# Unannounced Care Inspection Report
# 13 July 2016

# Bethany Care Home

**Type of Service: Nursing Home**
**Address: 69 Osborne Park, Belfast, BT9 6JP**
**Tel No: 028 9066 5598**
**Inspector: Lyn Buckley**

## 1.0 Summary

An unannounced inspection of Bethany Care Home took place on 13 July 2016 from 10:00 to 17:00 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.

Information was received by RQIA on 28 June 2016 from a relative who raised concerns in relation to the availability of the manager, communication with relatives generally and including relatives' meetings; and management of their specific complaints. These concerns were reviewed as part of the inspection process. Refer to sections 3.0 and 4.0 for details of the inspection findings.

**Is care safe?**

Concerns were identified in the delivery of safe care, specifically in relation to the management of infection prevention and control measures, the recording and monitoring of contemporaneous record keeping, recruitment practices and the availability/access to records required to be available for inspection. These deficits have the potential to impact on patient outcomes.

Three requirements and three recommendations were made; two stated for a second time.

**Is care effective?**

There was evidence of effective care delivery in the event of a staff shortage. As discussed in section 4.3 staff were commended for their efforts to ensure patients' needs were met and that no patient was adversely affected by the shortage of staff on the morning of the inspection. . Patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process and both were reviewed as required and that the care planning process included input from patients and/or their representatives, if appropriate.

Staff stated that there was 'effective teamwork'; this was evidenced through discussion and observation of interactions throughout the inspection process. Staff stated they were 'proud' to be a part of their team and to 'make a difference'. Each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the manager.

Effective communication with patients and their relatives was evident on a one to one basis, as recorded in the care records. Patients confirmed that the manager was available to them and knew who the manager was. Relatives meetings had been held on 8 and 21 June 2016. Minutes were available. The manager confirmed that specific and individual concerns were not discussed during the relatives meeting to ensure patient confidentiality.

Two recommendations were stated for a second time in relation to care records.

**Is care compassionate?**

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Patients commented positively regarding the staffs' attitude toward them and described staff as pleasant, kind and caring. 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.

Staff demonstrated a knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. There was evidence throughout the home of a varied programme of activities which was considerate of various levels of participation and interests. Patients spoke highly in relation to the activity therapist and discussion with this staff member confirmed that they had developed a detailed knowledge of patient's needs and wishes since their appointment in March 2016. One patient said they didn't know what they would do without the activity person.

Systems were in place to consult with patients, relatives and staff.

**Is the service well led?**

Concerns were identified specifically in relation to the leadership and management of the home. Based on the inspection findings detailed in the preceding domains it was evident that improvement was needed in relation to accessing the records held on computer in the absence of the manager and the day to day management and leadership of the home. Two requirements were made.

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 Department of Health (DHSSPS) Care Standards for Nursing Homes 2015.

## 1.1 Inspection outcome

| | Requirements | Recommendations |
|---|---|---|
| **Total number of requirements and recommendations made at this inspection** | 5 | 3* |

*Indicates that two of the three recommendations made were stated for the second time.

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

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

## 1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 28 June 2016. Other than those actions detailed in the QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

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

## 2.0 Service details

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| **Registered organisation/registered provider:**<br>Four Seasons Healthcare/<br>Dr Maureen Claire Royston | **Registered manager:**<br>See box below |
| **Person in charge of the home at the time of inspection:**<br>Mr Justin Bradley – interim manager | **Date manager registered:**<br>Ms Maura McIntyre – acting manager |
| **Categories of care:**<br>NH-I, NH-PH, NH-PH(E), NH-TI | **Number of registered places:**<br>40 |

## 3.0 Methods/processes

Prior to inspection we analysed the following information:

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

During the inspection the inspector spoke with 12 patients individually and greeted others in small groups, three care staff, two registered nurses, one catering staff, one member of staff from housekeeping, two relatives, the administrator and the activity therapist.

In addition questionnaires were provided for distribution by the manager; 10 for relatives, eight for patients and 10 for staff. One relative and one patient returned their questionnaires within the timescale for inclusion in this report.

