The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
17 August 2016

Woodlawn House

Type of Service: Nursing Home
Address: Quarry Lane, Dungannon, BT70 1HX
Tel No: 028 8771 3565
Inspector: Sharon Loane

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Woodlawn House took place on 17 August 2016 from 10.30 to 15.30 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.

Is care safe?

There was evidence that systems and processes were in place in the majority of areas reviewed to ensure the safe and competent delivery of care and other services. A review of the homes environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining room and storage areas. The home was found to be warm and clean throughout. One issue pertaining to infection prevention and control practice was observed however this was addressed immediately.

Staff consulted and observation of care delivery and interactions with patients clearly demonstrated that knowledge and skills gained through training and experience were embedded into practice. Staff were confident in carrying out their role and responsibilities in the home.

A recommendation has been made in regards to the management of the use of Overt Close Circuit Televisions (CCTV) for the Purpose of Surveillance in Regulated Establishments and Agencies.

Is care effective?

There was evidence that systems had been put in place to ensure that communication and information was maintained regarding patients' needs during the period of respite care. Review of records evidenced that regular communication had occurred with patient representatives regarding any changes in the patient's condition.

Shortfalls were identified in the review of patients care records in regards to keeping records up to date and reviewed and some information recorded in patients care plans was not reflective of the assessed need and care interventions required. Some assessments were also not completed on admission for respite care.

One requirement and one recommendation have been made to drive improvement and ensure compliance with legislative requirements and care standards.

Is care compassionate?

Patients were afforded choice, privacy, dignity and respect. Discussions with staff indicated that care delivered was very patient centred for example one staff member spoken with stated that 'if a patient wanted a lie in this was acknowledged and that unlike most homes, routine practices did not direct care'.

Interactions between patients and staff were positive, caring and kind. 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 interactions with staff.

There were no requirements or recommendations made under this domain.

Is the service well led?

The registered manager was on annual leave during this inspection and the inspection process was facilitated by the registered nurse in charge. It was evident that the registered manager ensured that her staff team were conversant with the homes management and governance processes and had developed guidance information of how and where to access records and information for inspection in her absence. It was evident that the registered nurse in charge was confident in her role and ability to facilitate the inspection process in the absence of the registered manager.

Comments received from staff and one patient's representatives spoken with indicated a high level of satisfaction with this service.

There were systems and processes in place to ensure the quality of care and services delivered and in the majority these resulted in positive outcomes. As referred to in section 4.4 shortfalls were identified in regards to care planning and a requirement has been made under the effective domain and a recommendation has been made under the well led domain to drive the necessary improvements in this area of practice and governance.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**1**	**3**

Details of the Quality Improvement Plan (QIP) within this report were discussed with Kathleen McBride, registered nurse in charge, 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 announced estates inspection undertaken on 9 December 2015. 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.

There were no further actions required to be taken following the last inspection.

2.0 Service details

Registered organisation/registered person: Southern HSC Trust/Mr Francis Rice	**Registered manager:** Ms Maureen Currie
Person in charge of the home at the time of inspection: Kathleen McBride	**Date manager registered:** 08 August 2008
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 8

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the last inspection
- the registration status of the home
- written and verbal communication received since the previous inspection
- the returned quality improvement plan (QIP) form inspections undertaken in the previous 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. Questionnaires were distributed to relatives and staff. We also met with seven patients, three care staff, the activities coordinator, one registered nurse and one kitchen assistant and one patient's representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training records for 2015/2016
- accident and incident records
- one staff personnel file
- complaints received since the previous care inspection
- records pertaining to NMC registration checks
- minutes of staff meetings
- a review of a selection of audits

