Unannounced Care Inspection Report
17 August 2016

Silverdale

Type of Service: Nursing Home
Address: 29a Castlegore Road, Castlederg, BT81 7RU
Tel No: 028 8167 9574
Inspector: Norma Munn

1.0 Summary

An unannounced inspection of Silverdale took place on 17 August 2016 from 10.00 to 17.20.

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?

Safe systems were in place for monitoring the registration status of current registered nursing and care staff. RQIA were suitably informed of notifications under Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. The home was found to be warm, well decorated, fresh smelling and clean throughout. A number of patients' bedrooms were personalised and comfortable. Weaknesses were identified in relation to recruitment and selection of staff, safe moving and handling of patients and the provision of moving and handling training for staff. These deficits have led to a reduction in positive outcomes for patients. One requirement and one recommendation have been stated to secure compliance and drive improvement. One requirement in relation to safe systems for moving and handling of patients within the home has been stated for a second time. The management of Access NI vetting was also discussed in written correspondence to the registered person under separate cover.

Is care effective?

Care records were well maintained and included assessment of patient need, risk assessments and a comprehensive care plan which evidenced patient/representative involvement. Staff were aware of the local arrangements for referral to other health professionals. Communications between health professionals were recorded within the patients' care records. Staff confirmed that if they had any concerns, they could raise these with the nursing sister or the registered manager. One recommendation has been made to ensure that staff meetings take place on a quarterly basis for all members of staff and appropriate records of the meetings are maintained.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were praiseworthy of staff and a number of their comments are included in the report. There were no areas for improvement identified during the inspection in relation to this domain.

Is the service well led?

Discussion with the registered nursing sister and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. There was evidence of systems and processes in place to monitor the delivery of care and services within the home. However, one requirement and two recommendations have been stated in the domain's relating to the safe and effective delivery of care. One requirement has been stated for a second time from the previous QIP.

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	2*	2

*The total number of requirements and recommendations made includes one requirement that has been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Val Humphrey, nursing sister, as part of the inspection process. The inspector discussed some of issues identified with the registered provider who telephoned the home during the inspection and also with the registered manager following the inspection. 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 18 May 2016. Other than those actions detailed in the previous QIP there were no further actions required.

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

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

2.0 Service details

Registered organisation/registered provider: SRB Care Ltd Mrs Sarah Roberta Brownlee	**Registered manager:** Mrs Geraldine Browne
Person in charge of the home at the time of inspection: Mrs Val Humphrey (Nursing Sister)	**Date manager registered:** 10 June 2009
Categories of care: NH-DE, NH-I, NH-PH	**Number of registered places:** 41

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 QIP
- pre inspection assessment audit

During the inspection we met with 13 patients individually and others in small groups, two patient representatives, three care staff, two registered nurses, three ancillary staff, the secretary and the hairdresser.

Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff. Nine patient, nine staff and seven patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- three patient care records
- staff training records
- staff induction records
- complaints records
- incidents / accidents records since the last care inspection
- minutes of staff meetings
- a selection of audit documentation
- two recruitment files
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- duty rota for the period 8 August 2016 to 21 August 2016

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 18 May 2016

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, 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 28 January 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (1)(b) **Stated:** First time	The registered person shall ensure that patients receive the care and treatment as outlined in their individualised plan of care, specifically with regards to the management of urinary catheters. A system should be implemented to monitor this area of practice.	**Met**
	Action taken as confirmed during the inspection: A review of one patient's care plan and discussion with staff evidenced that the management urinary catheters has been carried out in accordance with the written plan of care.	
Requirement 2 **Ref:** Regulation 14 (3) **Stated:** First time	The registered person shall make suitable arrangements to provide a safe system for moving and handling patients. Moving and handling training should be provided for staff with specific focus on the use of the "handling belt".	**Not Met**
	Action taken as confirmed during the inspection: Observation of the delivery of care evidenced staff using a "handling belt" inappropriately whilst assisting a patient with two separate mobility transfers. The patient was put at risk by the use of unsafe practice during these transfers. A review of training records evidenced that moving and handling training had been provided since the previous inspection. However, observation of the delivery of care to this patient and discussion with staff confirmed that the current training programme needs to be reviewed in keeping with best practice guidance. This requirement has not been fully addressed and has been stated for a second time. A further recommendation has been made in relation to moving and handling training.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 4.8 **Stated:** First time	It is recommended that when recording all bowel movements staff make reference to the type of stool passed in accordance with the Bristol Stool chart and best practice guidance.	**Met**
	Action taken as confirmed during the inspection: A review of bowel management records evidenced that in general records were maintained in accordance with the Bristol Stool Chart and best practice guidance. Entries were well recorded with the exception of a few entries made by night staff in one of the units. This was discussed with the nursing sister who has agreed to address this issue with the staff concerned.	

