The Regulation and Quality Improvement Authority

Inspection Report

13 December 2022

Hillcrest Care Facility

Type of service: Nursing
Address: 23 Old Mountfield Road, Omagh, BT79 7EL
Telephone number: 028 8225 1222

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Dunluce Healthcare Bangor Ltd **Responsible Individual:** Mr Ryan Smith	**Registered Manager:** Mr Caine McGoldrick **Date registered:** 13 July 2022
Person in charge at the time of inspection: Mr Caine McGoldrick	**Number of registered places:** 59 A maximum of 12 patients in category NH-DE. The home is also approved to provide care on a day basis to 4 persons.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** 55
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 59 patients. There are two units; Hillcrest and Hillview. Hillcrest unit has a designated dementia unit on the first floor and general nursing care on the second floor. Hillview unit which is adjacent to the Hillcrest units provides general nursing care. Patient bedrooms and living areas are located over two floors within each of the units and all bedrooms are single occupancy with an en-suite in most rooms. Patients have access to communal lounges, dining areas and an outdoor space. There is a Residential Care Home which occupies the ground floor of Hillcrest Care Facility and the registered manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 13 December 2022, from 9.50 am to 7.10 pm by a care inspector.

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

Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients and staff are included in the main body of this report.

Areas for improvement identified during the inspection are detailed throughout this report and within the Quality Improvement Plan (QIP) in section 6.0.

The findings of this report will provide the management team with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

Throughout the inspection patients and staff were asked for their opinion on the quality of the care and their experience of living or working in this home. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

Questionnaires and 'Tell Us' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The findings of the inspection were provided to the management team at the conclusion of the inspection.

4.0 What people told us about the service

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "The staff are just perfect here", "I have everything I need", "I couldn't ask for more", "The staff are all nice" and "More than happy here". There were no questionnaires received from patients or relatives following the inspection.

One response was received from a relative/visitor via the online survey. The respondent was satisfied that the service was delivering compassionate care but dissatisfied with the delivery of safe care and how the service was being led. No specific comments were made. This information was shared with the management team of Hillcrest Care Facility to review and action as necessary.

Staff said that management were approachable, teamwork was great and that they felt well supported in their role. A number of staff said that staffing levels were inconsistent due to short notice absenteeism but that they were aware of the ongoing recruitment drive. One staff member said: "I love it here" and a further staff member said: "Great team work" and "Staff morale improving".

Comments received during and after the inspection were shared with the management team.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 1 July 2021		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that care records are accurately maintained throughout all relevant documentation. With specific reference to the patients recommended daily fluid target.	**Partially met**
	Action taken as confirmed during the inspection: This area for improvement was partially met and has been stated for a second time. This is discussed further in section 5.2.2.	
Area for improvement 2 **Ref:** Standard 35 **Stated:** First time	The registered person shall ensure that quality governance audits are robust at identifying deficits with a clear action plan, the person responsible for completing the action and follow up. With specific reference to: • care records • environment • IPC.	**Partially met**
	Action taken as confirmed during the inspection: This area for improvement was partially met and has been stated for a second time. This is discussed further in section 5.2.5.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. A system was in place to ensure staff were recruited correctly to protect patients.

Appropriate checks had been made to ensure that registered nurses maintained their registration with the Nursing and Midwifery Council (NMC).

A monitoring system to evidence that care workers are registered with the Northern Ireland Social Care Council (NISCC) was not available during the inspection. This was discussed with the manager who advised that these checks were being completed by the regional manager. The importance of the manager having oversight of these records and being available within the home was discussed with the management team and an area for improvement was identified. Following the inspection, the management team provided written and verbal confirmation that all relevant staff were registered with NISCC and agreed to maintain these records within the home going forward.

The manager advised that a new eLearning system for staff mandatory training had recently been introduced to the home and was in the process of being completed by all staff. Review of the overall staff training statistics evidenced that they were below the desired percentage of staff having completed/updated their mandatory training. The manager provided adequate assurances that relevant action had been taken to address this with ongoing monitoring to ensure full compliance.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis and clearly identified the person in charge when the manager was not on duty.

Staff said they felt supported in their roles and that there was good team work with effective communication between staff and management. Staff also said that, whilst they were kept busy, the number of staff on duty was generally satisfactory to meet the needs of the patients. However; as mentioned above in section 4.0, a number of staff said that staffing levels were inconsistent due to short notice absenteeism but that they were aware of the ongoing recruitment drive by management. Comments received from staff were shared with the management team for review and action as necessary.

The manager confirmed that registered nurses' had completed a competency and capability assessment for taking charge of the home in the absence of the manager and a matrix system was in place to review this annually.

