Unannounced Care Inspection Report
5 and 6 April 2017

Clifton Nursing Home

Type of Service: Nursing Home
Address: 2a Hopewell Avenue, Carlisle Circus, Belfast, BT13 1DR
Tel no: 028 9032 4286
Inspector: Heather Sleator

1.0 Summary

An unannounced inspection of Clifton Nursing Home took place on 5 April 2017 from 09.30 to 17.00 hours and continued on 6 April 2017 from 09.40 to 17.00 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

As a result of the inspection, RQIA were concerned that the quality of care and service within Clifton Nursing Home was below the minimum standard expected. The registered providers were required to attend a meeting in RQIA on 13 April 2017, to discuss the inspection findings and to provide RQIA with a detailed and comprehensive action plan which illustrated how the home will return to compliance. Refer to section 1.1 for further information.

Is care safe?

Weaknesses were identified in the delivery of safe care, specifically in relation to the staffing arrangements in the home, including the deployment of staff; infection prevention and control procedures; and the doors to Toby Hurst and Donegal units having a key coded locking system in place (a restrictive practice). These deficits have led to a reduction in positive outcomes for patients. Four recommendations have been made to secure compliance and drive improvement.

Is care effective?

Weaknesses have been identified in the delivery of effective care specifically in relation to the management of the assessment of patient need, care planning and the regular review of care as evidenced through the review of patient care records. Improvements were in evidence regarding the approach to meals and mealtimes, especially in Benn unit. Two requirements have been made and two recommendations have been stated for the second time.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. A well established and varied activities programme was in evidence, led by three activities leaders. Patients were praiseworthy of staff and a number of their comments are included in the report. A small number of negative comments were stated in returned questionnaires from patients, relatives and staff. These were discussed with the manager who agreed to try and address the issues, as far as possible. There were no requirements or recommendations made.

Is the service well led?

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. Discussion with the manager and staff; and a review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. However, improvements were needed regarding the monitoring of the quality of the services provided by the home (auditing) as the outcome and action following audit were not clearly evident.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	3	7*

*Refers to one recommendation stated for the second time and one recommendation stated for the third and final time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Cathy McCorry, manager (registration pending), as part of the inspection process. The timescales for completion commence from the date of inspection.

As a result of the inspection, RQIA were concerned that the quality of care and service within Clifton Nursing Home was below the minimum standard expected. The findings were reported to senior management in RQIA, following which a decision was taken to hold a serious concerns meeting. The inspection findings were communicated in correspondence to John Rafferty, Responsible Individual, Runwood Homes Ltd and a meeting took place at RQIA on 13 April 2017. At this meeting an action plan was submitted by the responsible individual and the manager as to how and when the concerns raised at the inspection would be addressed by management. Following the meeting a revised action plan was submitted by the responsible individual which reflected the concerns discussed at the meeting on 13 April 2017. Appropriate assurances were provided to RQIA as to how the concerns would be addressed and a follow up inspection will be planned to validate compliance.

Further inspection is planned to validate compliance and drive improvements.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 23 February 2017. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

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

2.0 Service details

Registered organisation/registered person: Runwood Homes Ltd John Rafferty	**Registered manager:** See below
Person in charge of the home at the time of inspection: Cathy McCorry (manager)	**Date manager registered:** Cathy McCorry - Application for registration not yet received

Categories of care:	**Number of registered places:**
NH-PH, NH-DE, NH-I A maximum of 40 patients in category NH-DE and a maximum of 4 patients in category NH-PH.	100

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with 20 patients, five care staff, six registered nurses, domestic and catering staff, two activities leaders and three relatives.

Questionnaires for patients (eight), relatives (10) and staff (10) to complete and return were left for the registered manager to distribute. Please refer to section 4.5 for further comment.

