a priority. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: A matrix for staff supervisions and appraisals is in place.Supervisions are curently being carried out with all grades of staff . Staff appraisals were completed in November 2015 with all staff. These will be planned for Novemeber 2016

Recommendation 3 **Ref**: Standard 4.10 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should there is a robust system regarding the auditing of care records is established until such times as a consistent approach by registered nurses is in evidence. **Ref: Section 4.4** **Response by registered provider detailing the actions taken:** 16 out of the 35 care files have been transferred over to the new format. Full audits have been completed on the newly transferred files and an action plan is in place to address any issues. It is expected that the remainder of files will be transferred over by September 2016. Each resident has a key nurse and they have responsibility for reviewing the care plan documentation. A care file audit matix is in place to monitor compliance
Recommendation 4 **Ref**: Standard 35.6 **Stated:** First time **To be completed by:** 31 July 2016	The registered provider should ensure that the re-establishment of the regular monitoring of the quality of nursing and other services provided by the home is a priority. **Ref: Section 4.6** **Response by registered provider detailing the actions taken:** The following audit systems are now in place: care file audit, falls audit, medicine audit, environmental audit and infection control audit, .

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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