The following information was examined during the inspection:

- two patients' care plans and risk assessments
- eight randomly selected patients' repositioning records
- nursing and care staff roster from 3 to 16 July 2016
- staff training and planner/matrix for 2016
- one staff recruitment record
- complaints record
- record of quality monitoring visits carried out in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- records of audit/governance
- records pertaining to consultation with staff, patients and relatives.

Information was received by RQIA on 28 June 2016 from a relative who raised concerns in relation to the home's management of their loved one's care and the management of their complaints. This information was initially provided to an inspector during the medicines management inspection on 28 June 2016. Advice was provided at the time and assurances given that the home's care inspector would be informed of the concerns raised. The care inspector spoke with the relative, by telephone on 7 July 2016, and confirmed the advice provided in writing. The inspector also met with the relative during this inspection.

It is not the remit of RQIA to investigate complaints or safeguarding allegations made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a potential breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home. The decision was made, by the inspector, that the areas of concern raised by the relative would be reviewed as part of the scheduled unannounced care inspection planned for 13 July 2016.

## 4.0 The inspection

### 4.1 Review of requirements and recommendations from the most recent inspection dated 26 June 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP, when returned to RQIA, will be approved by the pharmacist inspector and validated during the next medicines management inspection.

## 4.2 Review of requirements and recommendations from the last care inspection dated 19 February 2016

| Last care inspection recommendations | | Validation of compliance |
|---|---|---|
| **Recommendation 1**<br><br>**Ref**: Standard 23.3<br><br>**Stated:** First time | Any patient identified as 'at risk' of pressure damage, using a validated tool, should be repositioned in accordance with their care plan and care charts should accurately reflect this. | **Not Met** |
| | **Action taken as confirmed during the inspection**:<br>Review of two patient's care records pertaining to the management of pressure damage evidenced that while nursing staff prescribed 'pressure relieving care' based on the outcome of risk assessments; records did not evidence that care was delivered as planned or monitored by nursing staff to ensure the prescribed care had been delivered.<br><br>This recommendation has not been met and is stated for a second time. | |
| **Recommendation 2**<br><br>**Ref**: Standard 4.9<br><br>**Stated:** First time | Patient records should be recorded contemporaneously to ensure they are accurate and reflective of the care delivered. | **Not Met** |
| | **Action taken as confirmed during the inspection**:<br>Review of eight randomly selected patient records pertaining to repositioning and fluid and food intake evidenced that staff did not record these records at the time of delivery of the care. One staff member stated that charts were usually completed twice a day.<br><br>Review of two patients' charts at 15:20 hours indicated that staff had yet to record the patient's fluid intake. Review of six patients' repositioning charts indicated that four patients had not been repositioned since 07:00 or 08:00 hours.<br>Patients and staff spoken with were able to confirm that food, fluids and repositioning had been provided.<br><br>Discussion with the manager, during feedback, emphasised the impact of poor record keeping.<br><br>This recommendation has not been met and is stated for a second time. | |

## 4.3 Is care safe?

Staffing levels were confirmed at the beginning of the inspection by the deputy manager. Three staff had reported sick for the morning shift and contingency plans were enacted. Two agency staff were secured and they commenced working at approximately 09:00 hours. Staff reporting for duty at 08:00 hours were advised of the situation and directed in the delivery of care by the deputy manager. The manager also came on duty early and assisted patients to get up. Observations confirmed that by 11:00 hours all patients had received their breakfast and assistance to rise, if that was their wish. Medications were also completed by this time. Staff were commended for their efforts.

The manager 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 from 4 May to 17 May 2016 evidenced that the planned staffing levels were adhered to. Where a deficit in staffing was identified in advance, cover for that shift was arranged. The manager said that short notice sick leave had not been a major issue "for a while" and today was unusual. The manager confirmed that the home had a clear policy on the management of staff absence and that staff were made aware of this policy during induction.

The majority of patients spoken with raised concerns about staffing levels being 'short' and staff "being rushed". Two patients described their concern about the turnover of staff and one stated that "you never knew who was coming in to get you up and you had to explain again and again what your needs were – this was exhausting." Two relatives spoken with also raised concerns about the staffing levels. Relatives praised the attitude of staff who were observed to be "working under constant pressure". In the returned questionnaires the relative and patient both raised concerns about staffing as follows:

- "staff seem to be on minimum level. Always rushed and no time to chat"
- "Always seem to be in a rush. Waiting time can be long on buzzing".