4.3 Is care safe?

The nursing sister confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for weeks commencing 8 August 2016 and 15 August 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients and staff evidenced that there were no concerns regarding staffing levels. Staff consulted confirmed that staffing levels met the assessed needs of the patients. However, one relative spoken with referred to the needs of their loved one which they felt were not being fully met due to the staffing levels. This was discussed with the nursing sister and it was evident that the staff were addressing this issue as a matter of urgency on the day of the inspection. Discussion with the nursing sister also confirmed that dependency levels were kept under review to determine staffing requirements. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

A review of the personnel files for two recently recruited staff members demonstrated that all the relevant information as outlined in Regulation 21, Schedule 2 of The Nursing Home Regulations (Northern Ireland) 2005 has been sought and retained. One file reviewed evidenced the date the enhanced Access NI check was applied for, however, the date the Access NI check was received had not been recorded. It was confirmed during the inspection that the enhanced Access NI check had been received after the member of staff commenced work. This was discussed with the registered provider during the inspection on the telephone. It was advised that Access NI checks must be undertaken and received prior to staff commencing work in the practice. A requirement has been made.

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.

Discussion with the nursing sister and review of training records evidenced that they had a system in place to ensure staff attended mandatory training. Review of the training schedule for 2015/16 indicated that training was planned to ensure that mandatory training requirements were met. Discussion with one staff member demonstrated a special interest in dementia care. The member of staff had recently attended a two day course on experiencing what life may be like for people living with dementia. She described the training as invaluable and discussed how it has increased her knowledge in relation to dementia and has helped her understand more about patients' needs within the dementia unit of the home.

A review of training records and discussion with staff confirmed that moving and handling training had been delivered 'in house' by a member of staff during 2015/2016. The moving and handling training records did not contain the qualifications of the trainer or the content of the training delivered. Following the inspection RQIA received a copy of the contents of the training by electronic mail on 30 August 2016. A review of training records and discussion with the registered manager following the inspection confirmed that the member of staff who delivered the training had not attended a recent update or refresher course in moving and handling training to keep their skills updated as a trainer. The registered provider must ensure that moving and handling training is delivered by a person or agency suitably qualified and in keeping with best practice guidance. The contents of the training delivered and the qualifications of the trainer should be included in the training records. A recommendation has been made.

Staff consulted advised they had completed moving and handling training however, responses indicated that the training did not include sufficient practical demonstrations that included best practice techniques. As previously discussed in section 4.2, observation of the delivery of care to one patient evidenced staff using a "handling belt" inappropriately whilst assisting the patient with two separate mobility transfers. Discussion with staff identified that the method of transfer used did not meet the needs of the identified patient being transferred. This issue had been identified during the previous inspection and a requirement had been made. It was advised that patients should not be put at risk by the use of inappropriate moving and handling practices. This was discussed with the staff and with the registered provider on the telephone on the day of the inspection. This requirement has been stated for a second time.

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

Staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Discussion with the nursing sister 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.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. There was evidence that risk assessments informed the care planning process. A review of one patient's care plan for moving and handling clearly stated the use of a handling belt. However, as previously discussed observation and discussion with staff identified that the method of transfer did not meet the patient's needs. The nursing sister agreed to reassess the identified patient's needs and review the care plan as a matter of urgency.

Following the inspection the registered manager confirmed in a telephone conversation that the patient's needs in relation to mobility had been reassessed and the care plan reviewed and updated.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since 28 January 2016 confirmed that these were appropriately managed. However, two separate falls had been recorded within one accident report. This was discussed with the nursing sister and it was agreed that each fall should have been recorded separately. The nursing sister has agreed to bring this to the attention of staff.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients and staff spoken with were complimentary in respect of the home's environment. The rooms and communal areas reviewed were clean and spacious. Fire exits and corridors were observed to be clear of clutter and obstruction. Some issues were identified within the home in relation infection prevention and control as follows:

- two pull cords in use without appropriate covering
- a ripped fall out mat in use
- a ripped pressure cushion

The above issues were discussed with the registered provider on the telephone on the day of the inspection. Following the inspection RQIA received confirmation from the registered manager that the pull cords had been covered, the fall out mat had been replaced and the replacement pressure cushion was on order.

Areas for improvement

The registered person must ensure that enhanced Access NI checks are received prior to any new staff commencing work in the home.

