Unannounced Primary Inspection

Name of establishment:	**Carryduff Nursing Home**
Establishment ID No:	**1068**
Date of inspection:	**17 July 2014**
Inspector's name:	**Loretto Fegan**
Inspection No:	**17101**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of home:	Carryduff Nursing Home
Address:	19 Church Road Carryduff BT8 8DT
Telephone number:	(028) 90814862
E mail address:	linda.kelly@adad.co.uk
Registered organisation/ Registered provider / Responsible individual	Mr Edwin Samuel Johnston & Mr Gerald William Beattie
Registered manager:	Mrs Linda Kelly
Person in charge of the home at the time of inspection:	Registered Nurse J Matthew
Categories of care:	NH-I ,NH-PH ,NH-PH(E) ,NH-TI
Number of registered places:	23
Number of patients accommodated on day of inspection:	21
Scale of charges (per week):	£581 - £617
Date and type of previous inspection:	22 January 2014, Primary unannounced care inspection
Date and time of inspection:	17 July 2014 10.00 – 19.00 hours
Name of inspector:	Loretto Fegan

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year is required.

This is a report of an unannounced primary care inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were met.

3.0 Purpose of the inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008).

Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/Process

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the DHSSPS Nursing Homes Minimum Standards 2008.

The inspection process has three key parts; self-assessment (including completion of self- declaration), pre-inspection analysis and inspection visit by the inspector.

Specific methods/processes used in this inspection include the following:

- analysis of pre-inspection information
- discussion with the registered nurse in charge

- observation of care delivery and care practices
- discussion with staff
- examination of records
- consultation with patients individually and with others in groups
- consultation with relatives
- tour of the premises
- evaluation and feedback.

Any other information received by RQIA about this registered provider has also been considered by the inspector in preparing for this inspection.

5.0 Consultation Process

During the course of the inspection, the inspector spoke with:

Patients	**8**
Staff	**5**
Relatives	**2**
Visiting Professionals	**0**

Questionnaires were provided, during the inspection, to patients, their representatives and staff seeking their views regarding the service. Matters raised from the questionnaires were addressed by the inspector either during the course of this inspection or following the inspection.

Issued To	**Number issued**	**Number returned**
Patients / Residents	**4 completed as part of an interview**	**4**
Relatives / Representatives	**1completed as part of an interview**	**1**
Staff	**7+ 1completed as part of an interview**	**2**

6.0 Inspection Focus

The inspection sought to establish the level of compliance achieved regarding the selected DHSSPS Nursing Homes Minimum Standards.

Criteria from the following standards are included;

- management of nursing care – Standard 5
- management of wounds and pressure ulcers –Standard 11

- management of nutritional needs and weight Loss – Standard 8 and 12
- management of dehydration – Standard 12

An assessment on the progress of the issues raised during and since the previous inspection was also undertaken.

The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.

The registered persons and the inspector have rated the home's compliance level against each criterion of the standard and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Guidance - Compliance statements	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of service

Carryduff Nursing Home is situated on Church Road, Carryduff.

The nursing home is owned and operated by Mr Edwin Samuel Johnston & Mr Gerald William Beattie.

Mrs L Kelly is the registered manager in the home for the past eight years.

Accommodation for patients is provided in 13 single and 5 double bedrooms located on both floors of the home. Some of the single bedrooms also have ensuite facilities.

Access to the first floor is via a passenger lift and stairs.

Communal lounge and dining areas are provided on both floors of the home. A number of communal sanitary facilities are available throughout the home.

The home also provides for catering and laundry services on the ground floor.

There is a small veranda area to the rear of the home with limited car parking facilities available.

The home is situated, close to shops and all local amenities.

The home is registered to provide care for a maximum of 23 persons under the following categories of care:

Nursing Care

I	Old age not falling into any other category
PH	Physical disability other than sensory impairment under 65
PH (E)	Physical disability other than sensory impairment over 65 years
TI	Terminally ill

8.0 Summary of Inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Carryduff Nursing Home. The inspection was undertaken by Loretto Fegan on 17 July 2014 from 10.00 to 19.00 hours.

The inspector was welcomed into the home by registered nurse J Matthew, who was in charge of the home in the absence of the registered manager and was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to registered nurse J Matthew at the conclusion of the inspection. A written summary of urgent actions required was also provided. Mrs L Kelly, registered manager, subsequently provided correspondence to RQIA as an outcome of inspection issues identified as requiring urgent action. The inspection findings and a safeguarding issue were discussed with Mrs L Kelly post inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. The completed self-assessment was received by RQIA on 7 May 2014.

The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector met with patients, staff and relatives. The inspector observed care practices, examined a selection of records, issued patient, staff and representative questionnaires and carried out a general inspection of the nursing home environment as part of the inspection process.

The inspector also spent a number of extended periods observing staff and patient interaction. Discussions and questionnaires are unlikely to capture the true experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help the inspector build up a picture of patient care experience. These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool was designed to help evaluate the type and quality of communication which takes place in the nursing home.

Good relationships were evident between staff and patients, and communication demonstrated that patients were treated courteously and with dignity and respect. Patients and relatives expressed high levels of satisfaction with the standard of care provided in the home. Further detail regarding patient experience can be found in section 11 of the report.

As a result of the previous inspection conducted on 22 January 2014, six requirements and six recommendations were issued. These were reviewed during this inspection. The inspector evidenced that three requirements and two recommendations had been fully complied with. A further three requirements and two recommendations were found to be substantially compliant; however, specific aspects of one of the requirements and recommendations were not validated on this occasion. The remaining two recommendations were moving towards compliance. Details can be viewed in the section immediately following this summary.

Standards inspected:

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed. (Selected criteria)

Standard 8: Nutritional needs of patients are met. (selected criteria)

Standard 11: Prevention and treatment of pressure ulcers. (selected criteria)

Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (selected criteria).

Inspection findings

- **Management of nursing care – Standard 5**

The inspector can confirm that at the time of the inspection there was evidence to validate that patients received safe and effective care in Carryduff Nursing Home.

There was evidence of comprehensive and detailed assessment of patient needs from the date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patient need was evidenced to inform the care planning process.

Comprehensive reviews of both the assessments of need, the risk assessments and the care plans were maintained on a regular basis and as required. A requirement was made in relation to specific care planning issues identified.

