Unannounced Care Inspection Report
13 – 14 April 2016

Rosevale Lodge

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Tel No: 028 9260 4433
Inspector: Dermot Walsh

1.0 Summary

An unannounced inspection of Rosevale Lodge took place on 13 April 2016 from 10.00 to 17.00 and 14 April 2016 from 09.50 to 18.15.

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

Is care safe?

Two areas for improvement were identified in the delivery of safe care, specifically in relation to the management of a malodour within an identified room and management regarding the unsafe use of equipment. Two recommendations have been made in this domain.

Is care effective?

Two areas for improvement were identified in the delivery of effective care, specifically in relation to issues around care planning and the dating and signing of patient care records. Two recommendations have been made in this domain.

Is care compassionate?

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

Is the service well led?

Two recommendations have been stated in the safe domain and two recommendations have been stated within the effective domain.

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

For the purposes of this report, the term 'patients' will be used to describe those living in Rosevale Lodge which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	6*

*One recommendation is stated for the second time and one recommendation is carried forward from the previous inspection.

Details of the quality improvement plan (QIP) within this report were discussed with the registered manager, Mayvelyn Talag, 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 care inspection on 27 and 28 January 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action was not required following this inspection.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Dr Claire Royston	**Registered manager:** Mayvelyn Talag
Person in charge of the home at the time of inspection: Mayvelyn Talag	**Date manager registered:** 28/12/2012
Categories of care: RC-I, NH-DE, RC-DE	**Number of registered places:** 66

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report and the returned quality improvement plan (QIP)
- pre inspection assessment audit.

During the inspection the inspector met with 8 patients individually and others in small groups, five care staff, two registered nursing staff, one ancillary staff, one visiting professional and one patient's representative.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- staff training records
- complaints records
- incidents / accidents records
- minutes of staff meetings
- a selection of audit documentation
- a recruitment file
- monthly monitoring reports in keeping with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- policies for communication and end of life care
- policies for dying and death and palliative and end of life care.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 27 – 28 January 2016

The most recent inspection of the home was an unannounced care inspection dated 27 - 28 January 2016. The completed QIP was returned and approved by the care inspector. Details of the validation of registered person's actions are detailed below.

4.2 Review of requirements and recommendations from the last care inspection dated 27 – 28 January 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation14 (3) **Stated:** Second time	The registered person must evidently ensure that staff carry out the moving and handling of patients in line with training provided and best practice.	**Met**
	Action taken as confirmed during the inspection: Safe moving and handling practices had been observed throughout the day. The practices observed were in line with training provided and best practice.	

Requirement 2 **Ref:** Regulation 15 (2)(b) **Stated:** First time	It is required that the assessments of patients' needs are revised as required but not less than annually.	**Met**
	Action taken as confirmed during the inspection: Five patient care records reviewed, evidenced that the assessment of patients' needs had been revised as required and in a timely manner.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 44 **Stated:** First time	It is recommended that all bedrooms in the home are reviewed and an action plan developed to address bedrooms in need of redecoration.	**Carried Forward to Next Inspection**
	Action taken as confirmed during the inspection: The completion date for the development of an action plan to address bedrooms in need of redecoration was 30 April 2016. Therefore, this recommendation will be carried forward to the next inspection.	
Recommendation 2 **Ref**: Standard 12 **Stated:** First time	The mealtime experience of patients should be reviewed to ensure that the mealtime experience is in accordance with the care standards for nursing homes and current best practice guidelines. Particular attention should focus on the areas identified on inspection.	**Met**
	Action taken as confirmed during the inspection: The mealtime experience in the nursing unit dining room was observed during lunchtime. Observations complied with best practice guidelines.	
Recommendation 3 **Ref:** Standard 4.9 **Stated:** First time **To be Completed by:** 14 March 2016	It is recommended that bowel function, reflective of the Bristol Stool Chart is recorded accurately and consistently in the patients' daily progress records.	**Partially Met**
	Action taken as confirmed during the inspection: Three patient care records reviewed in the nursing unit were not consistent with making reference to the Bristol Stool Chart when recording bowel management. Statements such as, 'continence care given' or 'pad changed for incontinence' was recorded.	

Recommendation 4 **Ref:** Standard 4 Criteria (1) (7) **Stated:** First time **To be Completed by:** 31 March 2016	It is recommended that patients' continence assessments and care plans are fully completed and include the specific continence products required by the patient.	**Met**
	Action taken as confirmed during the inspection: Specific continence products, required by patients to meet their continence needs, had been recorded in five patients' care plans reviewed. However, assessments of continence products required by patients were not included within the patient care records. This was discussed with the registered manager who confirmed and evidenced that assessment of continence products had been recorded and maintained within the patients' rooms. It was agreed a copy of this assessment would be included in the patient care records.	
Recommendation 5 **Ref**: Standard 12 Criteria (27) **Stated:** First time **To be Completed by:** 31 March 2016	Food intake charts should include the amount of food consumed along with the actual food product.	**Met**
	Action taken as confirmed during the inspection: A review of five food intake charts evidenced the amount and description of foods taken by patients on a daily basis had been recorded consistently.	