- 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 9 December 2015

The most recent inspection of the home was an announced estates inspection. The completed QIP was returned and approved by the estates 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 estates inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 26 August 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 41 **Stated:** First time	The duty rotas should record the full name of each staff member; their actual hours worked on a daily basis and verification from the registered manager or designated deputy that these hours have been worked. **Action taken as confirmed during the inspection**: A review of a sample of duty rotas evidenced that this recommendation was met.	**Met**
Recommendation 2 **Ref:** Standard 11 (Care Standards for Nursing Homes-April 2015) **Stated:** Second time	The duration of activities and the patient's participation level should be recorded. **Action taken as confirmed during the inspection**: A review of a sample of records pertaining to the management of activities included the information as stated above. This recommendation has been met.	**Met**

<table>
<tr><td rowspan="2">Recommendation 3

Ref: Standard 4

Stated: First time</td><td>The “All about me,” booklet should be completed consistently for all patients as the information obtained is helpful in informing care needs and communication.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of three patients care records evidenced that the “All about me” booklet had been completed for all patients. This recommendation has been met.</td></tr>
<tr><td rowspan="2">Recommendation 4

Ref: Standard 39

Stated: First time</td><td>The registered persons should review the training needs of individual staff to ensure that all staff have received training relevant to their roles and responsibilities in the following areas;

• how to report poor staff practice
• whistleblowing
• continence promotion and management</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of training records evidenced that training had been provided in the identified areas and discussion with staff confirmed that they were knowledgeable in these areas of practice. This recommendation has been met</td></tr>
<tr><td rowspan="2">Recommendation 5

Ref: Standard 16

Stated: First time</td><td>The registered persons should ensure records of all complaints are available for inspection, including details of communications with complainants, the results of any investigations, the actions taken, whether or not the complainant was satisfied with the outcome; and how this level of satisfaction was determined.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of the complaints record evidenced that these were both maintained and managed appropriately. This recommendation has been met.</td></tr>
</table>

4.3 Is care safe?

The registered nurse in charge confirmed the staffing levels for the home at time of the inspection. The registered nurse advised that as the home was a respite unit, staffing arrangements were reviewed regularly to ensure that staffing levels were appropriate to meet the assessed needs of the patients during the period of respite care.

A review of the staffing rota from the 8 -21 August 2016 evidenced that planned staffing levels were adhered to. Staff consulted confirmed that staffing levels were appropriate to meet the needs of the patients. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty during the morning and afternoon periods.

A review of the duty rota evidenced the nurse in charge of the home in the absence of the registered manager and the rota was maintained in line with the care standards for nursing homes, 2005. A recommendation made at the previous care inspection pertaining to the management of staffing duty rotas was met.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction both prior to and at commencement of their employment. A discussion with one member of staff who had recently commenced employment advised that they had been provided with training and were mentored both by the registered manager and experienced staff during their induction period. Records of induction for this staff member were reviewed and found to be completed in full and dated and signed appropriately by the inductee, the mentor and registered manager.

The registered nurse in charge advised that the recruitment processes for the home were managed by the human resource department within the Trust. The home held a personnel file for each staff member employed and a review one staff file evidenced that this had been managed appropriately. Staff consulted with stated that they had only commenced employment once all relevant checks had been completed, for example receipt of references and Access NI clearance.

Discussion with the registered nurse in charge and the administrator and a review of records evidenced that arrangements were in place to monitor the registration status of nursing staff with the Nursing and Midwifery Council (NMC). The most recent checks were completed on 1 August 2016 and evidenced that all nurses employed were on the current live NMC register.

During the inspection process, we were unable to access information in regards to the registration status of the care staff to ensure that they were currently registered with the Northern Ireland Social Care Council (NISCC). Following the inspection the registered manager confirmed by email to RQIA that all care staff employed were currently registered with NISCC.

Review of training records for 2015/2016 evidenced that training was planned to ensure that mandatory training requirements were met. Staff confirmed that they were required to complete mandatory training and other relevant training either "on line" and/or by attending "face to face" training. Staff advised that the registered manager monitored attendance at training robustly and records evidenced compliance levels was high.