There was also evidence that the referring health and social care trust (HSCT) maintained appropriate reviews of the patient's satisfaction with the placement in the home, the quality of care delivered and the services provided.

- **Management of wounds and pressure ulcers – Standard 11 (selected criteria)**

The inspector was informed by the registered nurse that there were no patients with wounds in the home.

Care plans for the management of risks of developing pressure ulcers were in place. However, it was identified that they need to include the specific type of pressure reducing / relieving equipment and the frequency of repositioning the patient in accordance with assessed need. A repositioning chart should also be put in place for one identified patient. A requirement has been stated for the second time in this regard.

- **Management of nutritional needs and weight loss – Standard 8 and 12 (selected criteria)**

The inspector reviewed the management of nutrition and weight loss within the home.

Robust systems were evidenced with risk assessments and appropriate referrals to General Practitioners (GP's), speech and language therapists (SALT) and or dieticians being made as required.

The inspector also observed the serving of the lunch time meal and can confirm that the meal service was well managed. Patients were observed to be assisted with dignity and respect throughout the meal. A requirement was made in relation to the recording of dietary intake.

- **Management of dehydration – Standard 12 (selected criteria)**

The inspector examined the management of dehydration during the inspection which evidenced that fluid requirements and intake details for patients were in the main well recorded for those patients assessed at risk of dehydration.

Patients were observed to be able to access fluids with ease throughout the inspection. Staff were observed offering patients additional fluids throughout the inspection. Fresh drinking water / various cordials were available to patients in lounges, dining rooms and bedrooms. A requirement was made in relation to the recording of fluids.

The inspector can confirm that based on the evidence reviewed, presented and observed; that the level of compliance with the standards inspected was substantially compliant.

Patient, representatives and staff questionnaires

Patients, representatives and staff who completed questionnaires or spoke with the inspector indicated that they were satisfied with the care provided in the home.

Some comments received from patients and their representatives:

"couldn't wish for better, all staff very kind"
"very happy with the care my relative receives"

Further detail can be found in section 11 of the report.

A number of additional areas were also examined.

- records required to be held in the nursing home
- Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)
- patient and staff quality of interactions (QUIS)
- complaints
- patient finance pre-inspection questionnaire
- NMC declaration
- staffing and staff comments
- comments from representatives/relatives
- environment

Full details of the findings of inspection are contained in section 11 of the report.

Conclusion

The inspector can confirm that at the time of this inspection the delivery of care to patients was evidenced to be of a good standard. In the main, there were processes in place to ensure the effective management of the themes inspected.

The home's general environment was well maintained and patients were observed to be treated with dignity and respect. However, areas for improvement were identified in relation to: care records; training; policy / procedure development; reporting of accidents/ incidents and an alleged event pertaining to safeguarding; recording of food and fluid intake and the availability of evidence based / best practice literature in relation to Human Rights legislation and the use of restraint.

Therefore, four requirements and three recommendations are made as a result of this inspection together with three restated requirements and four restated recommendations. These requirements and recommendations are detailed throughout the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, relatives, registered manager, registered nurse in charge and staff for their assistance and co-operation throughout the inspection process.

The inspector would also like to thank the patients, relatives and staff who completed questionnaires / participated in this process.

9.0 Follow-up on the requirements and recommendations issued as a result of the previous inspection on 22 January 2014

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1.	20 (1)	The registered person must ensure that suitably qualified, competent and experienced persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients. • The registered person must review the staffing arrangements for night duty and ensure they are increased to achieve the staffing ratios for the numbers of patients accommodated. • Analyse the patient dependency level using the Rhys Hearn framework to determine the required nursing hours and address any deficits. • The registered manager should differentiate on the duty rota when undertaking management or direct care nursing duties. • A formalised contingency plan should be put in place to ensure safe and effective care in the	The inspector examined duty rotas spanning a three week period and requested that one further weeks' duty rota with the corresponding patients' assessed dependency levels using the Rhys Hearn framework would be submitted for analysis to RQIA. The registered manager submitted this information to RQIA which indicated that the staffing arrangement met RQIA's recommended minimum staffing guidance for nursing homes for the number of patients currently accommodated in the home. The duty rota identified when the registered manager was undertaking management or direct care nursing duties. On returning the quality improvement plan in response to the unannounced primary care inspection on 22 January 2014, the registered manager provided confirmation of a contingency plan to ensure safe and effective care in the event of an emergency arising when only one registered nurse is on duty. The registered nurse on duty was aware	Compliant

		event of an emergency arising when only one registered nurse is on duty.	of this arrangement on the day of inspection.	
2	16 (2)	The registered person must ensure that care plans are kept under review and the following information is recorded : • Care plans for continence management should include specific information regarding the product in use • Care plans should include the specific moving and handling equipment used • Care plans should be in place in relation to the prevention of pressure ulcers for patients in accordance with assessed need • A daily repositioning / skin inspection chart should be put in place for patients with a wound or at risk of pressure damage • Ensure Care Plans which include a Do Not Resuscitate" (DNR) order, are completed in accordance with evidenced	The inspector reviewed specific aspects of three care records in relation to this requirement. All three records examined had a continence assessment in place and specific information regarding the product in use was recorded. There was evidence that where specific moving and handling equipment was used, this was recorded in the care plan. Examination of one relevant care plan evidenced that a" Do Not Resuscitate" (DNR) order, was completed in accordance with evidenced based nursing practice. Care plans were in place in relation to the prevention of pressure ulcers for patients, however these should be further developed to include the type of pressure relieving / reducing equipment used and the frequency of re-positioning the patient. A daily repositioning / skin inspection chart was in place for one patient deemed at risk of pressure damage,	Substantially compliant

		based nursing practice.	however this was not in place for another patient assessed as “at risk” of pressure ulcers. The registered nurse in charge advised the inspector that there were no patients with wounds. The aspects of this requirement pertaining to the development of care plans in relation to the prevention of pressure ulcers and the implementation of a daily repositioning / skin inspection chart will be stated for the second time and compliance followed up during the next care inspection.	
3	20(1)(c)(i)	The registered person must provide confirmation to RQIA that **all** staff have completed the required mandatory traini and or training updates.	The nurse in charge provided the inspector with a hard copy of the staff mandatory training record which indicated that the majority of staff had received the required mandatory training. Registered Nurse Matthews advised that ongoing mandatory training was provided since the date of the print out and the correct version was recorded electronically, however she did not have access to this information. The staff training matrix was subsequently submitted to RQIA by the registered manager. While the inspector acknowledges that there was evidence of significant ongoing provision of mandatory training, there were some staff members who had not attended specific training within the past year. It	Substantially compliant