The following were examined during the inspection:

- validation evidence linked to the previous QIP
- staff roster
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- complaints and compliments records
- incident and accident records
- records of quality audits and
- records of staff, patient and relatives meetings
- seven patient care records

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 23 February 2017

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 14 December 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (1) (a) and (b) **Stated:** First time	The registered provider must ensure that patient care records accurately reflect the assessed needs of any patient and evidence that assessed need has been reviewed and that care plans have been developed and reviewed to reflect the current assessed need of an individual.	**Met**
	Action taken as confirmed during the inspection: This requirement referred specifically to the Benn unit. The observation of care, discussion with staff and a review of care records evidenced that the delivery of care was in accordance with the assessed need of patients in the Benn unit.	
Requirement 2 **Ref:** Regulation 13 (4) (a) and (b) **Stated:** First time	The registered provider must ensure that topical applicants and creams must only be used for the named individual and not for communal use.	**Met**
	Action taken as confirmed during the inspection: This issue was discussed at a staff meeting held on 1 February 2017 at which time staff were informed that topical applications and creams were for named used only. On observation there was no evidence the topical applications and creams were being used on a communal basis.	
Requirement 3 **Ref:** Regulation 12 (4) **Stated:** First time	The registered provider must ensure that the patients' dining experience is improved. The dining experience must be regularly audited to ensure adherence with regulatory requirements and best practice guidance.	**Met**
	Action taken as confirmed during the inspection: This requirement referred specifically to the Benn unit. Observation of the midday meal service in Benn unit evidenced that the approach to meals and mealtimes had greatly improved.	

Requirement 4 **Ref:** Regulation 12 (4) (d) **Stated:** First time	The registered provider must ensure that patients who require a modified diet are afforded choice at mealtimes.	**Met**
	Action taken as confirmed during the inspection: As with requirement 3 this requirement referred to Benn unit. Evidence was present during the observed meal service in Benn unit that patients who required a modified diet were afforded a choice at mealtimes.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 43.2 **Stated:** Second time	The registered person must implement a programme of replacing chairs/seating in the Benn suite.	**Met**
	Action taken as confirmed during the inspection: There was evidence in the lounge areas in Benn unit that a number of armchairs had been purchased and the chairs that evidenced significant wear and tear had been removed.	
Recommendation 2 **Ref:** Standard 35.6 **Stated:** Second time	The registered person should ensure that management implement a systematic approach to the auditing of care records. Where shortfalls are identified the audit should evidence that remedial action had taken place.	**Not Met**
	Action taken as confirmed during the inspection: The review of the audits of care records which had been completed did not consistently evidence that where a shortfall had been identified that the identified remedial action had been taken. Evidence was present in some audits of the remedial action taken but not all. This recommendation has not been met and has been stated for a third and final time.	

Recommendation 3 **Ref:** Standard 39.4 **Stated:** First time	The registered provider should ensure staff complete update training in the promotion of continence. Emphasis should be given to ensuring staff understand their responsibilities when assisting with personal care, regarding the core values of privacy, dignity and respect.	**Met**
	Action taken as confirmed during the inspection: Training was provided to staff by the local health and social care trust in January 2017. There were no issues evident in relation to the core values of privacy, dignity and respect during the inspection.	
Recommendation 4 **Ref:** Standard 46.2 and 46.4 **Stated:** First time	The registered provider should ensure that continence products are stored in accordance with infection prevention and control procedures and the manufactures instructions.	**Met**
	Action taken as confirmed during the inspection: The reviews of the storage arrangements for continence products evidenced products were stored correctly and in accordance with infection prevention and control procedures.	
Recommendation 5 **Ref:** Standard 12 **Stated:** First time	The registered provider should ensure that dining tables are appropriately set with tablecloths/placemats and fluid and condiments should be readily available	**Met**
	Action taken as confirmed during the inspection: The observation of the midday meal service in the three units of Clifton Nursing Home evidenced that dining tables were attractively and appropriately set with a full range of condiments available for patients.	
Recommendation 6 **Ref:** Standard 12.6 **Stated:** First time	The registered provider should ensure that the day's menu is available for patients and is available in a suitable format and location.	**Met**
	Action taken as confirmed during the inspection: The observation of the midday meal service in the three units of Clifton Nursing Home evidenced that the day's menu was displayed on each dining table and also on a notice board in dining rooms.	