Staff spoken with demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibilities in general and specifically in relation to adult safeguarding. All staff consulted with stated that they had received training in this regard and that they knew how to report and escalate any concerns appropriately. Staff were aware of policies and procedures pertaining to adult safeguarding and also the whistleblowing policy. The registered nurse in charge was knowledgeable of the procedure for notifying safeguarding within the relevant Trust and advised that information was available for reference and included contact details.

A review of records evidenced that there was one ongoing safeguarding incident which was being managed appropriately and will be followed up at future inspection. A recommendation made at the previous care inspection pertaining to adult safeguarding was met.

A range of risk assessments were completed as part of the admission process; however the risk assessment used for assessing nutritional risk; MUST was not consistently completed for the care records reviewed. Refer to section 4.4 for further detail.

A review of accident and incident records confirmed that appropriate actions had been taken; care management and patients' representatives were notified appropriately. An analysis was completed on a monthly basis by the registered manager identifying any patterns and trends and actions were taken accordingly. A review of the above records also confirmed that notifications had been forwarded to RQIA appropriately.

A review of a care record evidenced that a non–recording device was being used to ensure an unidentified patients safety during night time. This was discussed with the registered nurse in charge who provided the rationale for using this intervention. There was documentary evidence available to include; consent had been obtained from the patient's representatives and the multi professional disciplinary team for its use and care management had also been involved in the decision making process. This matter was discussed with the registered manager post inspection who agreed to discuss and review this care intervention with relevant personnel and Trust representatives to review the need for this intervention. Whilst these actions are acknowledged and there was limited evidence that this intervention had impacted on the patient's privacy, a recommendation has been made that this practice should be reviewed in accordance with RQIA's guidance on the use of Overt Close Circuit Televisions (CCTV) for the Purpose of Surveillance in Regulated Establishments and Agencies.

Safety and medical/drug alerts were reviewed on a regular basis and relevant notices were 'actioned' and /or disseminated to staff as required. There was also evidence that any relevant alerts were discussed during the monthly staff meetings held. This is good practice.

A review of the homes environment was undertaken and included observations of a sample of bedrooms, bathrooms, lunges, dining room and storage areas. The home was found to be warm, fresh smelling and clean throughout. Items of clothing and continence aids were observed lying on two bedroom floors. A discussion with staff confirmed that they recognised these practices posed a potential infection and prevention control risk and gave their assurances to cease this immediately. This matter was brought to the attention of the registered nurse in charge who addressed this immediately and gave assurances that this would be monitored closely.

Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas for improvement

A recommendation has been made that the use of the non-recording device in use for an identified patient should be reviewed in accordance with RQIA's guidance on the use of Overt Close Circuit Televisions (CCTV) for the Purpose of Surveillance in Regulated Establishments and Agencies.

Number of requirements:	0	Number of recommendations:	1

4.4 Is care effective?

A review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. However a review of two care records evidenced inconsistencies in the completion of the nutritional risk assessment. The MUST assessment had not been completed for the current period of respite care. A recommendation has been made.

The registered nurse advised that care plans were written based on the information provided by the Trust, pre-admission information and also the admission checklist completed at the time of every respite admission. The care plan was then reviewed thereafter at three monthly intervals unless there had been a change identified in the patients assessed needs.

Review of three patient care records and care planning evidenced that care was very person centred and in the majority was relevant to meeting patients assessed needs. At time of admission for respite care an admission checklist was completed which included any changes to the patients assessed needs and care interventions required. A review of an admission checklist for one identified patient highlighted a new care need and the care plan had been reviewed and updated to reflect this information. However, the review of one care record for an identified patient evidenced that the information recorded in the care plan for nutrition was not consistent with the SALT assessment (speech and language). The registered nurse and staff confirmed that the patient was receiving fluids as detailed in the SALT assessment. The care plan had not been reviewed and updated to include this information.

Another patient’s care record evidenced that care plans had not been formally rewritten and/or reviewed since 2013. In regards to the aforementioned shortfalls, the registered provider must ensure that care records are reviewed to ensure that they are up to date and reflect the current needs of patients in keeping with best practice. A requirement has been made.

