Unannounced Care Inspection Report
3 November 2016

Ashbrooke Care Home

Type of Service: Nursing Home
Address: 2a Ashbourne Manor, Old Tempo Road, Enniskillen, BT74 4BB
Tel no: 028 6632 5500
Inspector: Sharon Loane

1.0 Summary

An unannounced inspection of Ashbrooke Care Home took place on 3 November from 7.20 to 14.45 hours.

Prior to inspection, RQIA had received information via the duty desk and also from the Western Health and Social Care Trust (WHSCT) in relation to the delivery of care and the day to day operational control of the home. While it is not the remit of RQIA to investigate complaints made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care; if RQIA is notified of a potential breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required.

Following discussion with senior management at RQIA, a decision was made to undertake an unannounced care inspection of the home to assess progress made with the requirements and recommendations made as a result of the previous care inspection, the management and governance arrangements for the home; and to evidence the delivery of safe, effective and compassionate care.

Significant concerns were identified during this inspection in respect of the delivery of care specifically within the nursing units. Some of the deficits identified in care delivery had the potential to impact negatively on patient outcomes. In addition, regulatory breaches were identified in regards to the governance arrangements and other areas of quality care provided in the home.

As a consequence, a meeting was held with senior management in RQIA and it was agreed that these concerns would be addressed under two separate meetings with the registered persons. Firstly, a meeting would be held with the intention of issuing a failure to comply notice in regard to the significant concerns identified in relation to care delivery. Additional findings in regards to governance/management and other areas of quality care would be discussed at a serious concerns meeting. Both meetings were held on 9 November 2016 at RQIA.

Both meetings were attended by Mr Nadarajah Logeswaran, Responsible Individual, Mr John Rafferty, regional operations director for Runwood Homes Limited, Northern Ireland, Ciara Cochrane, acting manager and Carol Shields, dementia experience regional manager.

During the intention meeting, an action plan to address the identified concerns was submitted by Mr John Rafferty. The action plan submitted required further development and a request was made that this would be reviewed and re-submitted to RQIA. It was acknowledged that whilst work was ongoing to address these concerns, RQIA were not fully assured that the actions had been sufficiently implemented and/or embedded into practice to enable the necessary improvements to be made. Given the potentially serious impact on patient care, it was decided that a failure to comply notice under Regulation 12 (1) (a) and (b), would be issued, with the date of compliance to be achieved by 11 January 2017. Further inspection will be undertaken at this time to validate compliance.

Full details of the enforcement action taken can be viewed at www.rqia.org.uk.
Ashbrooke Care Home were required to share some of the concerns identified at this time with the adult safeguarding team of the Western Health and Social Care Trust. Relevant stakeholders have also been advised of the enforcement action taken.

As previously discussed, a serious concerns' meeting was also held on the same date to discuss additional inspection findings in regards to the quality of care and the governance/management arrangements in the home. At this meeting, the same action plan was provided which outlined the actions taken to date and the proposed actions to ensure compliance with legislation and improve the governance/management arrangements in the home. As referred to previously, it was agreed that this action plan would be further developed and submitted to RQIA by 17 November. We can confirm that the revised action plan has been received and reviewed accordingly.

Given that Runwood Care Homes Ltd had only recently taken over the operational control of the home, August 2016 and the assurances that were provided, RQIA have agreed to give Ashbrooke Care Home a period of time in which to implement the actions and make the necessary improvements required in the areas discussed.

A follow up inspection of the home will be planned in the near future to validate compliance and drive improvements.

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

The term 'patients' is used throughout the report to describe those living in Ashbrooke Care Home which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	5*	4*

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ciara Cochrane, acting manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

*The total number of requirements and recommendations made includes one requirement stated for a second time, one recommendation stated for a second time and one recommendation carried forward until the next care inspection.

Enforcement action resulted 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 undertaken on 23 June 2016. Other than those actions detailed in the 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 person: Runwood Homes Ltd/ Mr Nadarajah (Logan) Logeswaran	**Registered manager:** Not yet registered
Person in charge of the home at the time of inspection: Ciara Cochrane	**Date manager registered:** Ciara Cochrane – application not yet submitted
Categories of care: **NH-I, RC-DE, NH-DE** A maximum number of 32 patients in category NH-DE and a maximum of 8 patients' category NH-I, accommodated in a separate unit. A maximum of 24 residents in category RC-DE	**Number of registered places:** 64

3.0 Methods/processes

Prior to inspection we analysed the following records:

- notifiable events received by RQIA since the last care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from inspections undertaken in the previous year
- the previous care inspection report
- pre-inspection assessment audit.