Recommendation 7 **Ref:** Standard 4.8 **Stated:** First time	The registered provider should ensure that care records reflect the desired daily fluid intake for each patient and at what stage further action needs to be taken.	**Partially Met**
	Action taken as confirmed during the inspection: The review of patient care records evidenced that the management of hydration was appropriately recorded in patient care records in Benn unit. Further work was required in the care records of patients in Toby Hurst and Donegal units. This recommendation has been partially met and has been stated for a second time.	
Recommendation 8 **Ref:** Standard 12.17 **Stated:** First time	The registered provider should that fluids are readily available for patients at any time of the day and also readily available for staff to prompt patients to drink and facilitate good hydration.	**Met**
	Action taken as confirmed during the inspection: This recommendation related specifically to Benn unit. Evidence was present in Benn and the remaining two units that fluids were readily available for patients and were visible.	
Recommendation 9 **Ref:** Standard 39.4 **Stated:** First time	The registered provider should ensure that staff complete refresher training regarding safe moving and handling best practice when supporting a patient to mobilise.	**Met**
	Action taken as confirmed during the inspection: The review of staff training records evidenced that a series of training sessions in respect of moving and handling was provided for staff in February 2017. The training records evidenced 30 care staff had attended the training.	

4.3 Is care safe?

The manager confirmed the planned daily staffing levels for the home, and that these levels were subject to regular review to ensure the assessed needs of the patients were met. Review of the staffing rotas of week commencing 27 March and 3 April 2017, evidenced that the planned staffing levels were adhered to. In the absence of the manager, a registered nurse is designated as the person in charge of the home. Competency and capability assessments for the nurse in charge of the home reflected the responsibilities of the position. The competency and capability assessments had not been reviewed from February 2016 however the manager stated that she was satisfied with the registered nurses competencies as there was an annual staff appraisal and staff supervision system in place. The manager agreed to review and update the competency assessments with the individual staff members.

Observation of the delivery of care did not evidence that patients' needs were met by the levels and skill mix of staff on duty. Concerns were identified regarding the health and welfare of patients and there was a lack of evidence to demonstrate that safe and effective care was being delivered consistently, particularly in regard to the following: the delay in assisting a patient with their personal care needs until the afternoon; the lack of attention to the personal care needs of a small number of patients on continuous bed rest; a lack of consistency regarding the completion of patient hydration records; and the delay of serving the midday meal in one unit. In discussion, staff advised that this was due to workload, deployment of staff and the dependency needs of patients accommodated. In addition, two relatives also stated that they felt the provision of fluids was not in keeping with their relative's needs. A requirement has been made that the staffing arrangements are reviewed to ensure that the staffing arrangements reflect the dependency levels and needs of patients at any time throughout a 24 hour period.

There were safe systems in place for the recruitment and selection of staff. A review of three personnel files evidenced that these were reviewed by the manager and were checked for possible issues. The review of recruitment records evidence that enhanced criminal records checks were completed with Access NI and the reference number and date received had been recorded.

Discussion with staff and a review of the staff training records confirmed that the manager had a system in place to monitor staff compliance with mandatory training requirements. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on a range of topics including; medicines management, fire safety, food safety, health and safety, infection prevention and control, moving and handling and adult prevention and protection from harm. A dementia specific training module had been completed by 87 percent of the staff team.

Discussion with the manager and staff confirmed that there were systems in place to monitor staff performance or to ensure that staff received support and guidance. Staff confirmed they received supervision and received a report on the wellbeing of the patients when commencing duty. An annual staff appraisal and supervision planner had been established by the manager.