A discussion was held with the registered nurse in charge in regards to the systems in place for the auditing of care plans. The registered nurse advised that care plans had been peer reviewed recently however could not provide any additional information in regards to the shortfalls that had been identified. We were unable to establish in detail what the arrangements for auditing care plans were however, due to the timeframe identified if systems were in place they had not been effective. Further details in regards to care plan audits are referred to in section 4.6.

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. The registered nurse and staff spoken with advised that the discussions at the handover provided the necessary information regarding any changes in the patient’s condition. The registered nurse in charge advised that the registered nurse referred to the patients care record during the handover to ensure that staff were kept updated of any changes during their time off duty. Staff confirmed that the implementation of this action had improved communication and care delivery.

Discussion with the registered nurse in charge and a review of records confirmed that staff meetings were held on a monthly basis and records were maintained. Records evidenced that the meetings were meaningful and provided a forum for any new learning for example; from previous incidents. Staff advised that if they were unable to attend, they had to read the minutes and sign the record accordingly. This is commended.

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.

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

Areas for improvement

A requirement has been made that care records are kept under review and reviewed at any time necessary to do so having regard to any change of circumstance and in any case not less than annually.

A recommendation has been made to ensure that nutritional screening is carried out on admission using a validated tool to identify patients who may be or are at risk of malnutrition.

Number of requirements	1	Number of recommendations	1

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. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

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. It was evident that there were good relationships between patients and staff. During the serving of the lunch time meal staff were observed chatting and engaging with the patients and from the conversations held it was very apparent that the staff knew the patients and also were able to relate to information regarding the patient's family members as part of their interactions. Patients were observed to respond by gestures for example; smiling and other means of nonverbal communication.

The activities co-ordinator was observed carrying out both one to one and group activities with some of the patients. Discussion and a review of information displayed confirmed that a variety of activities were available in the home. The 'All about me booklet' completed for each patient included information regarding their interests and what they enjoyed and the activity co-ordinator advised that they used this information to ensure that provision was made.

Records pertaining to the management and recording of activities was reviewed and was found to be satisfactory and a recommendation made at a previous care inspection was met.

Discussion with the registered nurse in charge and a review of information confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. One patient's representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

One patient's relatives spoken with at this inspection were very positive in relation to the care delivered, the environment, staff attitude and management of the home. In addition, 10 relative/representative questionnaires were provided by RQIA to the registered nurse in charge for distribution. At time of writing this report, none had been returned within the identified timeframe.

Comments made by staff during the inspection are referred to throughout the report. In addition, 10 staff questionnaires were provided by RQIA for distribution, for staff not on duty during the inspection. Staff spoken with on the day of inspection commented positively regarding the care delivered and spoke highly of the leadership and management of the home. Five staff questionnaires were returned within the timescale for inclusion in this report.

Comments included:

"Patients are looked after by a caring staff team who go above and beyond in providing a positive experience for all."
"If we had any concerns we would bring them up to management."

No concerns were raised.

Areas for improvement

No areas of improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

The registered manager was on annual leave during this inspection and the inspection process was facilitated by the registered nurse in charge. The registered nurse was able to access and provide the majority of records on request. Any records that were not available were submitted to RQIA following this inspection. It was evident that the registered manager ensured that the team were conversant with the homes management and governance processes and knew how to access records and information in her absence.

Discussion with the registered nurse and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion one patient's representatives spoken with 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 was current. Discussion and observations evidenced that the home was operating within its registered categories of care.

Discussion with the registered nurse and review of the homes complaint record evidenced that complaints were managed in accordance with the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. A recommendation made at a previous care inspection was met.

Discussion with the registered nurse and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA and/or other relevant bodies appropriately. A review of notifications of incidents since the last care inspection confirmed that these were managed appropriately.