			was also observed that some staff listed on the duty rota were not included in the staff training matrix. The registered manager advised that these staff were officially employed in other homes within the company. The registered manager must evidence that all staff working in the home, including those redeployed from other homes within the company have their mandatory training requirements up to date. **This requirement is raised for a third and final time. Further non-compliance will lead to enhanced enforcement action.**	
4	29 (4) (c)	The registered person must ensure that: • a written report is available for inspection in respect of all monthly visits undertaken • the identity of patients, visitors and staff is anonymised in the reports • the nominated person's opinion of the standard of nursing provided in the home should be robustly evidenced in the report	The inspector requested to view the three most recent reports in respect of all monthly visits undertaken . The most recent report available at the time of inspection was dated 29 April 2014. The registered manager subsequently provided evidence to RQIA which confirmed that a report is available for all monthly visits undertaken. Review of three reports evidenced that patients, visitors and staff were not identified. The nominated person's opinion of the standard of nursing provided in the home was also evidenced in the reports.	Compliant

5	14 (4)	The registered person shall make arrangements by training staff or by other measures, to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse by ensuring that • all staff receive an annual update in Safeguarding Vulnerable Adults • all staff receive training in relation to the management of restraint • complaints are assessed in accordance with regional guidelines (SOVA), to ensure any safeguarding issue/s contained therein are referred to the designated officer in the Trust in an appropriate and timely manner.	The nurse in charge provided the inspector with a hard copy of the staff mandatory training record. This indicated that with the exception of two staff, and a staff member who was on long term leave, all other staff had received an annual update in Safeguarding Vulnerable Adults. The staff training matrix was subsequently submitted to RQIA by the registered manager and the information on this concurred with the findings on the day of inspection. However, as some staff listed on the duty rota were not included in the staff training matrix, an assurance is required that all staff working in the home, including those redeployed from other homes in the company have undertaken an annual update in Safeguarding Vulnerable Adults. This aspect of the requirement will be stated for the second time and compliance followed up during the next care inspection. With regard to training on restraint, the registered manager has advised that this will be included in the “Challenging Behaviour” training which is arranged to take place in the home on 11th September and 14th October 2014. The relevant training programme was not available for inspection. This aspect of the requirement will be stated for the	Substantially compliant and part of the requirement was not validated on this occasion

			second time and compliance followed up during the next care inspection. The inspector reviewed the record of complaints and there were no safeguarding issues identified. As this part of the requirement was not validated by the inspector on this occasion, it will be carried forward and compliance followed up during the next care inspection.	
6	15 (2)	The registered person shall ensure that the assessment of the patient's needs is; (a) kept under review; and (b) revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually, by ensuring • a bedrail risk assessment is undertaken in respect of the identified patient, • a fall risk assessment is undertaken in respect of two identified patients	The inspector examined two care records in this regard and can confirm that a bedrail risk assessment was undertaken prior to using bedrails. A falls risk assessment was also completed.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	5.1	The registered manager should ensure that • patients diagnosed with dementia have a cognitive assessment completed • a body map is completed on each patients' admission to the nursing home • a validated pain assessment tool is in use for any patients on prescribed analgesia.	The inspector can confirm the following: • a cognitive assessment was completed with regard to a patient diagnosed with dementia • a record evidenced that since the last inspection, a body map was completed on the patient's admission to the nursing home • a validated pain assessment tool was in use for patients on prescribed analgesia as evidenced in three care records examined.	Compliant
2	5.2	The registered manager should audit care records of newly admitted patients following the 11 day timescale to enable improvements to be identified in a timely manner.	The registered nurse informed the inspector that these audits were undertaken by the registered manager and that a copy was retained in the patient's nursing records. However, on the day of inspection, there was no evidence available in the three records examined. This recommendation will be stated for the third time and compliance followed	Moving towards compliance

			up during the next care inspection.	
3	25.13	It is recommended that: • an annual quality report is compiled on the overall services provided in the home	An annual quality report was submitted to RQIA by the registered manager following the inspection.	Compliant
4	16.1 & 16.3	It is recommended that in relation to safeguarding vulnerable adults: • policies and procedures (including the flow-chart) are revised to fully reflect and reference all DHSSPS guidance, regional protocols (N Ireland) and local procedures issued by the Health and Social Care Trusts (HSCT). • the competency and capability assessments completed for all nurses taking charge of the home includes the action to be taken in the event of an allegation of abuse • guidance documents in relation to the safeguarding of vulnerable adults should be sourced and made available to staff	The inspector examined the policy in relation to safeguarding vulnerable adults that was provided by the registered nurse on duty. The review date on these policies was March 2011. The registered manager subsequently forwarded the home's policy to RQIA in relation to safeguarding vulnerable adults. This requires revision to fully reflect and reference all DHSSPS guidance, regional protocols (N Ireland) and local procedures issued by the Health and Social Care Trusts (HSCT). This aspect of the recommendation will be stated for the second time and compliance followed up during the next care inspection. There was a flow-chart placed on the noticeboard as a quick reference guide for registered nurses which identified key aspects with regard to safeguarding vulnerable adults' regional and local procedures.	Substantially compliant / some aspects not validated

		• the SOVA training programme contains the relevant DHSSPS guidance, regional protocols and local Trust procedures • all staff are aware of the whistleblowing policy	As the registered manager was not on duty on the day of inspection, the records pertaining to the competency and capability assessments completed for all nurses taking charge of the home or the SOVA training programme were not available to examine. However, the registered nurse confirmed that the competency and capability assessment that she undertook, included the action to be taken in the event of an allegation of abuse. Guidance documents in relation to the safeguarding of vulnerable adults were available to staff, therefore this part of the recommendation was compliant. All four staff whom the inspector asked were aware of the whistleblowing policy, therefore this part of the recommendation was compliant. Aspects of this recommendation not validated in relation to competency and capability assessments and the training programme will be followed up during the next care inspection.	

