Unannounced Care Inspection Report
14 October 2016

Rush Hall

Type of Service: Nursing Home
Address: 51 Broighter Road, Limavady BT49 9DY
Tel no: 02877769326
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Rush Hall took place on 14 October 2016 from 09.30 hours to 16.30 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.

Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. No concerns were identified in relation to staffing levels. Newly appointed staff completed a structured orientation and induction programme and there were systems in place monitor staff performance through training, supervision and appraisals. All those consulted with were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. Accidents that occurred in the home were managed appropriately.

The home was clean and warm throughout. However, weaknesses were identified in relation to agency staff inductions; competency and capability assessments; recruitment processes; notifications to RQIA of any head injuries sustained in the home; and personal emergency evacuation plans. One requirement and four recommendations have been made.

Is care effective?

With the exception of wound care, the care records were generally well maintained in line with legislative and professional requirements. Personal care records evidenced that patients were repositioned according to their care plans and patients' food and fluid intake had been monitored by staff. Communication was well maintained in the home and staff, patients' and relatives' meetings were held regularly.

All those consulted with expressed their confidence in raising concerns with the home's staff management. Weaknesses were identified in relation to the management of wound care. One requirement has been made in this regard.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with patients confirmed that patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. The atmosphere in the dining room was quiet and tranquil and patients were assisted as required. Patients were able to maintain contact with their families and friends and social care plans had been developed to ensure that patients' social care needs were met individually.

There were systems in place to obtain the views of patients, their representatives and staff on the quality of the service provided. All those consulted with confirmed that they had confidence that their concerns would be addressed appropriately.

Patients and their representatives provided positive comments in relation to the staff and a number of comments have been included in the report. One recommendation was made in relation to the development of palliative care plans.

Is the service well led?

There was a clear organisational structure within the home and there was a system in place to identify the person in charge of the home, in the absence of the registered manager. All those consulted with stated that they were confident that staff/management would manage any concern raised by them appropriately and described her in positive terms. The home was operating within its registered categories of care and a certificate of public liability insurance was current and displayed.

Complaints were managed appropriately and there were good working relationships between management and staff. There were systems in place to monitor and report on the quality of nursing and other services provided. However, given that a requirement had been made in relation to wound care, we were not assured of the effectiveness of wound analysis audits. A recommendation has been made in this regard.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	6

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

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 03 May 2016. There were no requirements of recommendations made as a result of the inspection and 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: Four Seasons Healthcare Claire Maureen Royston	**Registered manager:** Fiona Archer
Person in charge of the home at the time of inspection: Fiona Archer	**Date manager registered:** 15 April 2016
Categories of care: NH-DE, NH-I	**Number of registered places:** 66

3.0 Methods/processes

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

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. We met with six patients, three patients' representatives, five care staff, four registered nurses and three ancillary staff. Questionnaires were distributed to patients, relatives and staff.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- nine patient care records
- staff training records for 2015/2016
- accident and incident records
- audits in relation to care records and falls
- records relating to adult safeguarding
- one staff recruitment and selection record
- staff induction, supervision and appraisal records
- records pertaining to NMC and NISCC registration checks
- minutes of staff, patients' and relatives' meetings held since the previous care inspection
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

- complaints records

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 03 May 2016

The most recent inspection of the home was an unannounced medicines management inspection. There were no requirements of recommendations made as a result of the inspection and there were no further actions required to be taken.

4.2 Review of requirements and recommendations from the last care inspection dated 9 February 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 39 **Stated:** First time	The registered person should ensure that best practice guidance in continence management has been made available in the home for staff to refer to. This guidance should include, but not restricted to the following: • Urinary incontinence (NICE) • Faecal incontinence (NICE) • Continence care in Care Homes (RCN)	**Met**
	Action taken as confirmed during the inspection: The above documents were available in the home.	
Recommendation 2 **Ref**: Standard 39.9 **Stated:** First time	The registered person should ensure that update training in continence management is provided for all relevant staff. Training in urinary catheterisation should also be provided for registered nurses who have not yet completed this training.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of staff training records confirmed that training in continence management and urinary catheterisation had been provided to staff, as appropriate to their roles and responsibilities.	

Recommendation 3 **Ref**: Standard 39.7 **Stated:** First time	It is recommended that a continence link nurse is identified for the home.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager confirmed that a continence link nurse had been identified for the home. Discussion with the identified nurse confirmed that their role included ongoing staff training in continence management.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the week commencing 03 October 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients and staff evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare their understanding and competence. The registered manager had also signed the record to confirm that the induction process had been satisfactorily completed.