As stated previously in section 4.2, review of eight patient records pertaining to repositioning, fluid and food intake evidenced that staff did not record these records at the time of delivery of the care. This was discussed with the manager as it was another indicator that staff were 'working under pressure'. Two recommendations relating to record keeping have been stated for the second time.

RQIA acknowledged that the of delivery of care on 13 July 2016 had been managed effectively, given the short notice sick leave, but patients spoken with were 'not satisfied' with the care provided to them. It was evidenced following discussion with the manager and review of staff duty rotas over a 14 day period, that staffing levels were kept under review to ensure the assessed needs of patients were met. However, management should ensure that concerns raised by patients are managed through the complaints process and records maintained of the action taken in accordance with DHSSPS care standards for nursing homes. A recommendation was 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. New staff were supported through their induction by a dedicated mentor. Review of one staff member's induction record evidenced the induction process. Review of one staff member recruitment file evidenced that the person applied for the post via Four Seasons Health Care (FSHC) online application system. The on line application, printed and held on file did not evidence a full employment history, a satisfactory written explanation of gaps in employment and reasons why the employment or position ended. A requirement has been made. Discussion with the manager and administrator confirmed that there was no information held elsewhere for this person. The file did contain the required pre-employment checks such as two references with one from the last employer and AccessNI check completed prior to the person commencing work.

Review of the training planner/matrix 2016 indicated that training was planned to ensure that mandatory training requirements were met. Staff confirmed that they were required to complete mandatory training through the 'e-learning' portal and by attending 'face to face' training. The manager confirmed that 65% of staff had, so far this year, completed mandatory training. Records for 2015 were not available. Observation of the delivery of care evidenced that training had been embedded into practice. For example, moving and handling practices observed were appropriate.

The manager and 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. Patients and relatives spoken with confirmed that they were assured and confident of the staffs' ability to care for their loved ones, despite the staffing levels. RQIA also reviewed the management of adult safeguarding concerns.

Discussion with the manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff with the Nursing and Midwifery Council (NMC) and care staff the with Northern Ireland Social Care Council (NISCC, was appropriately managed. Safety and medical alerts were reviewed on a regular basis and relevant notices were 'actioned' and/or disseminated to staff as required.

Review of two patients' 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.

Accident and incident analysis were available but the original accident records held on the computer could not be accessed. A requirement was made.

Review of notifications forwarded to RQIA since September 2015 confirmed that these were managed appropriately.

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. Housekeeping staff were commended for their efforts. Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

In relation to infection prevention and control practices, there were no issues in regard to the overall cleanliness of the home as previously stated. The following issues were observed:

- staff wearing jewellery
- staff wearing nail polish
- rusted equipment such as 'sac' holders/bins
- inappropriate storage in high risk areas such as sluice rooms; for example, incontinence products in the sluice room.

Discussion with the manager during feedback confirmed that he had spoken with staff on duty regarding the wearing of jewellery. However, staff should be aware of the home's infection prevention and control policies and procedure and implement these on a daily basis with management ensuring compliance through a monitoring of practices. A requirement was made.

**Areas for improvement**

It was recommended that any expression of dissatisfaction regarding staffing levels or delays in receiving care are addressed with patients and relatives in accordance with DHSSPS care standards for nursing homes: standard 16.

It was required that all information in regard to the selection and recruitment of staff must be obtained prior to the commencement of employment.

It was required that records to be kept in a nursing home are available for inspection.

It was required that staff adhere to infection prevention and control measures to minimise the risk of spread of infection. Records relating to how management monitor compliance should be maintained.

| **Number of requirements** | **3** | **Number of recommendations**: | **1** |
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## 4.4 Is care effective?

As discussed previously in section 4.3 staff were commended for their efforts to ensure patients' needs were met and that no patient was adversely affected by the shortage of staff on the morning of the inspection.

