Unannounced Care Inspection Report
6 and 7 June 2017

Bradley Manor

Type of Service: Nursing Home
Address: 420 Crumlin Road, Belfast, BT14 7GE
Tel no: 028 9074 5164
Inspector: Heather Sleator

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing and residential care for up to 82 persons.

3.0 Service details

Organisation/Registered Provider: Healthcare Ireland (Belfast) Limited **Responsible Individual:** Amanda Mitchell	**Registered Manager:** See below
Person in charge at the time of inspection: David Steele	**Date manager registered:** David Steele – Acting – No Application
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. Residential Care (RC) DE – Dementia.	**Number of registered places:** 82 comprising: 41 – NH-DE, to be accommodated on the first floor 20 – NH-I, to be accommodated on the ground floor 21 – RC- DE, to be accommodated on the ground floor

4.0 Inspection summary

An unannounced inspection took place on 6 June 2017 from 10.30 to 17.00 hours and 7 June 2017 from 09.30 to 18.15 hours.

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 to describe those living in Bradley Manor which provides both nursing and residential care.

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the arrangements for the provision of activities; staff recruitment practices; staff induction, training and development; adult safeguarding arrangements and infection prevention and control practices The culture and ethos of the home promoted treating patients with dignity and respect. There was also evidence of good practice identified in relation to the governance arrangements and the management of complaints and incidents

Areas requiring improvement were identified and included; a review of the arrangements for meals and mealtimes in accordance with best practice in dementia care, that care records should accurately reflect patient need and that the staffing arrangements and deployment of staff satisfactorily meets the needs of patients.

Patients said that they were satisfied with the care and services provided and described living in the home, in positive terms. Refer to section 6.6 for further patient comment.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	2	6

Details of the Quality Improvement Plan (QIP) were discussed with David Steele, Manager, and Amanda Mitchell, Responsible Individual, 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.

4.2 Action/enforcement taken following the most recent inspection dated 20 October 2016

The most recent inspection of the home was an unannounced premises inspection undertaken on 20 October 2016. There were no further actions required to be taken following the most recent inspection.
Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection which included information in respect of serious adverse incidents (SAI's), potential adult safeguarding issues and whistleblowing.
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection the inspector met with 16 patients, 11 staff and seven patients' visitors/representatives. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution

A poster informing visitors to the home that an inspection was being conducted was displayed and invited visitors/relatives to speak with the inspector.

The following records were examined during the inspection:

- duty rota for all staff from 29 May 2017 to 11 June 2017
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- five patient care records
- four patient care charts including food and fluid intake charts and reposition charts
- staff supervision and appraisal planners
- records relating to adult safeguarding
- annual quality report
- emergency evacuation register
- complaints received from the previous care inspection
- compliments received
- RQIA registration certificate
- certificate of public liability insurance
- minutes of staff, patient and relatives meetings held since the previous care inspection
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 20 October 2016

The most recent inspection of the home was an unannounced premises inspection on 20 October 2016. There were no further actions required to be taken following the most recent inspection.

6.2 Review of areas for improvement from the last care inspection dated 6 and 7 October 2016

Areas for improvement from the last care inspection		
Action required to ensure compliance with The DHSSPS Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 4.9 **Stated:** First time	The registered provider should ensure that care records accurately and consistently evidence that patients' bowel function is being monitored on a daily basis. Care staff should be informed of where to report/record on bowel function in care records and evidence should be present that registered nurses are monitoring individuals' bowel function on a daily basis and record any action to this regard that may be required.	**Met**
	Action taken as confirmed during the inspection: The review of five patient care records evidenced that care staff were consistently recording reporting on patients' bowel function and this information was being monitored by registered nurses. Appropriate action had been taken, where necessary.	
Area for improvement 2 **Ref:** Standard 35.3 **Stated:** First time	The registered provider should ensure that a robust system of quality auditing of care records should be established. The current audit proforma should be revised and enhanced so as a more comprehensive audit is in use.	**Met**
	Action taken as confirmed during the inspection: The review of the care records audit evidenced that a new audit template had been developed and was in use. Whilst the recommendation has been met a recommendation of this report is made regarding the accuracy of the auditing process. Refer to section 6.7	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The manager and responsible individual confirmed the planned daily staffing levels for the home and stated 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 the week commencing 29 May 2017 to 11 June 2017 evidenced that the planned staffing levels were generally adhered to.