Staff consulted with stated that the home utilised a high level of agency staff. Although there was a system in place for agency staff to be inducted to the home, a review of the records evidenced that these were not consistently completed. Discussion with registered nurses also confirmed that the induction forms were not consistently available to them, if for example, they were required at the weekend. This was discussed with the registered manager. A recommendation has been made in this regard.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult safeguarding. Observation of the delivery of care evidenced that training had been embedded into practice. Overall compliance with training was monitored by the registered manager and this information informed the responsible persons' monthly monitoring visit in accordance with regulation 29.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision and completed annual appraisals. Although, the registered manager explained that competency and capability assessments were completed with all registered nurses who were given the responsibility of being in charge of the home, the review of records evidenced that the assessments were not completed on an annual basis. This was discussed with the registered manager. A recommendation has been made in this regard.

There were systems in place for the recruitment and selection of staff. A review of one personnel file evidenced that these were reviewed by the registered manager. Where nurses and carers were employed, their PIN numbers were checked, on a regular basis, with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), to ensure that their registrations were valid. Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. The review of recruitment records evidence that enhanced criminal records checks were completed with Access NI and we were able to verify the Access NI reference number and the date this had been received.

Although the recruitment records were generally well maintained, the review of the interview records of one staff member, did not evidence any recorded explanation of a two-year gap in their employment history. The registered manager provided assurances that this gap had been discussed verbally with the applicant, during the interview process. A recommendation has been made in this regard.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. A review of the records identified that concerns had been logged appropriately. A review of documentation confirmed that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

Validated risk assessments were completed as part of the admission process and were generally reviewed as required. Refer to section 4.4 for further detail. The risk assessments informed the care planning process.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were generally completed following each incident, care management and patients' representatives were notified appropriately. However, a review of notifications of incidents to RQIA since the last care inspection confirmed that an accident, which resulted in a patient sustaining a head injury, had not been reported, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. A requirement has been made in this regard.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. The areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. Infection prevention and control measures were adhered to and equipment was stored appropriately.

Fire exits and corridors were maintained clear from clutter and obstruction. Although there was a process in place to ensure that personal evacuation plans were completed for each patient, taking into account their mobility and assistance level, the review of the care records identified that these had not been completed for four patients who had been recently admitted to the home.

A review of the central emergency evacuation plan also identified that this had not been updated, to include the details of patients who had been recently admitted to the home; and that the names of patients who were no longer residing in the home, had not been removed. This meant that in the event of an emergency, the records relied on in such circumstances, were inaccurate. Following the inspection, the registered manager confirmed to RQIA, by email on 17 October 2016, that these records had been updated. A recommendation has been made in this regard.

Areas for improvement

A recommendation has been made that agency staff inductions are completed and records retained in the home. Agency staff profiles, which evidence the training and competency level achieved, should also be retained.

A recommendation has been made that competency and capability assessments are completed on an annual basis, for registered nurses who have the responsibility of being in charge of the home, in the absence of the registered manager.

A recommendation has been made that before making an offer of employment, any gaps in an employment record are explored and explanations recorded.

A requirement has been made that RQIA is notified of any serious injury to a patient in the home.

A recommendation has been made that the current fire risk assessment and fire management plan is revised on a regular basis and action is taken when necessary or whenever the fire risk has changed. This relates specifically to patients who are newly admitted to the home and those that are no longer residing in the home.

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

4.4 Is care effective?

As discussed in section 4.3, a review of nine patient care records evidenced that a range of validated risk assessments were generally completed as part of the admission process and reviewed as required. However, in relation to the care record of one identified patient who had a wound, the wound assessment had not been completed in 38 days. A review of the care plan for wound care management identified that although this had been updated on a regular basis, regarding the progress of the wound, there was no information recorded regarding wound measurements. Wound photography was also not available, in keeping with best practice guidelines.

The review of the records also evidenced that the dressing had not been consistently changed according to the care plan. For example, in four out of the seven weeks, reviewed, the wound dressing had not been changed in accordance with the care plan. Given that the home utilised a high number of agency staff, the process for communicating wound care regimens was discussed with the staff. Although, the staff consulted with confirmed that scheduled dressing changes were communicated in the unit diary, a review of the diary entries identified that this was not consistently completed by agency nursing staff. One requirement has been made in relation to the management of wound care. Refer to section 4.6 for further detail.

With the exception of wound care management, all other patient care records were maintained appropriately. There was evidence that patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day. Referrals were made to relevant health care professionals, such as GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of the patient's poor nutritional intake. Where a patient required a percutaneous endoscopic gastrostomy (PEG), as a means of feeding when oral intake is not adequate, a care plan was in place to direct the staff in the management of the PEG site and on administering medications. PEG guidelines were also in place in the patient care record, for staff to reference.