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 that the assessed needs of the patients were met. A review of the staffing rota for weeks commencing 4 and 11 April 2016 evidenced that the planned staffing levels were adhered to. Two staff members felt 'it would be better' to have an extra care assistant on duty during the morning shift rather than the evening shift. This was discussed with the registered manager who was confident that there were sufficient staff available to meet the needs of the patients within the current staffing arrangements. Evidence of regular dependency reviews was provided by the registered manager and previous changes to staffing arrangements to meet assessed dependency needs was discussed and evidenced on inspection. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

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. Staff performance was monitored through supervision, appraisal and competency and capability assessments. A file was maintained and reviewed monthly on the competency and capability assessments of all registered nurses who are left in charge of the home in the absence of the registered manager. These assessments had been verified and signed by the registered manager.

Staff records of supervision were clearly recorded on a matrix. Supervision was reviewed on a monthly basis. The registered manager confirmed they would conduct a supervision session with staff when a situation arose within the home as they found this more beneficial. The registered manager also confirmed that they operated an 'open door policy' were staff were welcome to come to the office to discuss any topic they felt was relevant. All staff had multiple records of supervision sessions having been completed.

A staff appraisal planner was established to clearly identify which staff member required annual appraisal on a monthly basis.

A review of appraisals 2015/2016 evidenced that 50 percent had been conducted. This was discussed with the registered manager who confirmed that there had been an unexpected high turnover of registered nursing staff during this year. The home currently had vacancies for three full time registered nurses and the registered manager explained they had had to work on the floor in a nursing capacity to meet staffing deficits that had not been met by alternative means. During the year the staff member who assisted with appraisals had also transferred from the home. Two nursing sisters have recently been recruited. One of these sisters was recruited in October 2015. The registered manager and this sister have discussed a plan to meet the shortfall in appraisals. Following training the first nursing sister will assist the registered manager in the appraisal of staff. The second nursing sister will also assist in the appraisal of staff when they have been suitably inducted to their new post.

Review of the training matrix/schedule for 2016/17 indicated that training was planned to ensure that mandatory training requirements were met. Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended and/or completed mandatory training. The online training matrix could inform the registered manager, at any time, with the percentage of staff that had completed training within the required timeframe on a specific topic. The stage of training for staff that had not completed the training was also easily identified. The registered manager could determine which staff had not started or were in progress with the training as well as those completed. The matrix was reviewed monthly and staff were reminded to complete training by means of a poster in the staffroom and nursing stations. Staff would be sent individual letters of reminder where training was starting to lapse.

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.

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). Monthly checks on registration status were conducted and recorded. The registered manager confirmed that where payment had been requested and not received for NISCC registration, the Four Seasons Health Care head office would notify the registered manager. The home's administrator would follow this shortfall up with staff and the registered manager would oversee the process until completion.

A review of the recruitment process evidenced a safe system in practice. Relevant checks and interviews had been conducted prior to the staff member commencing in post.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to the safeguarding of adults. A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

An ongoing refurbishment programme relating to communal toilets, bath and shower rooms was nearing completion. A new refurbishment programme identifying and rectifying shortfalls in patients' bedrooms was in the process of being developed. This had been an area for improvement identified on the previous care inspection and a recommendation made then was carried forward to be reviewed at the next inspection. Corridors and communal areas were found to be free from clutter and fire exits were clear.

However, the position of a pressure mat placed beside an open door to the entrance of a patient's room hindered the closure of the door. This was discussed with the registered manager and the position of the pressure mat was changed immediately allowing the closure of the door and the function of the pressure mat to continue. A kitchenette area within the residential unit was noted to have chipped and broken tiles on the wall. This was discussed with the registered manager and has been identified for inclusion within the new refurbishment programme.

During the review of the home environment, a malodour was detected in an identified patient's bedroom. The room was revisited later the same day and again on the second day of inspection. The malodour remained prevalent throughout. A recommendation was made.

When reviewing a communal toilet, a toileting aid was observed placed on top of a toilet seat. As a result, the feet of the toilet aid were suspended in the air and not on the floor for stabilisation. This was a potential hazard to any patient who may have sat on the toilet aid. A recommendation was made.

On the second day of inspection, a gas leak had been detected in the kitchen of the home at approximately 09.00. The leak was reported immediately to appropriately trained personnel and all appropriate actions were taken. Staff at the home ensured dietary requirements of each patient was met and the lunch menu was adapted in response to the leak. An electric cooker was transferred from another home to assist in meeting dietary needs and a contingency plan was in place to facilitate the evening meal if the leak had not been fixed. The leak was completely rectified by 11.00. The response to the gas leak was noted as commendable.