5	10.7	It is recommended that evidence based documents in relation to restraint • are available for ease of reference by staff • are incorporated / referenced in the home's associated policies/ procedures • are incorporated / referenced in the relevant training programme	Further to discussion with the registered nurse in charge, there was no evidence available on the day of inspection that evidence based documents in relation to restraint: • were available for ease of reference by staff • were incorporated / referenced in the home's associated policies/ procedures • were incorporated / referenced in the relevant training programme The registered manager has subsequently advised that the use of restraint will be incorporated into the challenging behaviour training from September 2014 onwards, This recommendation will be stated for the second time and compliance followed up during the next care inspection.	Moving towards compliance

6	5.3 & 11.7	It is recommended that: • all registered nurses undertake wound care training and their competency is assessed to ensure training has been embedded into practice. • all care staff complete training in relation to pressure area care and the prevention of pressure ulcers and their competency is assessed to ensure training has been embedded into practice. Confirm percentage of staff who have attended the above training when returning the QIP	The inspector examined the training record available on the day of inspection and discussed this recommendation with the registered nurse in charge. From the training records available, there was no evidence with regard to registered nurses undertaking wound care training or competency assessment in relation to this aspect of care. However, the registered nurse in charge advised that she had undertaken this training in recent months. The training records indicated that with the exception of two, all care staff had completed training in relation to pressure area care and the prevention of pressure ulcers, although there was no documented evidence with regard to how their competency was assessed. This recommendation will be stated for the second time and compliance followed up during the next care inspection.	Substantially compliant

9.1 Follow up on any issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

It is not the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if there is considered to be a breach of regulation as stated in the Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

RQIA have been informed by the adult safeguarding team from the Belfast Healthcare Trust of an ongoing investigation in relation to an alleged abuse issue in the home; RQIA are not part of this investigatory process. As notification was not submitted from the home regarding this matter to RQIA or NISCC in a timely manner, discussion took place with the registered manager regarding these concerns and requirements were made in this regard.

During the inspection, the inspector reviewed a sample of accidents / incidents recorded by the home. The inspector requested that one event recorded should be referred to the local HSC Trust to be considered under the safeguarding procedure and reported to RQIA in accordance with legislation. Requirements are made in this regard. Confirmation has been received by RQIA from the registered manager that this correspondence has taken place following the inspection.

10.0 Inspection Findings

Section A

Standard 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment** **Standard 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission** **Standard 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent** **Standard 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.**
Inspection Findings:
Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Nursing Homes Minimum Standards (2008). The inspector reviewed three patients' care records which evidenced that patients' individual needs were established on the day of admission to the nursing home through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks. Specific assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart, pain and continence were also completed on admission. A body mapping chart was also completed on admission to the home. Review of three patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within

11 days of patient's admission to the home. In discussion with the registered nurse in charge, she demonstrated a good awareness of patients who were assessed as being at risk of pressure ulcers, weight loss and dehydration. Registered nurse J Matthew confirmed that no patients had wounds at the time of the inspection.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section B

Standard 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Standard 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Standard 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Standard 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration** **Standard 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.**
Review of three patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Records also evidenced discussion with patients and/or their representatives following changes to the plans of care. Discussion with the registered nurse and review of two patients' care records confirmed that where a patient was assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention and treatment programme. However, it was identified that this needs to include the specific type of pressure reducing / relieving equipment and the frequency of repositioning the patient in accordance with assessed need. A repositioning chart should also be put in place for one identified patient. Review of the other patient's repositioning chart evidenced that the patient's skin condition was inspected at each positional change.

As agreed with the registered nurse who reviewed the care records with the inspector, the following care planning issues should also be addressed:

- Care plans on pain management should be in place for all three identified patients in response to the findings of the pain assessments undertaken.
- Care plans should have been reviewed in light of new assessment details in respect of one patient
- A care plan should be put in place regarding the use of bedrails, management of continence, and with regard to a newly prescribed medication for one identified patient

The registered nurse informed the inspector that there were no patients in the home who required wound management.

The registered manager confirmed in the self- assessment submitted that there were referral procedures in place to obtain advice and guidance from tissue viability specialists in the local healthcare Trust. The registered nurse on duty on the day of inspection was knowledgeable regarding the referral process and of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

The patients' weights were recorded on admission and on at least a monthly basis or more often if required.

The patients' nutritional status was also reviewed on at least a monthly basis or more often if required.

Daily records were maintained regarding the patient's daily food and fluid intake, however two patients' care plans should specify the amount of fluids required and fluid intake should be totalled for evaluation purposes over the 24 hour period.

Policies and procedures were in place for staff on making referrals to the dietician. The registered nurse on duty was knowledgeable regarding the referral criteria for a dietetic assessment.

Review of care records for one patient evidenced that the patient was referred for a dietetic assessment in a timely manner. This patient was also referred to the speech and language therapist. The patient's care plan however was not reviewed to incorporate the dietician's or speech and language therapist's recommendations in relation to the consistency of food and fluid and type of nutritional supplements prescribed.

Review of the self – assessment completed by the registered manager and discussion with the registered nurse and two care assistant on duty indicated that staff training was ongoing in relation to the care associated with patients who have swallowing difficulties. However, the inspector was unable to confirm the total number of registered nurses and care staff who have received this training commensurate with their role and also in relation to the management of nutrition. It is recommended that all staff receive training in this regard. The registered manager is asked to confirm this information when returning the quality improvement plan (QIP).

Patients' moving and handling needs were assessed and addressed in their care plans. There was evidence that equipment such as a hoist was used to minimise the risk of friction. There were no issues identified during the inspection regarding moving and handling practices.

The registered nurse informed the inspector that pressure ulcers if present were graded using an evidenced based classification system.