Review of two patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process and both were reviewed as required. For example, records in relation to the management of the risk of developing pressure ulcers indicated that when a patient was identified as being at risk, a care plan was in place to direct staff on the management of this risk. Where applicable, specialist healthcare professionals were involved in prescribing care in relation to the management of wounds.

Review of patients' repositioning records evidenced that while nursing staff prescribed 'pressure relieving care' based on the outcome of risk assessments; records did not evidence that care was delivered as planned or that nursing staff monitored the records to ensure the prescribed care had been delivered. A recommendation regarding this has been stated for a second time. Refer to section 4.2.

Review of food and fluid intake records evidenced that records were not maintained in accordance with best practice guidance, care standards and legislative requirements. As stated in section 4.2 and 4.3. A recommendation has been stated for a second time.

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. Relatives confirmed that they were kept informed of any changes in their loved ones' care.

Observations evidenced that call bells were answered promptly and patients requesting assistance in one of the lounge areas or their bedrooms were responded to in a calm, quiet and caring manner.

Staff confirmed that they were kept informed of changes or concerns regarding patients' needs through the handover reports at the beginning of their shift. Staff also confirmed that a staff meeting had been held earlier in the year. Minutes confirmed a general staff meeting had been held on 16 March 2016. RQIA acknowledge that because of the 'acting' management arrangements meetings had not been held regularly due to the changes in manager. This will be reviewed again during the next inspection.

Staff stated that there was 'effective teamwork'; this was evidenced through discussion and observation of interactions throughout the inspection process. Staff stated they were 'proud' to be a part of their team and to 'make a difference'. Each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

Effective communication with patients and their representatives was evident on a one to one basis as recorded in the care records and through observations of interactions. Patients confirmed that the manager was available to them and knew who the manager was. One patient during the lunchtime meal stated that they didn't know who the manager was but when the inspector pointed out the manager the patient said "I know him – he got me up this morning and talks to me every day". The manager was able to confirm that complaints had been received regarding a specific communication issue and that responses had been made to the individual concerned. RQIA were satisfied that the complaint was being managed appropriately by the home in accordance with the Department of Health's procedure.

Relatives' meetings had been held on 8 and 21 June 2016. Minutes were available. The manager confirmed that specific and individual concerns were not discussed during the relatives' meetings to ensure patient confidentiality.

**Areas for improvement**

There were no new areas for improvement identified. Two recommendation regarding records were stated for a second time. Refer to section 4.2.

| **Number of requirements** | **0** | **Number of recommendations**: | **0** |
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## 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. Patients did raise concern about staffing levels as discussed previously in section 4.3; however, patients commented positively regarding the staffs' attitude toward them and described staff as pleasant, kind and caring. 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.

Staff demonstrated a knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. There was evidence throughout the home of a varied programme of activities which was considerate of various levels of participation and interests. Patients spoke highly in relation to the activity therapist and discussion with this staff member confirmed that they had developed a detailed knowledge of patient's needs and wishes since their appointment in March 2016. One patient said they didn't know what they would do without the activity person.

Discussion with the manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. For example, patients, relatives, visitors to the home and staff were invited to provide feedback on an ongoing basis through a Quality of Life (QOL) computerised system. Questions asked were in relation to satisfaction levels with the care and general services provided. Views and comments recorded were analysed and if required an action plan was developed and shared with staff, patients and relatives. However, the manager was unable to access the records to validate the comments recorded and management responses to this consultation. Refer to section 4.6 for details of requirement made regarding access to records.

In addition to speaking with patients, relatives and staff RQIA provided questionnaires. At the time of writing this report one relative and one patient had retuned their questionnaires within the timescale for inclusion in this report.

The patient indicated that they found the care provided to be very satisifactory in relation to the the four domains. Comments recorded were in relation to staffing levels as discussed in section 4.3.

The relative indicated the same responses as the patient and raised concerns also regarding staffing levels referred to in section 4.3.

**Areas for improvement**

No new areas for improvement were identified during the inspection.

| Number of requirements | 0 | Number of recommendations: | 0 |
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## 4.6 Is the service well led?