Another patient who had displayed challenging behaviour, had a care plan developed which included potential triggers for the behaviour and effective strategies that would diffuse the identified behaviours. Patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

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

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored.

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

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The most recent staff meeting was held on 28 September 2016. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager.

Consultation with the registered manager and review of records evidenced that patients and/or relatives meetings were held on a regular basis and records were maintained. The registered manager also obtains feedback from three patients' representatives on a weekly basis, to ascertain their views on the home environment and the care of their relative. The most recent patients' and relatives' meetings were held on 29 September 2016. Minutes of the meetings held were reviewed and confirmed attendance and the detail of the issues discussed.

A notice board displaying information for relatives was provided in the front foyer area and included information on how to make a complaint and whistleblowing arrangements in the home. Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management.

Areas for improvement

A requirement has been made that patients' needs are assessed and that a treatment plan is developed, implemented accordingly and recorded to evidence all care provided, with particular reference to wound care. Consideration should also be given to the use of wound photography in keeping with best practice.

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

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with six patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and their feedback had been listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Menus were displayed clearly in the dining rooms. We observed the lunch time meal in two dining rooms. The atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set with tablecloths and specialist cutlery and plate guards were available to assist patients to maintain some level of independence as they ate their meal. The lunch served appeared very appetising and patients spoken with stated that it was always very nice.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. A review of the care records also evidenced that patients' life histories had been developed and social care plans were in place to ensure that patients' social care needs were met individually. There were various photographs displayed around the home of patients' participation in recent activities.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

The care plans reviewed, detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for patients, as appropriate. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met. However, one patient was identified as requiring palliative care and the review of the records did not evidence that a care plan had been developed to address the patient's end of life care needs. This was discussed with the registered manager. A recommendation has been made in this regard.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Views and comments recorded were analysed and areas for improvement were acted upon.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included praise for: 'the lovely family atmosphere and staff that care for the residents that they look after'.

During the inspection, we also met with six patients, three patients' representatives, five care staff, four registered nurses and three ancillary staff. There were no concerns raised during the inspection and all of the comments received were positive. Some comments received are detailed below:

Staff

"I enjoy working here, the care is good".
"It is very good here; we work very well as a team".
"The residents are well cared for".
"It is brilliant here, there is person-centred care and the residents always come first".
"When we are short (staffed), we all battle on and make sure the patients' needs are met".

Patients

"They are more than good, the food is good. If I wasn't happy, I would speak up".
"The care here is second to none".
"Everything is rightly here".
"Everything is good".
"It's alright, I am fine here".

Patients' representatives

"'I have no concerns".
"The staff are extremely polite. We are very pleased with the care and attention".
"They are all well looked after here".

In addition to speaking with patients, relatives and staff RQIA provided questionnaires. At the time of writing this report, two relatives, two patients and seven staff had returned their questionnaires within the timeframe for inclusion in this report. Although there were generally no issues raised in the returned questionnaires, one staff member provided a negative in relation to the registered manager, which has been referred to the regional manager, to address.

Areas for improvement

A recommendation has been made that care plans are developed, as appropriate, to address patients' palliative and end of life care needs.

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

4.6 Is the service well led?

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

Following the last inspection, it was evident that action had been taken to improve the effectiveness of the care. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. All those consulted with stated that they had confidence in the registered manager and all staff consulted with described her being 'approachable' and 'very friendly'.

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

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients were aware of who the registered manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. These included medication and equipment alerts and alerts regarding staff who had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, the registered manager outlined how the following audits were completed in accordance with best practice guidance:

- accidents
- wound analysis
- medicines management
- care records
- infection prevention and control
- environment audits
- complaints
- dependency assessments
- health and safety
- bedrails
- care reviews
- DNAR
- Restraint
- Weight loss
- dining experience audits
- human resource audits.

An audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. An action plan was in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous inspection, confirmed that these were appropriately managed.

However, given that a requirement has been made in relation to wound care management, we were not assured about the effectiveness of the wound analysis audits.

Although there was evidence that the audits were conducted on a monthly basis, it was concerning that the audits did not identify the shortfalls identified during this inspection. Refer to section 4.4 for further detail. This was discussed with the registered manager. A recommendation has been made in this regard.

Discussion with the registered manager and review of records evidenced that monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives.

The monthly monitoring report provided a comprehensive overview of areas that were meeting standards and areas where improvements were required. An action plan was generated to address any areas for improvement, which was followed up on during the next monitoring visit.

Areas for improvement

A recommendation has been made that the wound analysis audit tool is further developed to ensure that shortfalls identified during this inspection are identified and follow up action taken to address any identified deficits.