The staff consulted with were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The review of staff training records evidenced that 88 percent of staff had completed adult safeguarding training. The manager stated newly appointed staff had read the policy documentation but had not completed the online training, as yet. The complaints and safeguarding records provided evidence of concerns and safeguarding referrals. A review of the records identified that concerns had been logged appropriately. However, records did not clearly evidence if a satisfactory resolution had been gained in respect of complaints received and where a safeguarding referral had been made whether or not the case was closed. Please refer to section 4.6 for further information. A review of documentation confirmed that any potential safeguarding concerns were reported appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately

A range of risk assessments were generally completed as part of the admission process and were reviewed as required. The assessments included where patients may require the use of a hoist or assistance with their mobility and their risk of falling; the use of bedrails, if appropriate and assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties. Refer to section 4.4 for further detail regarding the assessment of need and care planning process.

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

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean and tidy.

Concerns were evident in the following areas:

- The personal protection equipment (PPE) units were observed to be empty in one unit. In discussion staff stated the equipment was stored in the linen rooms. The purpose of the PPE units is that disposable gloves and aprons are readily available and located throughout the unit. A recommendation has been made that the PPE units are fully stocked on all units for staff to access.

- A lounge in one of the units is used solely by one patient, this had been agreed with all relevant parties and a care plan was present regarding this. The lounge door could be locked from the inside by the patient, which was a potential safety risk. A recommendation has been made that a new lock is fitted to the door so as staff can override the mechanism and gain access to the room, if needed.

- Key coded locking mechanisms had been installed on the doors to Toby Hurst and Donegal units. A push button access point was present at one unit door. Discussion took place with the manager as to the rationale for the locking mechanism however the manager was unsure as the locking mechanisms were in place prior to her taking up her position. The use of the locking systems should be reviewed as this arrangement is a restrictive practice. The manager must ensure that the liberty of patients is not unduly affected by the use of the locking mechanisms.

- The home's fire safety risk assessment should be reviewed and updated, as necessary, regarding the key coded locking system on the doors to Donegal and Toby Hurst units.

Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

Staffing arrangements must be reviewed to ensure that the staffing arrangements reflect the dependency levels and needs of patients, at any time, throughout a 24 hour period.

In accordance with the regional infection prevention and control procedures, the PPE units throughout the home should be fully stocked and readily accessible for staff to use.

To ensure the safety and wellbeing of patients, a new lock should be fitted to the identified lounge door so as staff can override the mechanism and gain access to the room, if and when needed.

The use of key coded entries to the individual units in the home should be reviewed to ensure the liberty of patients is not unduly affected. .

The home's fire safety risk assessment should be reviewed and updated, as necessary, regarding the key coded locking system on the doors to the Donegal and Toby Hurst units.

Number of requirements	1	**Number of recommendations**	4

4.4 Is care effective?

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. The review of patient care records did not evidence a consistent approach to the completion of and regular review of risk assessments. The review of patient care records on the computerised system in operation evidenced that the risk assessments were overdue for review. This was discussed with the manager who stated that where risk assessments and/or care plans were being flagged as overdue it may be due to the system set-up. However, the regular review of patient needs or changing needs is complicit to the safe and effective delivery of care and a requirement has been made.

The review of care records, including risk assessments and care plans identified, as previously stated, that they were not maintained and regularly reviewed in response to the changing needs of the patient. The plan of care of a recently admitted patient did not reflect the assessed needs of the patient despite the need being clearly identified in the relevant risk assessments. This was concerning, as there was a lack of information to direct and inform the care required to meet patients' health and welfare needs. It was of concern that the review of the daily progress record of a patient evidenced that where the direction of patient care was being stated by night staff this was not being followed by day staff and had the potential to place the patient at risk. The care plans in place for patients must evidence that they accurately reflect the current and/or changing needs of the patient through review. A requirement has been made

Supplementary care charts such as repositioning records evidenced that care was delivered and records were maintained in accordance with best practice guidance, care standards and legislative requirements. Repositioning charts evidenced the frequency of repositioning and there were no obvious 'gaps' in recording. A consistent approach to the recording of patients' fluid intake within the supplementary care records was not in evidence. There was a lack of evidence that the registered nurses were reviewing the fluid intake of patients within the progress record in patient care records. There was a lack of evidence within patient care records that registered nurses had identified a daily target and subsequent action to be taken if and when the target was not achieved. Supplementary care records should be maintained accurately so as to inform of the wellbeing of the patients. This was a recommendation of the previous inspection of 14 December 2016 and the recommendation has been stated for a second time.