A requirement is made in regard to shortfalls in patients' care records inspected and a recommendation is made in relation to dysphagia and the management of nutrition training.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

Section C

Standard 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Homes Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**
Review of three patients' care records evidenced that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care for each patient. Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required, however one patient's care plan was not evaluated during May 2014. Review of care records also evidenced that nutritional care plans for patients were reviewed monthly or more often as deemed appropriate. The evaluation process included the effectiveness of any prescribed treatments, for example prescribed analgesia. Care records should be audited on a monthly basis and provide evidence that action was taken to address any deficits or areas for improvement identified through the audit process. This issue was raised in section 9.0 and a recommendation was stated for the third time in this regard.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

Section D

Standard 5.5

- **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.**

Standard 11.4

- **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.**

Standard 8.4

- **There are up to date nutritional guidelines that are in use by staff on a daily basis.**

Nursing Homes Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)

The inspector examined three patients' care records which evidenced the completion of validated assessment tools such as;

- the Roper, Logan and Tierney assessment of activities of daily living
- Braden pressure risk assessment tool
- Nutritional risk assessment such as Malnutrition Universal Screening Tool (MUST)

The inspector confirmed the following research and guidance documents were available in the home;

- DHSSPS 'Promoting Good Nutrition' A Strategy for good nutritional care in adults in all care settings in Northern Ireland 2011-16
- The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.
- The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care
- The European Pressure Ulcer Advisory Panel (EPUAP)
- .

Discussion with the registered nurse confirmed that she had a good awareness of these guidelines and was knowledgeable regarding the individual dietary needs and preference of patients and the principles of providing good nutritional care.

Two care staff consulted were knowledgeable regarding the specific support required by patients with regard to eating and drinking. The cook was also aware of patients who had specific dietary requirements.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section E

Standard 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Standard 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Standard 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.**
A policy / procedure relating to nursing records management was available in the home. Review of this policy evidenced that it broadly reflected The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance, however requires review. The registered nurse on duty was aware of her accountability and responsibility regarding record keeping. A review of the training records available on the day of inspection did not confirm that staff had received training on the importance of record keeping commensurate with their roles and responsibilities in the home. As the registered nurse was unsure if this had taken place, it was recommended that the registered manager would provide confirmation in this regard when returning the QIP. Review of three patients' care records revealed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient. These statements reflected nutritional management intervention and outcomes for patients as required. Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patients' status or to indicate communication with other professionals/representatives concerning the patients. Entries were noted to be timed and signed with the signature accompanied by the designation of the signatory.

Staff and patients confirmed that individual dietary preferences are accommodated. The menu plan operated on a three weekly cycle, however when cross referenced with the temperature of food record, it was apparent that on occasions the menu plan was not adhered to. The inspector reviewed a record of the meals provided for patients and this recorded the amount of food eaten however it did not specify what was eaten. A requirement is made that a record is maintained of the actual food eaten by each patient including any special diets taken.

The inspector reviewed the care records of three patients identified of being at risk of inadequate or excessive food and fluid intake. This review confirmed that;

- daily records of food and fluid intake were being maintained in terms of amount taken
- where necessary a referral had been made to the relevant specialist healthcare professional
- care plans had been devised to manage the patient’s nutritional needs and were reviewed on a monthly or more often basis.

Issues identified in relation to care planning included the following:

- As previously stated under Section B, a review of one patient’s care records evidenced a deficit in recording directions from the speech and language therapist and the dietician.
- The fluids required over a 24 hour period was estimated for patients at risk of dehydration. This should be individualised using an evidence based approach to calculate the desired amount.

Review of a sample of fluid balance charts for one identified patient provided evidence that the patient was offered fluids on a regular basis throughout the day.

However the fluid intake records and other care records for this identified patient failed to evidence;

- the total fluid intake for the patient over 24 hours
- an effective reconciliation of the total fluid intake against the fluid target established
- action to be taken if targets were not being achieved
- a record of reconciliation of fluid intake in the daily progress notes

A requirement is made that these care record issues pertaining to food and fluid intake are addressed.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

Section F

Standard 5.7
• **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.**
Please refer to criterion examined in Section C & E. In addition the review of three patients' care records evidenced that consultation with the patient and / or their representative had taken place in relation to the planning of the patient's care. This is in keeping with the DHSSPS Minimum Standards and the Human Rights Act 1998.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section G

Standard 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate** **Standard 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.**
Prior to the inspection a patients' care review questionnaire was forwarded to the home for completion by the registered manager. The information provided in this questionnaire evidenced that all the patients in the home had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014. The registered nurse informed the inspector that patients' care reviews were held post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff preferably the patient's named nurse attends each care review. A copy of the minutes of the most recent care review was held in the patients' care record file. The inspector viewed the minutes of two care management care reviews which evidenced that, where appropriate patients and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended, an updated assessment of the patient's needs and a record of issues discussed. It is required that one aspect of a patient's care plan in relation to diet requires updating following the review.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

Section H

Standard 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Standard 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.**
A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. It is recommended that the policy / procedure is updated to reflect the current evidence based including the following: • The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes (2014) • DHSSPS Promoting Good Nutrition. A Strategy for good nutritional care in adults in all care settings in N.I 2011- 2016. There was a three weekly menu planner in place. It is recommended that it is reviewed and updated in accordance with the most recent evidence based guidance and in consultation with patients, their representatives and staff in the home. It was confirmed by staff and patients that individual dietary preference and choice is accommodated. The inspector discussed with the registered nurse and the cook the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients (see section E).

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

Section I

Standard 8.6
• **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.**
Standard 12.5
• **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.**
Standard 12.10
• **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:**
    • **risks when patients are eating and drinking are managed**
    • **required assistance is provided**
    • **necessary aids and equipment are available for use.**
Standard 11.7
• **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.**

The inspector discussed the dietary needs of the patients with the registered nurse, care staff and the cook. As identified in section B, review of the self – assessment (see appendix) and from discussion with the registered nurse and two care assistants on duty, it was indicated that staff training was ongoing in relation to the care associated with patients who have swallowing difficulties. However, the inspector was unable to confirm the total number of registered nurses and care staff who have received training commensurate with their role in this regard and also in relation to the management of nutrition. It is requested that the registered manager confirms this information when returning the quality improvement plan (QIP). As identified in section B, review of one patient's care record evidenced that the care plan did not fully reflect the instructions of the speech and language swallow assessment or dietician's instructions. Discussion with registered nurse and cook confirmed that meals were served at appropriate intervals throughout the day in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.

The registered nurse and cook confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered mid-morning, afternoon and at supper times. The inspector observed that a choice of fluids to include fresh drinking water were available and refreshed regularly. Staff were observed offering patients fluids at regular intervals throughout the day. Staff spoken with were knowledgeable regarding pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. On the day of the inspection, the inspector observed the lunch meal. Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely manner.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

11.0 Additional Areas Examined

11.1 Records required to be held in the nursing home

Prior to the inspection a check list of records required to be held in the home under Regulation 19(2) Schedule 4 of The Nursing Homes Regulations (Northern Ireland) 2005 was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required records were maintained in the home.