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 the registered 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 30 (1) (c) **Stated:** First time **To be completed by:** 11 December 2016	The registered persons must ensure that RQIA is notified of any serious injury to a patient in the home. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Deficit amended and sent as priority to RQIA. All serious injury and all injury involving the head have been notified to RQIA Manager has quick reference guide provided by FSHC close to hand and is using this as reference to determine reportable issues. Regional Manager provides support and receives copies of all Regualtion 30 reports sent.
Requirement 2 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** 11 December 2016	The registered person must ensure that patients' needs are assessed and that a treatment plan is developed, implemented accordingly and recorded to evidence all care provided, with particular reference to wound care. Consideration should also be given to the use of wound photography in keeping with best practice. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Audit tool for Wound care and corresponding care plans has been developed. Incoprpoarting but not limited to: care plan review, assesment, initial and ongoing timeframes met, preparedness for future wound activities activities that outlines, photography of wound and paticipation. this tool forms the basis of an action plan, which addresses an needs highlighted in the audit. The tool and corresponding actions plan/s then faciliatate accurate reporting on a monthly basis. Resident Traca is conducted on a weekly basis which reviews all elements of care according to the dependency assessment and evlauation tools. Needs and issues are highlighted, represented to RN for action. Evidence of actions taken are reported and kept on file
Recommendations	
Recommendation 1 **Ref**: Standard 39.1 and 39.9 **Stated:** First time **To be completed by:**	The registered persons should ensure that agency staff inductions are completed and records retained in the home. Agency staff profiles, which evidence the training and competency level achieved, should also be retained. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken:

11 December 2016	Profiles for any agency nurse who undertakes shifts currently at Rush Hall care home are in place. These profiles are up to date , with the agency providing any profile that needed renewing. FSHC Inductions for each of the current agency nurses is held on file. An induction exists for each agency staff member.
Recommendation 2 **Ref**: Standard 39 **Stated:** First time **To be completed by:** 11 December 2016	The registered persons should ensure that competency and capability assessments are completed on an annual basis, for registered nurses who have the responsibility of being in charge of the home, in the absence of the registered manager. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: All nurses who have in charge resposnisibilities have completed and provided evidence of competency. Any registered nurse who has not undertaken this competency will not be allocated shifts where they are in charge. Home Manager holds evidence on file of the completed competencies

Recommendation 3 **Ref**: Standard 38.3 **Stated:** First time **To be completed by:** 11 December 2016	The registered persons should ensure that, before making an offer of employment, any gaps in an employment record are explored and explanations recorded. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Gaps in employment history will be explored at time of interview or prior to interview of candidates and offer of employment. Evidence of this exploration will be kept with recuritment documentation/human resource file. Recent recuitment activities evidence the exploration of any gaps in the employment history at the time of interview
Recommendation 4 **Ref**: Standard 48.1 **Stated:** First time **To be completed by:** 11 December 2016	The registered persons should ensure that the current fire risk assessment and fire management plan is revised on a regular basis and action is taken when necessary or whenever the fire risk has changed. This relates specifically to patients who are newly admitted to the home and those that are no longer residing in the home. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Fire risk assessment was in place having been conducted in Novmeber 2015. Fire risk assessment was reviewed on 26 th October 2016. Resident emermency evacuation plans have been updated and are a true reflection of the residents who currently reside at Rush hall. The manager will keep these records updated and reflective of the individual resident need in the event of an fire and or emergency
Recommendation 5 **Ref**: Standard 32.1 **Stated:** First time **To be completed by:** 11 December 2016	The registered persons should ensure that care plans are developed, as appropriate, to address patients' palliative and end of life care needs. **Ref: Section 4.5**
	Response by registered provider detailing the actions taken: Missing documentation was completed and put in place immediately to address the needs of the resident. This care plan was reflective of the residents needs. An audit has been conducted of all existing residents to highlight deficits and any deficits have been actioned. This audit process is to be repeated. Resident care file Traca is conducted for 2 residents each week.
Recommendation 6 **Ref**: Standard 35.4 **Stated:** First time	The registered persons should that the wound analysis audit tool is further developed to ensure that shortfalls identified during this inspection are identified and follow up action taken to address any identified deficits. **Ref: Section 4.6**

To be completed by: 11 December 2016	
	Response by registered provider detailing the actions taken: Audit tool for Wound care and corresponding care plan has been developed. Incoprpoarting but not limited to: care plan review, assesment, initial and ongoing timeframes met, preparedness for future wound activities activities that outlines, photography of wound and paticipation. This tool forms the basis of an action plan, which addresses all needs highlighted in the audit. The tool and corresponding actions plan/s then faciliatate accurate reporting on a monthly basis.

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.

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