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. Staff confidently described their role and responsibility in the home. In discussion, patients were aware of the roles of the staff in the home and to whom they should speak to if they had a concern. However, there was concern raised that the home did not have a permanent manager and some patients had raised concerns about staffing levels and staff turnover. Refer to section 4.3. A recommendation was made that expressions of dissatisfaction with staffing levels should be recorded as part of the complaint process.

Discussion with the manager confirmed that one specific complaint had been responded to, as previously described in section 4.4. Records to indicate the number of complaints received by the home and the action taken to address the concerns raised were not available. A requirement has been made previously in section 4.3.

Staff were knowledgeable of adult safeguarding processes commensurate with their role and function. Discussion with the manager and review of the available records evidenced that systems were in place to ensure that notifiable events, complaints, and/or potential adult safeguarding concerns were investigated and reported to RQIA or other relevant bodies appropriately. However, as previously stated, not all of the records required to be maintained in the home were available for inspection and a requirement was made.

Reports were available in the home of visits carried out on behalf of the responsible individual, in accordance with The Nursing Homes Regulations (Northern Ireland) 20015: regulation 29. Review of the reports dated from April 2016 confirmed that visits were unannounced, reviewed the quality of care and reviewed areas for improvement raised as a result of external inspections such as RQIA or those areas identified by the person undertaking the previous visit. 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.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were notified appropriately.

There was an effective system in place to ensure nursing staff were registered with the nursing and Midwifery Council; and that care staff were registered with the Northern Ireland Social Care Council (NISCC). New care staff not registered with NISCC were required and supported to register.

The registration certificate was up to date and displayed appropriately. A valid certificate of public liability insurance was current and displayed.

Discussion with the manager and observations evidenced that the home was operating within its registered categories of care.

Based on the inspection findings, detailed in the preceding domains it was evident that improvement was needed in relation to accessing the records held on computer in the absence of the manager. The current 'interim' manager confirmed that he had not received training in how to access the QOL and other computerised records. This was concerning and a requirement was made.

In addition, during discussion with a regional manager, who was asked to call to the home during the inspection, the concern was raised that RQIA had not been informed of the previous acting manager's resignation who left the home on 1 July 2016. A requirement was made.

In considering the findings from this inspection and the requirements and recommednations made and two recommendations stated for a second time; this would indicate the need for more robust management and leadership in the home.

**Areas for improvement**

It was required that any registered nurse given the responsibility of being in charge of the home, and in particular as 'acting' or 'interim' manager should be competent and capable to do so; this must include being able to access and use the computerised systems and processes to enable that person to respond to requests for information by the Regulator.

It was required that the responsible person notify RQIA of the proposed absence of the manager/registered manager in accordance with the Nursing Homes Regulations (Northern Ireland) 2005 - regulation 32.

| **Number of requirements** | **2** | **Number of recommendations**: | **0** |
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## 5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mr Justin Bradley, interim manager, as part of the inspection process. The timescales commence from the date of inspection.

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

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

## 5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on 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 may enhance service, quality and delivery.

## 5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for review 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

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| **Statutory requirements** | |
| **Requirement 1**<br><br>**Ref**: Regulation 21<br><br>**Stated:** First time<br><br>**To be completed by:**<br>31 August 2016 | The registered provider must ensure that all of the information required in relation to the selection and recruitment of staff is obtained prior to the commencement of employment.<br><br>**Ref: Section 4.3 and 4.6** |
| | **Response by registered provider detailing the actions taken:**<br>Home Manager and Home Administrator currently reviewing all personnel files to ensure that Application Forms have been completed, which will include all relevant information pertaining to employment history. Where an application is not on file staff will be asked to complete. The Home Manager will ensure that all future candidates applying for positions within the home have completed a FSHC Application Form. |
| **Requirement 2**<br><br>**Ref**: Regulation 19 (1) (a) and (2) Schedules 3 and 4<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate action required | The registered provider must ensure that records to be kept in the nursing home are available for inspection.<br><br>**Ref: Section 4.3 and 4.6** |
| | **Response by registered provider detailing the actions taken:**<br>The Nurse in Charge of the Nursing Home in the Home Managers absence will have access to all of the records the visiting RQIA Inspector requires.<br>The Home Manager is currently undertaking supervision with all nursing staff which will support and inform them of the inspection process and how to locate the information the inspector will request during the visit. |
| **Requirement 3**<br><br>**Ref**: Regulation 13 (7)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate action required | The registered provider must ensure that staff adhere to infection prevention and control measures to minimise the risk of spread of infection. Records relating to how management monitor compliance should be maintained.<br><br>**Ref: Section 4.3 and 4.6** |
| | **Response by registered provider detailing the actions taken:**<br>Staff have been advised of FSHC Infection Control and Prevention Polices and Procedures with emphasis on Uniform Policy. All staff currently updating e learning module on Infection Control.<br>The Home Manager will monitor during daily walk which is an intergal component of FSHC Quality of Life Audit process.<br><br>Home Manager has reviewed with Maintenance Man all sac holders/bins and where necessary repaired/replaced.<br><br>Items inappropriately stored in sluice rooms have been removed, this will be monitored by Home Manager . |