During the inspection, the inspector reviewed a sample of accidents / incidents recorded by the home. The inspector requested that one event recorded should be referred to the local HSC Trust to be considered under the safeguarding procedure and reported to RQIA in accordance with legislation. Requirements are made in this regard. Confirmation has been received by RQIA from the registered manager that this correspondence has taken place subsequent to the inspection. From the record of accidents held in the home, it was also observed that RQIA had not been notified of all accidents which had occurred in the home. A requirement is made that all accidents which occur in the nursing home are reported in accordance with legislation, including any which have not been reported to date.

11.2 Patients/residents under Guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) Order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection.

Registered nurse J Matthew advised the inspector that there were no patients subject to a Guardianship Order currently resident at the time of inspection in the home. This was also confirmed by the registered manager post inspection.

11.3 Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspector discussed the Human Rights Act and Human Rights Legislation with the registered nurse and two care staff. While staff demonstrated an awareness of these documents and how they impact on care delivery, copies were not available in the home on the day of inspection.

It is recommended that these documents are sourced, and that all staff are made aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patients care and accompanying records.

The inspector also discussed the Deprivation of Liberty Safeguards (DOLs) with the registered nurse including the recording of best interest decisions on behalf of patients. While the registered nurse demonstrated an awareness of this document, a copy of DOL’s was not available in the home on the day of inspection. It is recommended that this should also be available to staff.

11.4 Quality of interaction schedule (QUIS)

The inspector undertook two periods of observation in the home which lasted for approximately 35 minutes each.

The inspector observed the lunch meal being served in the dining room and in the interactions between patient and staff in an upstairs sitting room. The inspector also observed care practices in the sitting room following the lunch meal.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area being observed.

Positive interactions	11
Basic care interactions	
Neutral interactions	
Negative interactions	

The inspector evidenced that the quality of interactions between staff and patients was positive.

A description of the coding categories of the Quality of Interaction Tool is appended to the report.

11.5 Complaints

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being pro-actively managed.

The inspector reviewed the complaints records. This review evidenced that complaints were investigated in a timely manner and the complainant’s satisfaction with the outcome of the investigation was sought.

11.6 Patient finance questionnaire

Prior to the inspection a patient financial questionnaire was forwarded by RQIA to the home for completion. The evidence provided in the returned questionnaire indicated that patients’ monies were being managed in accordance with legislation and best practice guidance.

11.7 NMC declaration

Prior to the inspection the registered manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC.

11.8 Questionnaire findings

Staffing/Staff Comments

The inspector examined duty rotas spanning a three week period and requested that one further weeks' duty rota with the corresponding patients' assessed dependency levels using the Rhys Hearn framework would be submitted for analysis to RQIA. The registered manager submitted this information to RQIA which indicated that the staffing arrangement met the DHSSPS's recommended minimum staffing guidance for nursing homes for the number of patients currently in the home. The ancillary staffing levels were found to be satisfactory.

During the inspection the inspector spoke with 5 staff individually. On the day of inspection two staff also completed questionnaires. The following are examples of staff comments during the inspection and from the questionnaires;

"we are very fortunate in having an excellent manager who is very approachable and fair. Her priority is the residents and she is very supportive to both residents and staff"
"it would be nice to have more time to sit and chat with the residents…..sometimes this is possible but the majority of the time it is not"
"we are providing care according to the residents' wishes"

Patients' comments

During the inspection, the inspector spoke with eight patients individually and with a number in groups. Three of these patients responded to the questions in the questionnaire. All eight patients whom the inspector had the opportunity to speak with, indicated that they were content living in the home.

The following are examples of patients' comments made to the inspector and recorded in the returned questionnaires.

"couldn't wish for better, all staff very kind"
" I know all the staff"
"happy living here"
"can get something else if I don't like what's on the menu"

Patient Representative/relatives' comments

During the inspection, the inspector spoke with two patient representatives/relatives. The following are examples of relatives' comments:

"very happy with the care my relative receives"
100% for the care – spotless room"

11.9 Environment

As part of the inspection process, the inspector observed the general environment in the nursing home. This included viewing fourteen bedrooms, two lounges, two dining rooms, and bathroom / toilet facilities. The home was comfortable and all areas were maintained to a high standard of hygiene.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with registered nurse J Matthew as part of the inspection process. Mrs L Kelly, registered manager subsequently provided further correspondence to RQIA as an outcome of issues identified as requiring urgent action. The inspection findings were discussed with Mrs L Kelly post inspection.

The timescales for completion commence from the date of inspection.

The registered provider / manager is required to record comments on the Quality Improvement Plan.

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

Enquiries relating to this report should be addressed to:

Loretto Fegan
The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Appendix 1

<table>
<tr><th colspan="2">Section A</th></tr>
<tr><td colspan="2">Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</td></tr>
<tr><td>Criterion 5.1
At the time of each patient’s admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient’s immediate care needs. Information received from the care management team informs this assessment.
Criterion 5.2
A comprehensive, holistic assessment of the patient’s care needs using validated assessment tools is completed within 11 days of admission.
Criterion 8.1
Nutritional screening is carried out with patients on admission, using a validated tool such as the ‘Malnutrition Universal Screening Tool (MUST)’ or equivalent.
Criterion 11.1
A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.
Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>A pre assessment is carried out before admission and an up to date assessment from the care management team involved is obtained. This information is recorded and retained in the resident's folder.
An holistic assessment of resident's needs is completed within 11 days of admission using validated tools.
Nutritional Assessment using MUST tool is carried out on all new residents and kept under review.
On admission a pressure ulcer risk assessment is completed for all residents.</td><td>Compliant</td></tr>
</table>

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
On admission the nurse is responsible for planning the nursing intervention to meet the needs of the resident thus promoting rehabilitation and independence where possible. Tissue Viability nurses can be contacted through call management for advice and support . When a resident is at risk a plan is put in place, after consultation with other health care providers, in an effort to	Substantially compliant

prevent pressur ulcers from occurring. Referral to podietary through call management is made if there is ulceration of lower limb or foot. Referral to dietatian is made when required and advice recieved is adherred to by staff in the home.	
Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
A daily report is completed by nurses on duty to reflect the care provided. Daily report must be signed and dated giving time report is completed.	Compliant