The concerns identified in patient care records should have been identified through the quality monitoring process in place. The review of the audits of care records evidenced that a significant number of care records had recently been audited however, it was not clear that action had been taken or followed up by the manager or deputies. This was a recommendation of previous inspections and the recommendation has been stated for a third and final time.

There was evidence that the care planning process included input from patients and/or their representatives, where appropriate. There was evidence of regular communication with representatives within the care records.

We observed the serving of the midday meal in all three units during the course of the inspection. The observation of the mealtime service was that it was calm and organised activity, with the exception of one unit, please refers to section 4.3 for further information. Dining tables were appropriately set with a range of condiments and fluids in evidence. The day's menu was displayed on each table and in the dining room. We were able to evidence that patients, including those on a modified diet were afforded choice at mealtimes, either by reviewing the menu choice records or observing staff offering patients a visual choice of meal.

Meals were served directly to the patients in the dining areas from a heated trolley by care staff and registered nurses were observed assisting in the dining rooms during the meal service. The quality of the meals provided was good and a choice of fluids was offered.

We observed the serving of the mid-morning tea and snack. Patients had a choice of tea, coffee, milk or juice and a snack (biscuits and fresh fruit) was provided. Milky puddings and yoghurts were available for patients who required a modified diet.

Areas for improvement

Evidence must be present in patient care records of the regular review of the assessed needs of patients and reflect patients changing needs, where applicable**.**

Patients care plans must evidence that they accurately reflect the current and/or changing needs of the patients specifically in Toby Hurst and Donegal units.

Number of requirements	2	**Number of recommendations**	0

4.5 Is care compassionate?

There was a varied and busy activities programme in place which was coordinated by three activity leaders. The programme evidenced that not only do outside entertainers and arts and crafts groups come to the home but a range of activities outside of the home were provided. Opportunities for patients to visit community facilities have increased in the last few years and these opportunities were greatly enjoyed by patients. Patients attend a local arts and cultural centre, tea dances in local community centres and there is a 'bocchia' team who participate in competitions and recently came third in the Northern Ireland competition. 'Dad's Army' style entertainers provided lively entertainment for patients on the first day of the inspection.

Observation of the activities at the time of the inspection evidenced staffs' knowledge of the importance of spending individual time with those patients who are unable to participate in more formal or group activities. This was good practice. Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. Patients meetings are held monthly and chaired by the activities leaders. There was evidence of many notice boards throughout the home for relatives and visitors information. Information detailed included; the activities programme, up and coming events, information regarding staff and patient meetings, the name of the registered nurse in charge of each unit on any given day and the home's complaints procedure.

Consultation with patients individually, and with others in smaller groups, confirmed that living in Clifton Nursing Home was, in general, a positive experience.

Comments included:
“I’m very pleased with Clifton.”
“I would be confident the manager would sort anything out for me if I asked.”
“It’s very good here, I have no complaints.”

We met with three relatives who expressed their satisfaction with the care afforded by staff to their relatives.

Comments included:
“Very satisfied with the home, I would recommend it to anyone.”
“Staff are very attentive to my (relative).”
“Staff are very caring.”
“Staff keep me informed of anything that happens to my (relative).”
As stated in section 4.4, two relatives commented that they did not feel staff had time to attend to their relatives’ hydration needs. This was discussed with the manager who agreed to raise this issue with staff.

Staff also commented very positively about working in the home.