During this inspection, care delivery and care practices were observed and a review of the general environment of the home was undertaken. We also spoke with five patients individually and with others in small groups, two registered nurses, and two care team managers in charge of the residential unit, a group of care staff, one ancillary staff member, the maintenance man, the administrator and one patient's representative.

The following information was examined during the inspection:

- validation evidence linked to the previous care inspection QIP
- a review sample of staff duty rotas
- observation of the staff handover
- four patient care records
- accident and incident records
- supplementary care records

- monthly monitoring reports in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 23 June 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. This QIP was validated at this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 23 June 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13 (1) (a) **Stated:** First time	The registered persons must ensure that the home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. Fluid must be provided to patients and records and fluid intake records must be completed contemporaneously.	**Not Met**
	Action taken as confirmed during the inspection: A review of information and observations of care delivered evidenced that this requirement had not been met. Please refer to section 4.3.2 for further details. **This requirement has been stated for a second time**	
Recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 5.1 **Carried forward from last inspection**	The registered persons should ensure that the mealtime experience is reviewed, to ensure that patients are afforded choice and treated with respect and dignity.	**Not Met**
	Action taken as confirmed during the inspection: An observation of the breakfast mealtime experience evidenced that this recommendation was not met. Please refer to section 4.3.2 for further details. **This recommendation has been stated for a second time**	

Recommendation 2 **Ref**: Standard 4.9 **Stated:** First time	The registered persons should ensure that the systems for recording personal care delivery, which includes bathing and elimination records, are reviewed to ensure that the contemporaneous records of all nursing interventions are maintained within the patient care record.	**Carried forward until next inspection**
	Action taken as confirmed during the inspection: This recommendation was not reviewed in its entirety and therefore has been carried forward for review at the next care inspection.	

4.3 Inspection findings

4.3.1 Care delivery and practices

Care records examined within the nursing units were identified as requiring improvements and they were not sufficiently detailed to reflect the assessed needs of patients. Significant concerns were identified regarding the quality of care delivered within both nursing units. There was a lack of evidence to demonstrate that safe effective care and treatment was being delivered consistently, in regards to the management of weight loss, wounds, pressure damage and accidents and incidents. Care records examined did not evidence a systematic approach to assessing, planning and evaluating care. The deficits identified had the potential to impact negatively on patient outcomes.

The review of four patient care records did not evidence that risk assessments were accurately and consistently completed and reviewed in accordance with changes in patient's condition. Care plans were either not in place, or not sufficiently reviewed in response to the changing needs of patients.

The following issues were identified in the named care records provided to the home manager.

There was insufficient evidence within the care records reviewed that patient weight loss was being identified and appropriately managed. A review of weight monitoring information identified that seven patients had significant weight loss of up to and including one stone and seven pounds within a five month period. The Malnutrition Universal Screening Tool (MUST) used by the home, had not been completed consistently and significant gaps were noted of up to and including a period of four calendar months, despite patients having significant weight loss. Care plans for the management of weight loss were not in place for all care records reviewed in regards to this area of care.

These findings could have potentially serious consequence for patient's health and welfare.

Shortfalls were also identified in the prevention and/or management of pressure damage and wounds. A review of care records identified that appropriate and timely actions had not been taken in regards to pressure damage identified for one patient. Care records had not been updated and appropriate actions taken when the pressure damage was first identified by nursing staff, for up to and including a two week period. It was acknowledged that the home manager had identified these shortfalls the day prior to the inspection, and subsequent actions had been initiated.

Repositioning charts were not being recorded accurately and repositioning was not carried out in accordance with the information provided at the staff handover. A review of repositioning records for the identified patient evidenced that they had not been repositioned for up to and including 10 hours when they required two hourly positional changes. Similar shortfalls were identified in other repositioning records reviewed and in some instances the recorded information was difficult to understand and inaccurate. There was no evidence that these records were being monitored and reviewed by registered nurses and corrective actions taken.

A review of accident and/or incident management records identified shortfalls in relation to the completion of records. Risk assessments and care plans had not been reviewed and updated accordingly and in some instances, risk assessments and care plans had never been completed. It was concerning that appropriate actions had not been taken in some instances. For example; a review of accident records and care records for two identified patients demonstrated that appropriate actions had not been taken following accidents when both patients had sustained a potential head injury. Staff had not sought appropriate medical attention nor monitored the patients for any adverse side effects. RQIA had not been notified appropriately in regards to one incident and a request was made by the inspector that a notification should be submitted to RQIA retrospectively. The shortfalls in relation to the, management of head injuries again have the potential to impact negatively on the patients' health and welfare.