Review of five 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.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA were appropriately managed.

Areas for improvement

It was recommended that the registered manager ensures the malodour detected within the home has been managed accordingly.

It was recommended that equipment used within the home is used in a manner that does not pose a risk to patient safety.

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

4.4 Is care effective?

Five patient care records were reviewed as part of the inspection process. In one care record the patient's handling profile developed on 9 October 2015 and last reviewed on 15 February 2016 gave an assessed need for two staff to be involved in the transfer of the patient. However, the patient's care plan developed on 24 October 2014 and reviewed consistently monthly stated that the patient requires one staff member for all mobility needs.

A second patient's mobility care plan developed on 26 January 2014 stated that the patient requires one staff member for mobility needs. The care plan was consistently reviewed monthly. However, on three reviews dated 29 June 2015, 27 October 2015 and 7 January 2016, the review stated the need for two staff to assist with mobility. The original care plan had not been amended to reflect this change in care need. A new care plan was written on 20 January 2016 reflecting the need the assistance of one staff in mobility. However, the old care plan dated 26 January 2014 was not discontinued and remained within the care record. A recommendation was made.

A third patient had a care plan developed on 20 August 2014 to meet their personal hygiene needs. An addition to this care plan had been made by another staff member. However, the addition to the care plan had not been dated to evidence when the new part of the plan came into effect. Another patient's bowel assessment had not been completed appropriately. The bowel assessment had not been signed or dated by the staff member completing the assessment. A recommendation was made.

Two staff in the residential unit consulted stated a new bowel assessment had been introduced for use in patients' care records three weeks prior to the inspection. The staff stated some staff were unsure how to complete the new record. This was discussed with the registered manager who stated two staff had been shown how to complete the document and they were to disseminate this information down to other staff. The registered manager confirmed they were unaware any staff was having difficulty in completing the assessment and that they would consult with staff to ensure staffs' knowledge on completion of the new assessment.

Care records accurately 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. Registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), SALT, dietician, TVN.

Supplementary care charts such as repositioning/food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. However, as previously stated in section 4.2, further information is required when recording bowel management reflective of the Bristol Stool Chart.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift.

Discussion with the registered manager and staff confirmed that staff meetings were held on a quarterly basis and records were maintained. Minutes of staff meetings conducted on 23 February 2016 were reviewed on inspection. Detail of the minutes included date, staff present, time started/finished, topics discussed and any other business not on the agenda discussed. Minutes were posted on the staff room notice board and located at the nurse's station. An action plan for the meeting conducted 23 February 2016 was not included within the minutes as this meeting was an information giving meeting. Staff meetings are evidenced to be normally conducted in peer groups such as registered nurse meetings or care assistant meetings. Relatives meetings in addition to Trust care reviews are conducted six monthly. However, the registered manager also advised they operate an 'open door policy' for relatives and/or patients to consult with them at any given time.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

One patient's representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. Patients and representatives were aware of who their named nurse was and knew the registered manager.

Information leaflets were available to staff, patients and/or representatives at the entrance to the home. They included information on Person Centred Care, Hand Hygiene, MRSA, Hearing Problems, Diabetes, Stroke, Continence, Alzheimer's and Palliative Care.

Areas for improvement

It was recommended that care plans reflect the assessed needs of the patients and that were there are any changes to the plan of care, the care plan would be amended/renewed to reflect the change. Any care plans not reflecting current patient needs are discontinued.

It was recommended that all documented entries to patient care records are signed and dated by the person making such entries.

Number of requirements	0	Number of recommendations:	2

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. 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. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Nine staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. Two of the questionnaires were returned to RQIA. The two staff were positive in their feedback. On inspection two registered nurses, five carers and one ancillary staff were consulted to ascertain their views of life in Rosevale Lodge.

Some staff comments are as follows:
'I really like working here'.
'I'm happy here. It's a good environment to work in'.
'It's very hard and busy work'.
'Service users have a say in their care as much as capacity lets them. Most decisions are made by next of kin'.

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. A 'Quality of Life' feedback system was available at the reception area in Rosevale Lodge. This is an iPad which allows patients, relatives/representatives, visiting professionals and/or staff to provide feedback on their experience of Rosevale. A portable iPad is also available for use by the PAL to record feedback from patients unable to give feedback at reception. This feedback is ongoing and is shared with the regional manager. Anyone completing the feedback has the option to remain anonymous or leave their name. Management have the option to contact people who leave their contact details to gain further clarification on the feedback received. All feedback reports are acknowledged by the registered manager. Any actions taken as a result of the feedback is submitted to Four Seasons Health Care head office. Views and comments recorded were subsequently analysed and an action plan was developed and shared with staff, patients and representatives through staff and relative meetings. Any urgent feedback would be handed over during daily staff handovers or through supervision. A feedback file was maintained by the registered manager to record and evidence feedback and any actions taken to address the feedback

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Consultation with eight patients individually, and with others in smaller groups, confirmed that living in Rosevale Lodge was safe, effective, compassionate and well led. Nine patient questionnaires and nine relative questionnaires were left in the home for completion. One patient and two relative questionnaires were returned within the timeframe. The respondents were of the opinion that the services provided were commendable.