Comments included:
“Staff are very good, very friendly.”
“Generally there’s enough staff on duty as long as everyone comes in.”
“Sometimes it’s difficult in the afternoon and evening as some staff go home after lunch.”
“More change in the home with a new manager, it takes time.”

Questionnaires

In addition (10) relative/representatives; (eight) patient and (10) staff questionnaires were provided by RQIA to the registered manager for distribution. At the time of issuing this report; four staff, seven relatives and four patients returned their questionnaires within the specified timeframe. The responses within the returned questionnaires were generally positive in respect of the care and attention afforded to patients and the quality of nursing and other services provided by the home. However, comments were received from staff, relatives and patients regarding the staffing arrangements in the home. Comments included; “staff are very busy,” “always short staffed in Donegal unit,” and “we often feel that day staff are more attentive than night staff.” The comments stated on the returned questionnaires were discussed with the manager, by telephone, prior to the issue of the report. The manager acknowledged the comments and agreed to address the issues, where possible.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.6 Is the service well led?

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion, representatives were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

The registration certificate was displayed in the entrance lobby. A certificate of public liability insurance was current and displayed.

Discussion with the manager and review of the home's complaints record evidenced that complaints were generally managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015, with the exception of stating if satisfactory resolution was gained with the complainant. Representatives spoken with and who responded by questionnaire, confirmed that they were aware of the home's complaints procedure. This was discussed with the manager who agreed to ensure the complaints record reflected if a satisfactory resolution was gained. Staff and representatives generally confirmed that they were confident that management would manage any concern raised by them appropriately. An issue was raised by a relative and the manager was informed of the comment/s; refer to section 4.5 for further detail.

Discussion with the manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. A review of notifications of incidents to RQIA since the last care inspection in December 2016 confirmed that these were managed appropriately.

Discussion with the manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in relation to infection prevention and control, incidents and accidents, the use of restrictive practice, adult safeguarding referrals, complaints and the environment. Whilst there were detailed audits in place, where a shortfall had been identified evidence was not always present if remedial action had been taken. The quality auditing systems of the services provided by the home should evidence that identified shortfalls have been actioned and the action has been verified by the manager. A recommendation has been made.

Discussion with the manager and review of records for January to March 2017 evidenced that Regulation 29 monthly quality monitoring visits were completed in accordance with the regulations and/or care standards. The review of the reports evidenced that an action plan had been generated to address any areas for improvement.

Areas for improvement

The quality auditing systems of the services provided by the home should evidence that identified shortfalls have been actioned and the action has been verified by the manager. A recommendation

Number of requirements	0	**Number of recommendations**	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Cathy McCorry, Manager, as part of the inspection process. The timescales commence from the date of inspection.

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

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

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref:** Regulation 20 (1) (a) **Stated:** First time **To be completed by:** 8 June 2017	The registered provider must ensure that the staffing arrangements reflect the dependency levels and needs of patients, at any time, throughout a 24 hour period. **Ref: section 4.3**
	Response by registered provider detailing the actions taken: Resident dependency levels have been reviewed and staffing levels now reflect same. Toby hurst unit now have additional staff between 14:00hrs-20:00hrs
Requirement 2 **Ref:** Regulation 15 (2) (a) and (b) **Stated:** First time **To be completed by:** 8 June 2017	The registered provider must ensure that the assessment of patient need is kept under review and revised to reflect patients' changing needs. **Ref: section 4.4**
	Response by registered provider detailing the actions taken: Resident assessment of needs is now completed within six hours of admission and is audited by home management. A new Assessment checklist has been implemented to identify shortfalls.
Requirement 3 **Ref:** Regulation 16 (1) and (2) **Stated:** First time **To be completed by:** 8 June 2017	The registered provider must ensure that patients' care plans accurately reflect the current and/or changing needs of the patient and evidence is present of regular evaluation of care. **Ref: section 4.4**
	Response by registered provider detailing the actions taken: Resident care plans have been evaluated to reflect their changing needs. Named Nurse have been allocated to ensure compliance with evaluation of same.In the event that a named nurse is on leave management will delegate care plans to other nursing team members.