Observation of the delivery of care evidenced that patients' needs were not always met by the number and skill mix of staff on duty. A small number of patients were observed without shoes or slippers, the fingernails of a small number of patients were observed to be long and unclean and one patient's clothing which was observed to be stained following breakfast, had not been changed by lunchtime. Discussion with the relatives of two patients evidenced that they felt that, at times, there were not enough staff on duty with one relative stated this was more evident in the evening time. Two staff members stated that the staffing arrangements were satisfactory as long as there was no short notice staff sickness or staff were not moved to another unit to cover staff shortage. These comments were relayed to the manager and responsible individual during feedback. The responsible individual stated that the staffing arrangements were reviewed on a regular basis and that the staffing could and was adjusted as required. The manager and the responsible individual must review the daily routine to ensure that there is evidence of management oversight and leadership, regarding the deployment of staff and delegation of duties, to ensure that safe and effective care is being delivered. This was identified as an area for improvement.

Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

Discussion with the manager and the responsible individual and a review of two staff personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005, Regulation 21, Schedule 2. Where registered nurses and carers were employed, their registration status was checked with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC), to ensure that they were suitable for employment. The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI and satisfactory references had been sought and received, prior to the staff member starting their employment.

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. Two completed induction programmes were reviewed. The induction programmes included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare understanding and competence. The manager had also signed the record to confirm that the induction process had been satisfactorily completed.

Discussion with the manager and staff confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, undertook competency and capability assessments and completed annual appraisals.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and records were kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. The records reviewed confirmed that between 80 to 90 percent of staff had, so far this year, completed their mandatory training.

Overall compliance with training was monitored by the manager and this information informed the responsible persons' monthly monitoring visit in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

The manager and staff also confirmed that training had been provided (electronically) on dementia care to all staff. A member of staff had recently completed training and was the home's designated 'dementia champion.' In discussion with the staff member ideas for the future to enhance the lived experience for patients were discussed including exploring different communication mediums, especially with families.

Discussion with the manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff were appropriately managed in accordance with the NMC. Similar arrangements were in place to ensure that care staff were registered with NISCC.

Staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The staff understood what abuse was and how they should report any concerns that they had. The relevant contact details were available in a folder for all staff to access.

Discussion with the manager and the responsible individual confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified and the relevant training had been planned for the near future.

Review of patient care records evidenced that validated risk assessments were completed as part of the admission process and were reviewed as required. These risk assessments informed the care planning process.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were consistently completed following each incident and that care management and patients' representatives were notified appropriately.

Where patients required bedrails, to maintain their safety whilst in bed, there was evidence that risk assessments had been completed; and that regular safety checks had been carried out, when the patients were in bed. The care plans reflected the assessment outcome and included the reasons why less restrictive measures were not suitable for the patients.

Infection prevention and control measures were adhered to and equipment was stored appropriately. Observation of the laundry facilities evidenced that there was a lack of available equipment present to ensure infection prevention and control measures were in accordance with the regional guidance. This was brought to the attention of the responsible individual during the inspection and resolved by the completion of the inspection.

A review of the home's environment was undertaken which included a number of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, tidy and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. Paintwork in the corridor areas and some patients' bedrooms evidenced signs of wear and tear. This was brought to the attention of the responsible individual who stated she was aware of the issues and maintenance personnel had commenced redecorating the affected areas.

In discussion with relatives, we were informed that the flooring in their relative's bedroom had 'bubbled.' The bedroom and another patient's bedroom and the kitchen flooring also evidenced a similar effect. The responsible individual stated she was aware of the issues and that a management strategy was being considered as the kitchen would need to be closed to replace the flooring and vacant rooms were needed to move the patients out of the affected rooms to repair the flooring in the identified bedrooms. An area for improvement was identified to ensure that an audit of all rooms in the home would be undertaken to identify the number of rooms with flooring that requires replacing. On completion of the audit the information should be forwarded to RQIA along with an action plan, detailing timescales for addressing the remedial works.

The residential unit was furnished to a good standard and presented as a comfortable environment for those accommodated.. We observed that there was a lack of orientation cues and points of interest/notice boards in the unit. The corridor areas therefore appeared bare and the enhancement of these areas would provide patients with a more interesting and stimulating environment. This was discussed with the manager and responsible individual who agreed to review and action the areas discussed, as far as possible.

Fire exits and corridors were observed to be clear of clutter and obstruction. The emergency evacuation register was up to date and included the details of the last patient admitted to the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding and risk management.