Professional standards and guidelines regarding malnutrition, wound care and/or pressure management and accident and/ incident management were not evidenced to be adhered to.

Given the identified concerns and the potential impact to patients health and welfare, it was considered that these matters be addressed through a failure to comply notice in respect of regulation 12 (1) (a) and (b) of the Nursing Homes Regulations (Northern Ireland) 2005. Further inspection will be undertaken to ensure compliance with regulation is achieved.

As discussed previously, areas for improvement were identified with regards to the completion of care records and risk assessments. A review of care records identified that risk assessments and care plans were not being completed within five days of admission to the home. Significant gaps were identified of up to and exceeding two weeks following admission. A requirement has been made in this regard.

During the inspection, information evidenced in regards to an identified patient's blood sugar reading demonstrated that appropriate monitoring checks had not been carried out. Following a low blood sugar reading, the registered nurse had administered 'glucagon' as per the medicine kardex. However, monitoring checks had not been completed in a timely manner to determine the effectiveness of the treatment given. Following prompt from the inspector, a registered nurse re-checked the patient's blood sugar reading. This was concerning, as the lack of timely actions could have posed negative outcomes for the identified patient. A requirement has been made in this regard.

4.3.2 Meals and Mealtimes

We observed the serving of the breakfast in the nursing units. It was concerning to observe there had been limited progress made in the arrangements of the dining experience for patients as recommended at previous inspections undertaken on 3 May and 23 June 2016. We observed that some patients were seated in the dining room for up to and including 45 minutes before receiving anything to eat and/or drink. Whilst it is acknowledged that staff were trying their best to attend to patients, there was a lack of organisation; staff were observed asking patients their meal choice for lunch time, when patients still had not received any breakfast. Some patients had to wait on food being served, whilst other patients were being attended to. Patients who had finished their cereal were not offered other food and fluids in a timely manner. Some patients were assisted with their breakfast in bed. Discussion with staff indicated that this was not the patient's choice but that there was insufficient staff to have all patients up, washed and dressed and brought to the dining room.

Food was served from a heated trolley, however some food (scrambled eggs) was observed sitting on top of the heated trolley uncovered for a lengthy period of time and the food was getting cold. Staff were observed serving the food to patients and did not check the temperature of the food. The menu in the nursing dementia unit was not displayed appropriately or in a suitable format. A staff member was observed kneeling on the floor beside the patient's bedside to assist them with their breakfast. All of these practices observed demonstrated that the dining experience was not reflective of best practice guidance and some aspects of patients' dignity had not been considered.

A recommendation that had been made in relation to the mealtime experience at a previous care inspection 3 May 2016 continued not to be met. The dining experience was discussed at the serious concerns meeting held and assurances were given that this area of practice would be addressed in accordance with best practice guidance. This recommendation has been stated for a second time.

Other observations evidenced that patients who had been awake and up prior to 07.00 had not being offered or received any fluids or food in a timely manner. Some of the records reviewed evidenced that fluid intake had not been recorded since 20.00 hours on the previous evening. Care staff were observed completing these records at the end of the night shift and records completed by day staff were also non-contemporaneous. This matter was discussed with staff and they advised that they did not have time to complete them. Again, this matter was raised at an inspection undertaken 23 June 2016 and a requirement made continued to be not met. This requirement has been stated for a second time.

4.3.3 Environment

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, the dining room and storage areas. In general, the areas reviewed were found to be clean and reasonably tidy. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. An odour was detected in one identified bedroom within the nursing dementia unit. This has been followed up with the home manager and assurances have been provided to address same.

Concerns were identified in relation to the ambient temperature in some areas of the home. The temperature in one identified bedroom in the nursing dementia unit was recorded below the recommended temperature as detailed in the DHSSPS Standards for Nursing Homes 2015. It was also noted that the patient who occupied this room had a very unsettled sleep pattern which may have been as a result of the reduction in temperature. The home manager and the maintenance man advised that this had been raised with senior management however; appropriate actions had not been taken to solve this problem. This was concerning. The information received was shared with the estates team for follow up action. This matter was also discussed during the serious concerns meeting and assurances have been given by Runwood Care Homes Ltd that appropriate actions have been taken to resolve this problem and also that interim measures have been implemented. A requirement has been made.