Discussion with the registered nurse in charge 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 infection prevention and control, hand hygiene audits, record keeping; nutritional audits, complaints and incidents/accidents. 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.

Discussion with the registered nurse in regards to the inspection findings for care plans confirmed that care plans had been peer reviewed recently however this process had not identified some of the shortfalls identified at this inspection. The registered nurse in charge was unable to provide information in regards to any other measures in place to monitor this area of practice. A requirement has been made under the effective domain in regards to care plans and a recommendation has also been made under this domain that a more robust system of auditing should be developed to ensure that the necessary improvements are made following this inspection and going forward.

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. This included the discussion and review of any relevant alerts at monthly staff meetings.

Discussion with the registered nurse and review of records evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, and staff and Trust representatives.

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. Staff spoken with and responses received in return questionnaires were complimentary regarding the registered manager and stated that they felt confident to deliver care and other services under her leadership and guidance. One staff member stated, “The manager was very approachable and one of the most organised managers they had worked under.”

As discussed in the preceding sections it was evident that the registered manager had implemented and managed systems of working within the home which were patient focused, impacted positively on the patient experience and involved and encouraged staff to deliver care appropriately to meet the assessed needs of patients. Staff advised that the registered manager was available to patients, their relatives and the home had an open door policy for contacting her.

Areas for improvement

A recommendation has been made that the registered person should ensure that robust systems are developed to ensure that care plans are reviewed and up to date to accurately reflect the assessed needs of the patients.

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 the QIP were discussed with Kathleen McBride, registered nurse in charge, 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 nursing.team@rqia.org.uk 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 16 (1) (b) **Stated:** First time **To be completed by:** 17 October 2016	The registered provider must ensure care records are kept under review and reviewed at any time necessary to do so having regard to any change of circumstances and in any case not less than annually. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: A comprehensive care record audit was undertaken of all patient files in September 2016. The registered manager has reviewed the outcomes of the audit and has planned to meet with each named/associate nurses on an individual basis to highlight care records which require to be reviewed and updated. The registered manager will monitor compliance with this by setting target dates for completion. In-House guidelines in relation to the completion and reviewing of care records are available to all staff.
Recommendations	
Recommendation 1 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 17 October 2016	The registered provider should ensure that nutritional screening is carried out on admission using a validated tool to identify patients who may be or are at risk of malnutrition. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: It has been reiterated to all registered nurses that nutritional assessments should be undertaken on each admission for each patient having obtained the patients consent to be weighed. Registered Nursing staff have been futher advised that in the event that a patient refuses to be weighed they should ensure that this is clearly recorded in the patients care records.
Recommendation 2 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 17 October 2016	The registered provider should ensure that a robust system is developed and maintained for reviewing care records to ensure they are reviewed and kept up to date in accordance with legislative requirements, DHSSPS Care Standards and other related guidance. **Ref: Section 4.4. & 4.6**
	Response by registered provider detailing the actions taken: A comprehensive care record audit was undertaken of all patient files in September 2016. The registered manager has reviewed the outcomes of the audit and has planned to meet with each named/associate nurses on an individual basis to highlight care records which require to be reviewed and updated. The registered manager will monitor compliance with this by setting target dates for completion. The registered manager will ensure comprehensive care record audits are

	undertaken more regularly and will be available for inspection upon request.
Recommendation 3 **Ref:** Standard 5 **Stated:** First time **To be completed by:** 17 October 2016	The registered provider should ensure that the use of the non-recording device in use for an identified patient is reviewed in accordance with RQIA's guidance on the use of Overt Close Circuit Televisions (CCTV) for the Purpose of Surveillance in Regulated Establishments and Agencies. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: This has been discussed with patients community case manager who has arranged a review meeting on 24th October 2016 to discuss the use of the non recording camera. The patients sleep pattern whilst availing of a short break in the home will inform the review. The use of the non recording camera will be withdrawn from use if it is determined following the outcome of the review that it is no longer required.

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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