Areas for improvement

The following areas were identified for improvement:

The manager and the responsible individual must review the daily routine to ensure that there is evidence of management oversight and leadership, regarding the deployment of staff and delegation of duties.

An audit of the flooring in all areas of the home should be undertaken and the information forwarded to RQIA, along with an action plan, detailing timescales for addressing the remedial works.

	Regulations	Standards
Total number of areas for improvement	1	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

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

There were a number of examples of good practice found throughout the inspection in this domain. For example, registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), Speech and language therapist (SALT), dietician and Tissue Viability Nurse Specialists (TVN). Discussion with registered nurses and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record. However, the review of patient care records also evidenced a number of weaknesses. There was a lack of consistently in relation to recording and reporting on patients' weight on a monthly basis. A patient was observed to be seated in a wheelchair without the footplates being used; this was a safety risk and increases the risk of pressure damage. Staff stated they thought this was due to the individual's posture. The patient's care plan did not reflect that the use of footplates was contraindicated.

The care plan of a patient who displayed distressed reactions was generalised and did not clearly state how the behaviour presented or how to support the patient at these times. There was conflicting information within one patient's care plan regarding mobility. The information within the monthly summary did not reflect the information within the care plan regarding mobility.

Care plans should be revised as and when patient need changes. A system had been introduced whereby a patient's care record in each of the units was peer reviewed on a daily basis. This is good practice however it was concerning that the issues as previously discussed were not identified during the peer review. Patient care records must accurately reflect the assessed needs of patients and evidenced that a care plan has been revised as and when patient need changes. This was identified as an area for improvement.

Personal care records evidenced that records were generally maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a sampling of food and fluid intake charts confirmed that patients' fluid intake was monitored. The patients' total daily fluid intakes were also recorded in a format which enabled the registered nurses to have an overview of the patients' fluid intake. The review of repositioning records evidenced that patients were repositioned according to their care plans. Advice was given to the manager and responsible individual and an area for improvement was identified in relation to the need for staff to report on the condition of the patient's skin when repositioning.
Patients' bowel movements were monitored by the registered nurses on a daily basis, to ensure that any changes from the patients' usual bowel patterns were identified and timely action taken.

The care plans detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for the patients, as appropriate. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met.

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 confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective.

Staff meetings were held at least quarterly and records were maintained and made available to those who were unable to attend. In discussion with staff it was stated that staff had requested a staff meeting. Staff stated that instead of a staff meeting individual supervision was undertaken with staff. One staff member stated they found this 'intimidating'.

The majority of staff consulted with confirmed that if they had any concerns, they could raise these with the manager. Eight staff responded via questionnaire, seven of whom agreed they could raise any issue with management. One respondent stated that they felt there was some instability in management. Relatives' meeting are held quarterly; the home also communicates with relatives and friends via social media. This medium has proven very successful and popular. A review of records evidenced that patients' meetings are also held quarterly and chaired by the activities coordinator.

We observed the serving of breakfast and the midday meal during the course of the inspection. Meals served appeared appetising and patients spoken with stated that they were satisfied with the meals provided. The atmosphere was quiet and tranquil and patients were encouraged to eat their food; assistance was provided by staff, as required. Tables were not set with tablecloths, placemats or condiments as staff stated patients tended to "lift everything." This is not considered a positive dementia perspective. Staff training regarding the approach to meals and mealtimes focusing on a dementia perspective should be completed by staff. This was identified as an area for improvement. We also observed that menus were displayed in pictorial format on the sideboard in dining rooms in a booklet format. This format did not provide patients with readily accessible and easy to understand information regarding the menu.

Patients were asked by staff of their preferred menu choice. The review of the menu choice evidenced that the majority of patients chose the same meal choice. This was discussed with staff who stated that patients tended to say they would have the same as others or staff chose for the patient based on their knowledge of the individual. Discussion took place with the manager and responsible individual of providing patients with a visual choice. Discussion also took place with the chef regarding the choice of meals available for patients who required a specialised diet. It was stated that catering staff decided what the patients who required a specialised diet would have based on the greatest quantity available of the meal choices on the day. Patients who require a specialised diet should not be disadvantaged regarding their meal preferences. The manager and responsible person were advised to review mealtime arrangements including meal choice, in accordance with best practice in dementia care and the regional nutritional guidelines for nursing and residential homes 2014. This was identified as an area for improvement.