Recommendations	
Recommendation 1 **Ref:** Standard 35.6 **Stated:** Third time **To be completed by:** 1 June 2017	The registered person should ensure that management implement a systematic approach to the auditing of care records. Where shortfalls are identified the audit should evidence that remedial action had taken place. **Ref: section 4.2**
	Response by registered provider detailing the actions taken: Care plan audit and action plans have been reviewed and modifed. A new assessment check list has now been implemented in order to identify shorfalls and what actions need to be completed within a reasonable time frame by the Named Nurse. Each unit has its own folder and 10 care plans a month will be audited and reviewed by managemet and signed off when completed.
Recommendation 2 **Ref:** Standard 4.8 **Stated:** Second time **To be completed by:** 1 June 2017	The registered provider should ensure that care records reflect the desired daily fluid intake for each patient and at what stage further action needs to be taken. **Ref: section 4.2**
	Response by registered provider detailing the actions taken: Resident's nutrition care plans now have the desired fluid intake recorded for each resident and what action to take if this is not met. Fluid intake is recorded in daily progress notes twice daily at 14:00hrs and 18:00hrs. This action will alert Nursing staff when a client is not meeting their fluid target, and what action is to be taken to prevent complications related to dehydration.
Recommendation 3 **Ref:** Standard 46.2 **Stated:** First time **To be completed by:** 11 May 2017	The registered provider should ensure that in accordance with infection prevention and control procedures that the personal protection equipment (PPE) units throughout the home are fully stocked and readily accessible for staff to use. **Ref: section 4.3**
	Response by registered provider detailing the actions taken: PPE units around the units are fully stocked and staff allocated daily to ensure compliance with same. The manager will audit the stock levels.
Recommendation 4 **Ref:** Standard 13.2 **Stated:** First time **To be completed by:** 11 May 2017	The registered provider should ensure that in respect of the safety and wellbeing of patients, a new lock is fitted to the identified lounge door so as staff can override the mechanism and gain access to the room, if and when needed. **Ref: section 4.3**
	Response by registered provider detailing the actions taken: The lock on the door identified during the inspection has now been removed in order to ensure staff have quick access to the room if needed.

Recommendation 5 **Ref:** Standard 5.1 and 5.2 **Stated:** First time **To be completed by:** 8 June 2017	The registered provider should ensure that the use of key coded entries to the individual units in the home is reviewed to ensure that the liberty of patients is not unduly affected. **Ref: section 4.3**
	Response by registered provider detailing the actions taken: Statement of purpose is reviewed and updated to take into account the liberty of clients. Clients with capacity who want to leave the locked units are given the code to the keypad.
Recommendation 6 **Ref:** Standard 48.1 **Stated:** First time **To be completed by:** 18 May 2017	The registered provider should ensure that the home's fire safety risk assessment is reviewed and updated, as necessary, regarding the key coded locking system on the doors to the Donegal and Toby Hurst units. **Ref: section 4.3**
	Response by registered provider detailing the actions taken: The Fire safety risk assesment was completed on the 31/08/ 2016 after the the new key coding locking system was implemented for the Toby Hurst unit. This assessment will be repeated when it it is due according to mandatory requirements
Recommendation 7 **Ref**: Standard 35.6 **Stated:** First time **To be completed by:** 1 June 2017	The registered provider should that he quality auditing systems, for example; complaints, restrictive practice, safeguarding referrals, evidence that where a shortfall had been identified, through audit, that remedial action had been taken and verified by the manager. **Ref: section 4.6**
	Response by registered provider detailing the actions taken: The quality auditing system has been reviewed. New systems have been implemented in order for the registered Manager to identify shortfalls and what actions need to be completed within a time frame.

Please ensure this document is completed in full and returned via web portal

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