Some patient comments are as follows:
'It's a very nice place. I'm well impressed'.
'They are very thoughtful'.
'I'm doing well here'.
'It's grand here'.
'They are very nice'.
'It's not too bad. Some days are better than others'.

A representative's comment is detailed below:
'We are very happy here. The care is good. We know the manager. They come around and ask us if all is alright. I've no problem raising a concern'.

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. Staff were able to describe their roles and responsibilities.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the registered manager evidenced that the home was operating within its registered categories of care.

The registered manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis. Policies and procedures were available online. Staff confirmed that they had access to the home's policies and procedures.

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 were knowledgeable of the complaints process.

A review of notifications of incidents to RQIA during the previous inspection year/or since the last care inspection confirmed that these were managed appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to wound management, care records, infection prevention and control, environment, complaints, incidents/accidents, restraint, mattress/cushion and quality dining. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

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. The registered manager maintains a file of all alerts received. This information was given to the staff nurses on duty who would disseminate the information to the care assistants on duty. The care assistant would sign the alert when informed of the content and the form would be returned to the registered manager who can then evidence all staff informed of alert.

Discussion with the registered manager and review of records evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. An action plan was generated within the report to address any areas for improvement. A review of the previous action plan was also documented. Copies of the reports were available for patients, their representatives, staff and trust representatives.

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

Areas for improvement

No areas for improvement were identified during the inspection.

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

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager, Mayvelyn Talag, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 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 manager 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 weaknesses that exist in the service. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 44 **Stated:** First time **To be completed by:** 30 April 2016	The registered person should ensure that all bedrooms in the home are reviewed and an action plan developed to address bedrooms in need of redecoration. **Ref: Carried forward from previous inspection** **Response by registered person detailing the actions taken:** All bedrooms have been reviewed and an action plan devised. Any rooms that have been identified as priority have now been redecorated with the remainder to be completed by the end of July 2016.
Recommendation 2 **Ref:** Standard 4 Criteria (9) **Stated:** Second time **To be Completed by:** 31 May 2016	The registered person should ensure that bowel function, reflective of the Bristol Stool Chart is recorded accurately and consistently in the patients' daily progress records. **Ref: Section 4.2** **Response by registered person detailing the actions taken:** The Home Manager has advised the Registered Nurses and Senior Care Assistants in the residential unit that they must ensure bowel movements are recorded consistently in the patients daily progress notes and that this is reflective of the Bristol Stool Chart. Nursing Sister, Team Leader and Home Manager to monitor on a regular basis.
Recommendation 3 **Ref**: Standard 44 Criteria (1) **Stated:** First time **To be completed by:** 14 May 2016	The registered person should ensure that the malodour within the identified room has been managed effectively. **Ref: Section 4.3** **Response by registered person detailing the actions taken:** The identified room has been deep cleaned and redecorated. There is no malodour within the identified room, but this will be monitored closely by the Maintenance Man and Home Manager.
Recommendation 4 **Ref**: Standard 43 Criteria (4) **Stated:** First time **To be completed by:** 15 April 2016	The registered person should ensure equipment, such as toilet aids, are used safely and minimise any risk to patient safety. **Ref: Section 4.3** **Response by registered person detailing the actions taken:** The toilet aid identified has been adjusted to the height that would be safe for the resident to use and minimise any risk to patient safety. Maintenance man and Home Manager to ensure this is the same for all other aids within the home.

Recommendation 5 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 31 May 2016	The registered person should ensure that holistic assessments of patient need, inform the care plans and where the assessment of need changes, the care plan is amended/renewed to reflect the change. Care plans not reflective of current care needs should be discontinued. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: A weekly care profile audit is carried out using the QOL Ipad system and any identified changes in the assessments and care plans are reflected in the audit. This audit is given to the trained staff to ensure the outcome of the assessments and care plans are similar by making the necessary amendments or renewals when necessary. Once all actions are completed, the Home Manager verifies the actions taken to ensure compliance.
Recommendation 6 **Ref**: Standard 37 **Stated:** First time **To be Completed by:** 31 May 2016	The registered person should ensure that staff date and sign any record they create in accordance with best practice and professional guidance. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: The Senior Care Assistants in the residential unit have been reminded to ensure that they date and sign after each entry to ensure that it is in accordance with best practice and professional guidance. Team leader and Home Manager to monitor this regularly.

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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