<table>
<tr><th colspan="2">Section D</th></tr>
<tr><td colspan="2">Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</td></tr>
<tr><td>Criterion 5.5
All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.
Criterion 11.4
A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.
Criterion 8.4
There are up to date nutritional guidelines that are in use by staff on a daily basis.
Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>All nursing interventions, activities and procedures carried out in the home must be supported by best practice evident based guidelines.
Where there is skin damage a validated grading tool is used and appropriate intervention put in place in an effort to promote healing. If necessary the revelant professional bodies are involved in an effort to have the desired outcome.
There are booklets available in the home for staff use.</td><td>Compliant</td></tr>
</table>

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing records of all interventions,activities and procedures are retained in the home in accordance to NMC guidelines Records of all meals provided in the home are retained for inspection and provide details of meals taken by all residents. An indept record is kept of all residents who require full assistance at meal times or residents who require daily monitoring due to their health status. Where necessary referrals to relevant professionals are made and records of outcome retained in resident's notes.	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All care delivered is monitored on a day to day basis and recorded in daily records by nurse on duty. Care plans are reviewed on a monthly basis or more often if required. Staff and Management are in daily communication with residents, and their relatives during their visits to the home, so they are aware of all interventions being carried out. If a resident requires treatment the next of kin is contacted either directly on their visit to the home or by telephone to ensure they are aware of any changes to care..	Substantially compliant

<table>
<tr><th colspan="2">Section G</th></tr>
<tr><td colspan="2">Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</td></tr>
<tr><td>Criterion 5.8
• Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.
Criterion 5.9
• The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>Residents are where possible involved in any reviews carried out by the local trust.
There is a print out of all reviews carried out and any changes required are carried out with the ageement of resident and their representatives.</td><td>Substantially compliant</td></tr>
</table>

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences. Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided. A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Residents receive a nutritious and varied diet providing all the required dietary needs. Advice received from professional bodies is implemented. Menu is in place but there is always great effort to provide resident with the meal of their choice. The cook will communicate with residents directly if they require a specific meal.	Compliant

<table>
<tr><th colspan="2">Section I</th></tr>
<tr><td colspan="2">Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</td></tr>
<tr><td>Criterion 8.6
• Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.
Criterion 12.5
• Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.
Criterion 12.10
• Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:
    ○ risks when patients are eating and drinking are managed
    ○ required assistance is provided
    ○ necessary aids and equipment are available for use.
Criterion 11.7
• Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20</td><td></td></tr>
<tr><th>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</th><th>Section compliance level</th></tr>
<tr><td>Nurses have up to date knowledge on the managemant of feeding of residents with swallowing difficulties. Care staff have also received training provided by the Belfast Trust in this area.
Meals are provided at conventional times allowing staff suficient time to assist residents with their meals.
Snacks hot and cold drinks are available at all times on request. Fresh water and juice is available at all times. Snacks</td><td>Compliant</td></tr>
</table>

are given mid morning,mid afternoon and in the evening to all residents. Staff are aware of residents with eating difficulties and the risks involved. The home has availed of training provided by the trust in this field. Where necessary assistance is provided to residents. Aids and equipment are available for resident use. Nurses have received training on wound management and how to assess wounds thus providing the most appropriate dressings.	

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	**COMPLIANCE LEVEL**
	Substantially compliant

Appendix 2

Explanation of coding categories as referenced in the Quality of Interaction Schedule (QUIS)

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic Care: (BC) –** basic physical care e.g. bathing or use if toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc. (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away • Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others	**Examples include:** Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (NS) –** communication which is disregarding of the residents' dignity and respect.
Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions • Not showing interest in what the patient or visitor is saying	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness') • Seeking choice but then ignoring or over ruling it • Being angry with or scolding older patients • Being rude and unfriendly • Bedside hand over not including the patient

References

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.

Quality Improvement Plan

Unannounced Primary Inspection

Carryduff Nursing Home

17 July 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with registered nurse J Matthew, nurse in charge during the inspection visit and subsequently with Mrs L Kelly, registered manager.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers/managers should note that failure to comply with regulations may lead to further enforcement and/or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider/manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Statutory Requirements **This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on the HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and the Nursing Homes Regulations (NI) 2005**					
No.	**Regulation Reference**	**Requirements**	**Number of Times Stated**	**Details Of Action Taken By Registered Person(S)**	**Timescale**
1	16 (2)	The registered person must ensure that care plans are kept under review and the following information is recorded : • Care plans should be in place in relation to the prevention of pressure ulcers for patients in accordance with assessed need • A daily repositioning / skin inspection chart should be put in place for patients with a wound or at risk of pressure damage **Ref- Follow up on previous issue (Section 9.0 & Section 10 B)**	Two	Care plan in relation to the prevention of pressure ulcers is in place for residents at risk. Daily repositioning chart has been put in place for resident specified, although this resident is at risk, he has the ability to reposition himself. A daily skin inspection is carried out on all residents and a record retained for inspection.	From date of inspection
2	20(1)(c)(i)	The registered person must provide confirmation to RQIA that **all** staff have completed the required mandatory training and / or training updates. **This requirement is raised for a third and final time. Further non-compliance will lead to enhanced enforcement action.** **Ref- Follow up on previous issue (Section 9.0)**	Three	We continue to provide an extensive training programme but due to long term sickness and maternity leave there are a small number of staff who require some updates on training. There is great difficulty in having 100 percent compliance in this area but we are in the process of addressing this matter.	From date of the previous inspection

3	14 (4)	The registered person shall make arrangements by training staff or by other measures, to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse by ensuring that • all staff receive an annual update in Safeguarding Vulnerable Adults • all staff receive training in relation to the management of restraint **Ref- Follow up on previous issue (Section 9.0)**	Two	Four members of staff require an update on Safeguarding Vulnerable Aduts and we are in the process of addressing this issue Trainer providers have been requested to include management of restraint in training program.	From date of the previous inspection
4	14 (4)	The registered person shall make arrangements by training staff or by other measures, to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse by ensuring that • complaints are assessed in accordance with regional guidelines (SOVA), to ensure any safeguarding issue/s contained therein are referred to the designated officer in the Trust in an appropriate and timely manner. **Ref- Follow up on previous issue as not reviewed (Section 9.0)**	One	Complaints are being referred to designated officer in the Trust in timely manner.	From date of the previous inspection