4.3.4 Governance and management arrangements

As previously discussed in section 1.0 of the report, Runwood Care Homes Ltd had taken over the operational control of the home in August 2016. Prior to this inspection, information received by RQIA raised concerns regarding the management arrangements for the home. During this inspection concerns were identified in relation to recent changes in management arrangements which appeared to have a negative impact on the quality of care and other services provided. The acting manager had been appointed 17 October 2016 and there was limited evidence available to demonstrate adequate structures had been put in place to support her in this role. This matter was discussed during the serious concerns meeting held and assurances were given that structures and support systems were now in place to support the home manager and that a structured induction programme, including mentorship was available to enable her to settle into her new role and also to drive the necessary improvements. RQIA acknowledged that at the inspection, the home manager demonstrated her ability to fulfil her role and responsibilities and make the necessary improvements required although the need for additional support was required.

Observations made during the inspection identified poor deployment of staff. There was a lack of leadership and direction provided by registered nurses on duty. Registered nurses on duty were unsure as to which of them had the overall responsibility of being in charge of the shift. A review of duty rotas did not identify the nurse in charge of the building in the absence of the manager. A recommendation has been made.

Staffing arrangements in place were found to be insufficient and /or inadequate to ensure that patients received safe, effective compassionate care and supervision. This observation was made specifically in relation to the morning routine and the serving of the breakfast in the nursing units as previously discussed in section 4.3.2. Patients' needs were not being met in a timely manner in some aspects of care delivered. At this inspection, one care staff member was allocated to the nursing unit which accommodated eight patients. The carer was required to seek assistance from colleagues in the nursing dementia unit; this was not ideal and had the potential to impact on the operations and care delivered within both units. A discussion with care staff indicated that the new manager had reviewed the staffing arrangements and allocation of duties. However, it was indicated that agreed actions had not been implemented in a consistent manner. This was discussed with the home manager and at the serious concerns meeting. Assurances were given that the number and ratio of staff on duty at all times met the care needs of patients. The home manager advised that a review had been completed in regards to staffing arrangements; including allocation of duties and responsibilities; and staff had been informed accordingly. This will be monitored by the home manager during 'daily walk around' and 'flash meetings'. The effectiveness of these actions will be monitored by RQIA at subsequent care inspections.

During the inspection it was identified that RQIA had not been notified in relation to a number of incidents that had occurred in the home as per regulation 30 of the Nursing Homes Regulations (Northern Ireland), 2005 since the previous inspection. A requirement has been made.

A discussion with the home manager evidenced that although there were systems in place to monitor and report on the quality of nursing care and other services provided these were limited and had not been implemented in recent months. The home manager advised that management systems were being currently developed and implemented to monitor, audit and review the quality of nursing care and other services provided. A review of documentation confirmed this information. Whilst this information is acknowledged, actions to address this shortfall in regards to robust auditing and governance systems has been included in the failure to comply notice issued.

In addition, it was concerning that the issues identified at this inspection had also not been identified during the monitoring visits undertaken in accordance with Regulation of the Nursing Homes Regulations (Northern Ireland) 2005. A recommendation has been made in this regard.

At the serious concerns meeting, Mr Rafferty advised that the issues identified at this inspection had also been identified by the management team. However, there was limited evidence to support this information and furthermore RQIA advised Mr Rafferty, given the provision of this information it was of further concern that appropriate actions had not been taken and/or followed up to assure the safe delivery of quality care in the areas aforementioned. The absence of appropriate actions had the potential to impact on patient's health and welfare.

It was evident at this inspection that the overall management of the home, the leadership arrangements and the lack of governance systems and processes in the recent months had had a direct impact on the delivery of safe, effective and compassionate care. The concerns identified were addressed during the intention meeting to serve a failure to comply notice and the serious concerns meeting on 9 November 2016. As a consequence of the meetings held, significant concerns which had the potential to impact negatively on patients' health and welfare have been actioned in a failure to comply notice issued and other concerns have been addressed in the Quality Improvement Plan included in this report.

RQIA will undertake further inspections to validate that compliance has been achieved.

4.3.5 Consultation

In addition to feedback from patients and staff as detailed in previous sections RQIA also spoke with one relative visiting at the time of the inspection. The relative commented positively in relation to the care their loved one received, staff attitude and the managers approachability and willingness to address concerns raised. The relative advised that they had been dissatisfied with previous management arrangements however recent management changes had been positive for the home.