We observed the serving of the mid-morning tea to patients. At this time, patients were offered a cup of tea and a biscuit. A choice of fluid, for example, coffee, milk or juice, was not available. Tea was served to patients in a cup, no saucer was available. The snack on offer was a selection of biscuits. A staff member was asked what was available for patients who required a specialised diet; the staff member stated digestive biscuits were 'softened' with tea. A second staff member then stated that catering staff provide a soft pudding/mousse on a daily basis for patients requiring a specialised diet and that this is put in the fridge in the kitchenette in the dining rooms. We were shown the pudding/mousse which was in the fridge. The pudding was not covered, dated nor did it state exactly what it was. This was not in accordance with food hygiene procedures. Any food stored in a fridge should be identified and dated. The arrangement for the mid-morning tea and snack provision was discussed with the manager and the responsible individual who were advised improvement was required. Patients should be afforded choice at this time and patients who require a specialised diet should have a nutritious snack in accordance with their dietary requirements.

Areas of good practice

There were examples of good practice found throughout the inspection in relation communication between patients, staff and relatives and that consultation took pace with the patient and/or their representative when planning care.

Areas for improvement

The following areas were identified for improvement:

Patient care records must accurately reflect the assessed needs of patients and evidence that care plans has been revised as and when patient need changes.

Staff should complete refresher training in relation to the arrangements for meals and mealtimes. The training should have a dementia care focus in accordance with best practice in dementia care.

Patients should be offered a choice at mealtimes in a manner which is meaningful to them. This includes patients who require a specialised diet.

Repositioning records should include information on the condition of a patient's skin each time repositioning occurs.

Patients should be afforded choice of beverage and snack mid-morning and mid-afternoon and patients who require a specialised diet should have a nutritious snack in accordance with their dietary requirements.

	Regulations	Standards
Total number of areas for improvement	1	4

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with 16 patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. An activities coordinator plans and provides activities in the home. There was evidence of a variety of activities in the home and discussion with patients confirmed that they were given a choice with regards to what they wanted to participate in. There were various photographs displayed around the home of patients' participation in recent activities. There was evidence of regular church services to suit different denominations. Links with the local community have been established and children and young people from local schools are actively involved in the life of the patients in the home. The home has established a volunteer network and currently a volunteer, who was previously a visiting relative, comes to the home five days per week. Patients have attended tea dances organised by local community groups. The home also keeps relatives and visitors informed of events and occasions in the home via their social media website. The activities coordinator produces a newsletter which is available for patients and relatives, on a regular basis.

Discussion with the manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. An annual quality report of 1 May 2017 was available for review; views and comments recorded were analysed and areas for improvement had been acted upon.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and their relatives in a kindly manner

During the inspection, we met with 16 patients, five care staff, two registered nurses, two catering staff, one laundry staff member, the activities coordinator and seven patients' representatives. Some comments received are detailed below:

Staff

"I like it here."
"The care is very good."
"Good teamwork, we all help each other out."

Patients

"They're (staff) very good to me here."
"Just like you're in your own home."
"It's pleasant enough."
"Staff are brilliant."
"Staff can't do enough for you."

Patients' representative

"I would recommend this home to anyone."
"I think staff are brilliant."
"Anytime I've gone to staff with something it's been resolved immediately."
"I leave here content."

We met with two relatives who raised issues regarding their relatives care. These issues were discussed with the manager and the responsible individual who agreed to address the issues raised, as far as possible.

We also issued ten questionnaires to staff and relatives respectively and eight questionnaires to patients. Eight staff, seven patients and three relatives had returned their questionnaires, within the timeframe for inclusion in this report. Comments and outcomes were as follows:

Patients: six respondents indicated that they were 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. One respondent was satisfied regarding the four domains. Written comment was received including, "Staff are everything to me,' and, 'Not sure who the manager is but if I asked to speak to them I could."

Relatives: one respondent indicated that they were 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. The remaining two respondents indicated that they were 'satisfied' across the four domains. Additional written comments were received and were in relation to staffing and management arrangements. The manager was informed of the comments by telephone.

Staff: five respondents indicated that they were 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. Three staff respondents indicated that they were 'satisfied' across the four domains. Additional written comments were received and were in relation to staffing and management arrangements. The manager was informed of the comments by telephone.

Any comments from patient representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients. Activities were plentiful and well managed.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

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

Discussions with the staff confirmed that there were generally good working relationships and that management were responsive to any suggestions or concerns raised. Most staff consulted with described the manager in positive terms and that they felt confident that the manager would respond positively to any concerns/suggestions raised. There were some exceptions which have been discussed in section 6.6 regarding staffing and management arrangements.