5	14 (4)	The registered person must make arrangements by training staff or by other measures, to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse by : • reporting suspected, alleged or actual incidents of abuse to the relevant persons in a timely way • referring any potential safeguarding issue identified through the accident / incident reporting process in the home to the designated safeguarding officer in the health and social care trust **Ref- Section 9.1 & 11.1**	One	All accident reports will now be sent to both RQIA and Trust	From date of the inspection
6	30 (1) (d, f & g)	The registered person must give notice to the Regulation and Quality Improvement Authority without delay of the occurrence of – • any event in the nursing home which adversely affects the wellbeing or safety of any patient • any accident in the nursing home, including any which have not been reported to date • any allegation of misconduct by the registered person or any person who works at the nursing home **Ref- Section 9.1 & 11.1**	One	All reports have been forwarded to Regulation and Quality Improvement Authority as requested.	From date of the inspection

7	16 (2)	The registered person must ensure that care plans are kept under review and are put in place • in response to assessed need • to incorporate recommendations made by other professionals Corresponding fluid intake charts should reflect individualised patient need and ensure the following: • the total fluid intake for the patient over 24 hours • an effective reconciliation of the total fluid intake against the fluid target established • action to be taken if targets are not achieved • a record of reconciliation of fluid intake in the daily progress notes **Ref- Section 10 (B, G, E, G)**	One	Care plan review is ongoing. Staff have been reminded to total fluid intake over 24hour period and record same in daily notes. We have made some time changes to this to aid staff in completing this. Action taken if targets not achieved to be documented in resident's care plan	From date of the inspection

8	19 (2), Schedule 4 (13)	The registered person should maintain records of the food provided for patients in sufficient detail to enable any person inspecting the record to determine whether the diet is satisfactory, in relation to nutrition and otherwise, and of any special diet prepared for individual patients. Therefore a record should be maintained of the actual food eaten by each patient including any special diets taken. **Ref- Section 10 (E)**	One	Food records have been expanded in order to provide a more comprehensive record of all food intake.	From the date of inspection

Recommendations **These recommendations are based on the Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.**					
No.	**Minimum Standard Reference**	**Recommendations**	**Number Of Times Stated**	**Details Of Action Taken By Registered Person(S)**	**Timescale**
1	5.2	The registered manager should audit care records of newly admitted patients following the 11 day timescale to enable improvements to be identified in a timely manner. **Ref- Follow up on previous issue (Section 9.0 & Section 10 C)**	Three	Audit of care records for new residents being audited within 11 days of admission	From date of previous inspection
2	16.1	It is recommended that in relation to safeguarding vulnerable adults: • policies and procedures (including the flow-chart) are revised to fully reflect and reference all DHSSPS guidance, regional protocols (N Ireland) and local procedures issued by the Health and Social Care Trusts (HSCT). **Ref- Follow up on previous issue (Section 9.0)**	Two	Policies and proceedures in relation to safeguarding vulnerable adults have been revised in July 2014 in line with new guideance	From date of previous inspection

3	16.3	It is recommended that in relation to safeguarding vulnerable adults: • the competency and capability assessments completed for all nurses taking charge of the home includes the action to be taken in the event of an allegation of abuse • the SOVA training programme contains the relevant DHSSPS guidance, regional protocols and local Trust procedures **Ref- Follow up on previous issue as not reviewed (Section 9.0)**	One	We have in place a competency assessment in relation to safeguarding Vulnerable Adults for all nurses who are in charge of the home. SOVA training programme includes all revelant guidance	From date of previous inspection
4	10.7	It is recommended that evidence based documents in relation to restraint • are available for ease of reference by staff • are incorporated / referenced in the home's associated policies/ procedures • are incorporated / referenced in the relevant training programme **Ref- Follow up on previous issue (Section 9.0)**	Two	Documents and policies in relation to restraint are available in the home for staff information and guidance. This information is also incorporated in the training programme.	From date of previous inspection

5	11.7	It is recommended that: • all registered nurses undertake wound care training and their competency is assessed to ensure training has been embedded into practice. • all care staff complete training in relation to pressure area care and the prevention of pressure ulcers and their competency is assessed to ensure training has been embedded into practice. Confirm percentage of staff who have attended the above training when returning the QIP **Ref- Follow up on previous issue (Section 9.0)**	Two	Training is an ongoing process and all relevant staff are sent on wound care training. Assessments on this to be carried out. Care staff in the home are given in-house training in relation to pressure ulcer prevention and the majority of staff have also received training in this area from an external provider. Assessments on compencies to be carried out. To date over 50% of nurses and over 73% of care staff have received external training from the Trust. Prevention of Pressure Ulcers awareness training is booked for 29 September 2014 for all remaining staff.	From date of previous inspection
6	28.4	It is recommended that all staff receive training commensurate with their role in relation to: • dysphagia • the management of nutrition • record keeping	One	Training is ongoing Those staff who have not receive training from an external provider have attended in-house training in relation to the areas stated.	By 30 November 2014

		Confirm the percentage of staff who have attended the above training when returning the QIP **Ref- Section 10 (B, E, I)**		At least 40% of all staff have received training from an external provider.	
7	12.1	It is recommended that the policy / procedure in regard to nutrition and dietary intake is updated to reflect the current evidence based guidance • The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes (2014) • DHSSPS Promoting Good Nutrition. A Strategy for good nutritional care in adults in all care settings in N.I 2011-2016. and that the menu planner is also reviewed to ensure this evidence based guidance is incorporated **Ref- Section 10 (H)**	One	Policy / procedures in regard to nutrition have been updated to reflect current evidence based guidance	By 30 September 2014
8	1.1	It is recommended that the following information is available for staff reference: • Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS • Deprivation of Liberty Safeguards (DOLS)	One	Information on Human Rights Act 1998 and European Conventionon Human Rights (ECHR) DHSSPS Deprivation of Liberty Safeguards (DOLS) are available for staff reference.	By 31 August 2014

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person and return to nursing.team@rqia.org.uk

Name of Registered Manager Completing Qip	Linda Kelly
Name of Responsible Person / Identified Responsible Person Approving Qip	Chris Arnold

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	√	L Fegan	16/9/14
Further information requested from provider			