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| **Requirement 4**<br><br>**Ref**: Regulation 20 (3)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate action required | The registered provider must ensure that any registered nurse given the responsibility of being in charge of the home, and in particular as 'acting' or 'interim' manager, should be competent and capable to do so.<br><br>This must include being able to access and use the computerised systems and processes to enable that person to respond to requests for information from the regulator.<br><br>**Ref: Section 4.6** |
| | **Response by registered provider detailing the actions taken:**<br>Home Manager will continue to undertake nurse competency assessments for those staff who are designated in charge in the Home Managers absence. As some information required by the inspector can only be accessed via Home Managers computer and is password protected, the Regional Manager will be advised of any requests for information and provide same. |
| **Requirement 5**<br><br>**Ref**: Regulations 32<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate action required | It was required that the responsible person notify RQIA of the purposed absence of the registered manager/manager in accordance with the Nursing Homes Regulations (Northern Ireland) 2005 - regulation 32.<br><br>**Ref: Section 4.6** |
| | **Response by registered provider detailing the actions taken:**<br>Regional Office had notified ,in writing the RQIA on the 3rd May 2016 that the current Home Manager had resigned and the date of her last working day, however a Notification of Absence had not been forwarded to the RQIA.<br><br>Regional Office will ensure that this is completed in future. |
| **Recommendations** | |
| **Recommendation 1**<br><br>**Ref**: Standard 23.3<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>31 August 2016 | Any patient identified as 'at risk' of pressure damage, using a validated tool, should be repositioned in accordance with their care plan and care charts should accurately reflect this.<br><br>**Ref: Section 4.2 4.3, 4.4 and 4.6** |
| | **Response by registered provider detailing the actions taken:**<br>Home Manager has implemented a robust audit process which requires nursing staff to randomly select resident charts on a daily basis to ensure that repositioning is occuring as prescribed.<br><br>Home Manager will also as part of daily walk about continue to audit care records daily.<br><br>The recording and importance of clinical records was also discussed at length during a recent staff meeting. |

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| **Recommendation 2**<br><br>**Ref**: Standard 4.9<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>31 August 2016 | Patient records should be recorded contemporaneously to ensure they are accurate and reflective of the care delivered.<br><br>**Ref: Section 4.2, 4.3, 4.4 and 4.6** |
| | **Response by registered provider detailing the actions taken:**<br>Staff have been informed of the requirement that records are completed at the time of the care intervention, as stated Nursing Staff and Home Manager continue to audit compliance daily.<br><br>Home Manager is currently reviewing all care records, including location and storeage of same. |
| **Recommendation 3**<br><br>**Ref**: Standard 16<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate action required | The registered provider should ensure that any expression of dissatisfaction regarding staffing levels or delays in receiving care are addressed with patients and relatives in accordance with DHSSPS care standards for nursing homes: standard 16.<br><br>**Ref: Section 4.3 and 4.6** |
| | **Response by registered provider detailing the actions taken:**<br>Any expression of dissatisfaction will be addressed in accordance with FSHC Complaints Procedure.<br><br>Home Manager has reiterated to staff the procedure to follow should a service user express dissatisfaction with any area of service/care delivery, this will include recording on Datix, and informing Home Manager verbally, and via 24hr Shift Report. |

***Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address***

The Regulation and Quality Improvement Authority

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