Discussion with the manager, the responsible individual and staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the manager.

Discussion with the manager and the responsible individual and a review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes 2015. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure.

Discussion with the manager and the responsible individual, 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 falls, wound management, infection prevention and control, environment, complaints, incidents/accidents and bed rails. 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. However, the exception to this process was in relation to the auditing of care records. As stated in section 6.5, the manager had revised the process and template for the auditing of care records. The review of care records at the time of the inspection did not evidence that the process was robust as weakness in the care records reviewed were present. This was discussed with the manager and responsible individual who agreed to discuss the findings of the review with the registered nurses and review and improve the process. This was identified as an area for improvement.

A review of the patient falls audit evidenced that this was analysed to identify patterns and trends, on a monthly basis. An action plan was in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection, confirmed that these were appropriately managed.

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. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

Discussion with the manager and the responsible individual and the review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and Trust representatives. An action plan was generated to address any areas for improvement; discussion with the manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships within the home.

Areas for improvement

The following area was identified for improvement: the auditing of patient care records should identify any shortfalls in the care planning process and ensure that all aspects of care planning accurately reflect the current needs and wellbeing of any patient.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with David Steele, Manager, and Amanda Mitchell, Responsible Individual, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The DHSSPS Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 20 (1) (a) **Stated:** First time **To be completed by:** 31 July 2017	The registered person shall ensure that the dependency levels of patients is kept under regular review to ensure that the numbers and skill mix of staff deployed is appropriate to meet the needs of the patients. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: A full review is currently been undertaken by the Home manager and the Registered Individual, and it has been identifed the staffing levels reflect the current need of the patients however it is the appropriate deployment of staff and this has been addressed with the unit managers through supervision.
Area for improvement 2 **Ref:** Regulation 15 (2) and 16 (2) **Stated:** First time **To be completed by:** 31 July 2017	The registered person shall ensure that patient care records are maintained with accuracy and contain a detailed and comprehensive assessment of need, appropriate risk assessments, detailed person centred care plans and appropriate regular reviews. Registered nurses must complete records in keeping with NMC guidance. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: An audit of patient care records in the home will be completed by the 31.08.17 and action plans identifed for review
Action required to ensure compliance with The DHSSPS Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref:** Standard 43 **Stated:** First time **To be completed by:** 31 July 2017	The registered person shall complete an audit of the condition of the flooring in all areas of the home. The audit should specify that where remedial action is required the timescale for the completion of the required improvement. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: An environmental audit of flooring has been completed . 3 bedroom and bathroom floorings have been replaced in July 2017. An action plan detailing further action with timescales is in place for the other areas identifed at audit

Area for improvement 2 **Ref:** Standard 12.13 **Stated:** First time **To be completed by:** 31 July 2017	The registered person shall ensure that the menu affords patients a choice at mealtimes. Patients who require a specialised diet should also be afforded choice at mealtimes, in accordance with their food preferences. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: A review of the menu with the cook manager will be completed ensuring it reflects adequate choices for patients in line with food preferences and those on specialised diets
Area for improvement 3 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 3 July 2017	The registered person shall ensure that staff report on the condition of a patient's skin when repositioned. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: The registered individual will ensure a themed supervision will occur with staff in relation to appropraite recording of skin care and daily audit from the registered nurse will be completed to monitor compliance.
Area for improvement 4 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 31 July 2017	The registered person shall ensure that staff complete refresher training in relation to the arrangements for meals and mealtimes. The training should have a dementia care focus in accordance with best practice in dementia care. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: A plan for this training will be completed and implemented with expected completion date 31.08.17
Area for improvement 5 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 3 July 2017	The registered person shall ensure that patients are afforded a choice of beverage mid-morning and mid-afternoon. Patients who require a specialised diet shall be afforded a snack at these times which meets their dietary requirements. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: A review with the cook on the current service has been completed and she has reviewed choices in line with dietary needs and this will be monitored with walk rounds from the cook manager,registered individual and nurses in charge

Area for improvement 6 **Ref:** Standard 4.8 **Stated:** First time **To be completed by:** 31 July 2017	The registered person shall ensure that the outcome of any audit of patient care records ensures that all nursing and social care interventions, activities and procedures are appropriate to and reflect the patient's individual needs. **Ref: Section 6.7**
	Response by registered person detailing the actions taken: Audits of careplans will be cross audited for review from peers to ensure complete oversight

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