4.3.6 Placement of patients within the home environment

During a review of patients accommodated in the home it was evidenced that the placement of some patients within the home had not been appropriately managed to ensure that the holistic needs of patients were being met. This matter was discussed with the home manager and Mr John Rafferty and has been addressed under a separate correspondence issued by RQIA.

Areas for improvement

The improvements required have been included in the failure to comply notice issued under Regulation 12 (1) (a) and (b) of the Nursing Homes Regulations (Northern Ireland) 2005. Additional areas for improvement have been included in the Quality Improvement Plan appended to this report.

Number of requirements	4	Number of recommendations	2

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ciara Cochrane, acting manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to the web portal for assessment by the inspector.

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

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 13 (1) (a) **Stated:** Second time **To be completed by:** 9 December 2016	The registered persons must ensure that the home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. Fluid must be provided to patients and records and fluid intake records must be completed contemporaneously. **Ref: Section 4.2 & 4.3.1 & 4.3.2**
	Response by registered provider detailing the actions taken: Fluids are readily available and fluid targets have been established for all residents. Fluid intake records are completed.
Requirement 2 **Ref:** Regulation 30 (1) **Stated:** First time **To be completed by:** 3 November 2016	The registered persons must ensure that notifications are submitted to RQIA in accordance with legislative requirements. **Ref: Section 4.3.1 & 4.3.4**
	Response by registered provider detailing the actions taken: All notifications to RQIA now follow legislative requirements.
Requirement 3 **Ref:** Regulation 14 (4) **Stated:** First time **To be completed by:** 9 December 2016	The registered persons must make arrangements by training staff or by other measures to prevent patients being harmed or being placed at risk. This requirement has been made with specific reference to the concerns identified in regards to the management of the patient with diabetes. 93% of the staff have been trained in safeguarding adults. Training Records of training should be retained for inspection. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: 93% of the staff have been trained in safeguarding adults. Three Nurses have diabetes training and further training has been planned for 19/01/2017.

Requirement 4 **Ref:** Regulation 27 (2) (p) **Stated:** First time **To be completed by:** 3 November 2016	The registered persons must ensure that the heating provided in all parts of the nursing home used by patients is in accordance with Standard 44, of the DHSSPS Care Standards for Nursing Homes, 2005. Records should be maintained of temperature checks. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: The heating system was repaired, monitored and progress fed back to RQIA. Records are and have been available for inspection.
Requirement 5 **Ref:** Regulation 15 (2)(a) (b) **Stated:** First time **To be completed by:** 3 November 2016	The registered persons must ensure that risk assessments and care plans are completed at time of admission and are kept under review and updated according to any changes in patient's needs. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: All care plans have been reviewed. New care plans have been put in place.
Recommendations	
Recommendation 1 **Ref**: Standard 5.1 **Stated:** Second time **To be completed by:** 9 December 2016	The registered persons should ensure that the mealtime experience is reviewed, to ensure that patients are afforded choice and treated with respect and dignity. **Ref: Section 4.2 & 4.3.2**
	Response by registered provider detailing the actions taken: New meal time standards have been implemented in the care home. The dining rooms have also been decorated. New menu boards have been installed and new table displays are in place.
Recommendation 2 **Ref**: Standard 4.9 **Carried forward from last inspection**	The registered persons should ensure that the systems for recording personal care delivery, which includes bathing and elimination records, are reviewed to ensure that the contemporaneous records of all nursing interventions are maintained within the patient care record. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: New record keeping standards are implemented and all the records identified have been maintained.

Recommendation 3 **Ref**: Standard 41 Criteria 7 **Stated:** First time **To be completed by:** 3 November 2016	The registered provider should ensure that the duty rota identifies the name of the nurse in charge of the home on each shift and is in line with the DHSSPS Care Standards for Nursing Homes, 2005. **Ref: Section 4.3.4**
	Response by registered provider detailing the actions taken: The nurse in charge of the home is now highlighted in yellow on the duty rota.
Recommendation 4 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that the Regulation 29 monitoring visits include a focus on the requirements and recommendations made during this inspection. A robust action plan to address any areas for improvement should be developed and subsequent remedial actions taken. **Ref: Section 4.3.4**
	Response by registered provider detailing the actions taken: All quality monitoring visits have focused on the required improvements Identified and an action plan was developed and submitted to RQIA.

Please ensure this document is completed in full and returned to the web portal

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