It is recommended that moving and handling training is delivered by a person or agency suitably qualified in keeping with best practice guidance. Training records should contain the qualifications of the trainer and the content of the training delivered.

Number of requirements	1	**Number of recommendations**	1

4.4 Is care effective?

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. There was evidence that risk assessments informed the care planning process. 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 speech and language therapist (SALT) or dieticians. As previously discussed, one patient's care plan needed to be reviewed to meet their changing needs identified on the day of the inspection. This was actioned on the day of the inspection.

Supplementary care charts such as repositioning charts and bowel management records evidenced that in general records were maintained in accordance with best practice guidance, care standards and legislative requirements. As previously discussed in section 4.2 not all entries in relation to bowel motions made reference to the type of stool passed in accordance with the Bristol Stool Chart and best practice. This was discussed with the nursing sister who has agreed to address this with the night staff.

Review of three patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

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. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

Discussion with the nursing sister and a review of records pertaining to staff meetings confirmed that since the previous care inspection, a 'care assistant meeting' had occurred on 17 May 2016 and a 'kitchen, domestic, laundry, administration and maintenance meeting' had occurred on 14 June 2016. Minutes of the meetings were available and maintained within a file that included details of attendees; dates; topics discussed and decisions made. Discussion with staff confirmed that a recent trained staff meeting had not taken place. This issue was discussed with the registered provider on the telephone on the day of the inspection. A recommendation has been made to ensure all staff within the home have an opportunity to attend a meeting at a minimum quarterly.

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 the nursing sister or the registered manager.

Patient and 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.

Areas for improvement

It is recommended that staff meetings for all staff occur at a minimum quarterly.

Number of requirements	0	**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.

The serving of the lunchtime meal was observed in the lounge of the dementia unit. The mealtime was well supervised. Food was served in an organised manner; when patients were ready to eat or be assisted with their meals. Staff wore appropriate aprons when serving or assisting with meals and patients were provided with clothing protectors. The food appeared nutritious and appetising. A menu was on display offering choice of meal. The mealtime experience was observed to be well organised and pleasurable for the patients.

A programme of activities was displayed in the home. On the day of the inspection the hairdresser was in attendance. Patients attending the hairdresser were observed to be content, happy and were thoroughly enjoying the experience. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Discussion with the nursing sister confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. Views and comments were displayed on the notice board in the foyer. They were recorded, analysed and an action plan was developed and shared with staff, patients and representatives. Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

As part of the inspection process, we issued questionnaires to the home to distribute to staff, patients and patient representatives.

Staff

Nine staff questionnaires were issued and four were returned within the required time frame. All four questionnaires provided very positive responses although one comment was provided in relation to not enough staff meetings. As previously discussed, a recommendation has been made.

Other comments received during discussion are as follows:

- "Well run."
- "Good dementia training."
- "Good team work."
- "Management approachable."

Patients

Discussions were held with approximately 13 patients individually and to others in groups. Patients spoken with were positive regarding the care they were receiving; all were complementary of the staff and were complementary regarding the food served. There were no issues raised during the inspection by patients.

Nine patient questionnaires were issued and six patient questionnaires were returned within the required time frame; all returned questionnaires again provided very positive outcomes.

Comments made during the inspection included:
- "Very nice here, good food"
- "I have a bell in my room to call for help and they always answer this efficiently"
- "I have a comfortable chair, food is ok, if I want anything I can make a request"
- "There is always someone to help"
- "Happy here"
- "No complaints"
- "It is always good here""
- "I would like to use a stronger word than, super for the food'
- "I am not happy, but I am never happy"

Patients' representatives

During the inspection two relatives were spoken to, they were very positive regarding aspects of care. As previously discussed, one issue was raised in relation to the staffing levels and their relative's care. It was evident on the day of the inspection that staff were addressing the concerns raised in a timely manner and had involved other professionals within the multi-disciplinary team in regards to meeting the patient's care needs.

Three questionnaires were returned by relatives stating that there was a good to high level of satisfaction in all domains. A comment was made in one of the questionnaires regarding staffing levels.

Comments made during the inspection included:
- "They are well looked after."
- "Care is good."
- "The best home possible."

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 nursing sister and staff evidenced that there was a clear organisational structure within the home.

A review of the duty rota identified a member of staff working in the capacity as a 'pre-registration nurse.' Observation confirmed that this member of staff had been provided with a staff nurse uniform, however, the member of staff was not yet registered with the Nursing and Midwifery Council (NMC) and was awaiting registration. Discussion with the member of staff confirmed that they were working in the capacity as a care assistant and not a registered nurse. This was discussed with the nursing sister and with the registered provider on the telephone during the inspection. Following the inspection the registered manager confirmed that the uniform had been changed to reflect the role of the member of staff and the designation recorded on the duty rota had been amended.

Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the nursing sister, staff and review of records evidenced that the home was generally operating within its registered categories of care. However, an issue was identified in regards to the accommodation arrangements of one identified patient. This matter was brought to the attention of the nursing sister. Following the inspection RQIA received confirmation that this issue had been addressed.

The nursing sister confirmed that the policies and procedures for the home were systematically reviewed at least three yearly. Staff confirmed that they had access to the home's policies and procedures.

Discussion with the nursing sister also 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. Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/ representatives confirmed that they were confident that staff would manage any concern raised by them appropriately. Patients/representatives were aware of who the registered manager and registered person was. A copy of the complaints procedure was available and staff were knowledgeable of the complaints process.

A record of compliments was maintained. Some examples of compliments received are as follows:

"Thank you for the excellent care given to our brother."
"I would like to say a huge thank you to all the nursing staff for the loving care you all gave my mum during her stay for over two years at Silverdale. I appreciated all the hard work and support you gave her."
"Thank you for looking after my daddy so well."

Discussion with the nursing sister and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. Systems were also 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 falls, accidents, wound management, care records, infection prevention and control and complaints. 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.

Discussion with the nursing sister 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, 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. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

The registered manager was not available on the day of the inspection. In the absence of the registered manager staff were able to identify the person in charge of the home.

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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Val Humphrey, nursing sister, as part of the inspection process. Some of the issues identified were discussed with the registered provider who telephoned the home during the inspection and also with the registered manager on the telephone following the inspection. 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 14(3) **Stated:** Second time **To be completed by:** 17 August 2016	The registered provider must make suitable arrangements to provide a safe system for moving and handling patients. Moving and handling training should be provided for staff with specific focus on the use of the "handling belt". **Ref: Section 4.2 and 4.3**
	Response by registered provider detailing the actions taken: The Moving and Handling requirements for identified patient was updated with immediate effect and all staff instructed regarding this amendment. Mandatory Moving and Handling trainings are ongoing within the home with the appropriate use of handling belts a specific focus within the course content. Ongoing auditing of Moving and Handling compliance continues.
Requirement 2 **Ref:** Regulation 21 Schedule 2 **Stated:** First time **To be completed by:** 17 August 2016	The registered provider must ensure that enhanced Access NI checks are received prior to the commencement of employment of any new staff. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: As the Registered Provider I note this finding and have taken action to prevent reoccurrence on my part. Silverdale adhere to strict selection and recruitment processes. In this instance only, I followed the process presently adopted by the Regional Recruitment of Nurses for the Public Sector. I have been informed this was not acceptable and have taken this as learning and shared. I wrote to the Chief Executive of RQIA on this issue, for the wider system learning, as to why the difference in the Public Sector to the Private Sector of recruting a nurse (Access NI checks). My letter was acknowledged and I hope by my raising this issue this can be influenced at senior level for consideration.

Recommendations	
Recommendation 1 **Ref:** Standard 39 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that moving and handling training is delivered by a person or agency suitably qualified in keeping with best practice guidance and a record is kept of the qualification of the trainer and the content of the training delivered. **Ref: Section 4.2 and 4.3**
	Response by registered provider detailing the actions taken: A full day Moving and Handling training was attended by ten of our nursing and care staff on 29th September 2016 and the registered Home Manager has also been booked to attend a Moving and Handling training session with the Trust on the 26th October 2016. Mandatory Moving and Handling trainings are ongoing within the Home. A record is maintained of the course content of all Moving and Handling trainings delivered to our staff.
Recommendation 2 **Ref**: Standard 41 criteria (8) **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure staff meetings take place on a regular basis for all staff to attend and at a minimum quarterly. Records are kept which include: • The date of all meetings • The names of those attending • Minutes of discussions • Any actions agreed **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Meetings of all grades of staff take place at different intervals and minutes recorded. We had a Care Assistant meeting on the 17th May 2016 and another meeting planned for the 5th October 2016. A Kitchen, Domestic, Laundry, Maintenance and Administration staff meeting was held on the 4th June 2016 with another scheduled for the 20th October 2016. A Registered Nurses meeting took place on the 20th September 2016 and minutes recorded. Each week we have a fire drill, staff discussion takes place on a range of issues and topics and notes kept of this. This weekly discussion includes Registered Nurses. On the day of your inspection you were not shown this record of evidence.

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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