A matrix system was also in place for staff supervision and appraisals to record staff names and the date that the supervision/appraisal had taken place.

5.2.2 Care Delivery and Record Keeping

There was clear evidence of a relaxed, pleasant and friendly atmosphere between patients and staff. The inspector also observed where staff facilitated patients' favourite music or television programme for those who were on bed rest.

Patients who were less able to mobilise require special attention to their skin care. Whilst staff were observed attending to patients care needs throughout the inspection gaps were evident in the recording of repositioning within recording charts. Care records relating to repositioning also contained inconsistent information regarding the recommended frequency of repositioning. This was discussed in detail with the management team and an area for improvement was identified.

Care records specific to wound care identified a number of discrepancies including; the evaluation of individual wounds; gaps in the recording of the recommended frequency of dressing renewal; and care plans that were no longer relevant and/or reflective of the patient's current wound care treatment. Details were discussed with the management team and an area for improvement was identified.

Records confirmed that in the event of a patient falling, a post falls protocol was in place. Records evidenced that the post falls observations had been recorded and necessary referrals made.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The lunchtime dining experience was seen to be a pleasant opportunity for patients to socialise and the atmosphere was calm and relaxed. Patients who choose to have their lunch in their bedroom had trays delivered to them and whilst the main meal was covered on transport the desserts were not. This was discussed with the manager who agreed to communicate with relevant staff and to monitor going forward.

Staff had made an effort to ensure patients were comfortably seated and enjoyed their meal. There was evidence that patients' needs in relation to nutrition and the dining experience were being met. For example, staff recognised that patients may need a range of support with meals and were seen to helpfully encourage and assist patients as required.

A menu was displayed within each of the general nursing care dining rooms reflective of the meals being served. However; a menu was not displayed within the dementia unit. This was discussed with the manager who agreed to communicate with relevant staff and to monitor during daily walk arounds.

There was a choice of meals offered, the food was attractively presented by the catering staff and smelled appetising. Staff knew which patients preferred a larger/smaller portion and demonstrated their knowledge of individual patient's likes and dislikes. Patients said they very much enjoyed the food provided in the home.

Staff said they were made aware of patients' nutritional needs to ensure that recommendations made by the Speech and Language Therapist (SALT) were adhered to. Discussion with staff evidenced that they were providing the correct diet as recommended by SALT. However; care

records contained inconsistencies in the recommended dietary requirements as per SALT assessment. It was further identified that historical SALT recommendations including old terminology not in accordance with the International Dysphagia Diet Standardisation Initiative (IDDSI) terminology remained in a number of care files. Details were discussed with the management team and an area for improvement was identified.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain. If required, records were kept of what patients had to eat and drink daily.

Review of care records for patients at risk of dehydration evidenced that a recommended daily fluid intake was recorded within the patients' daily fluid intake charts. However; care plans regarding dietary requirements did not contain the recommended daily fluid intake or the action to take if the daily fluid intake was below the target. This was discussed in detail with the management team and an area for improvement has been stated for a second time.

Confidential patient information was not held securely in two areas of the home. This was discussed with the management team and an area for improvement was identified.

Care records for recently admitted patients evidenced that relevant care plans and risk assessments had not been completed within the required time frame. It was further noted for one patient returning from hospital that relevant risk assessments and care plans had not been updated following re-admission to the home. This was discussed in detail with the management team and an area for improvement was identified.

Review of four patients care records identified a number of discrepancies. For example; risk assessments and care plans were either incomplete and/or not regularly reviewed; clinical observations were not consistently obtained as directed within care plans. Not all care files had a photograph of the patient; signed consent for the use of bedrails and/or care plan agreements; the overall maintenance of care records was not in keeping with NMC guidelines. Details were discussed with the management team who acknowledged the shortfalls in the documentation and agreed to communicate with relevant staff the importance of accurately recording such information within patients' care records. This was identified as an area for improvement.

Following the inspection, the Responsible Individual provided verbal confirmation that, given the areas for improvement identfied, a full review of all care records had commenced and that action had been taken to ensure that relevant staff complete training in record keeping.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was warm and comfortable and patients' bedrooms were personalised with items important to them. A number of bedrooms had been painted since the last inspection and the management team confirmed that a schedule of refurbishment/redecoration works had commenced including the replacement of identified furniture and floor coverings to ensure the home is well maintained.

Whilst corridors were clear of clutter and obstruction, two fire doors were observed propped open preventing them from closing in the event of the fire alarm being activated. This was brought to the attention of staff and both doors were immediately closed. An area for improvement has been stated to ensure sustained compliance.

In some areas of the home, prescribed supplements, thickening agents, cleaning items, denture cleaning tablets and razors were not securely stored. It was further identified that two electrical cupboards were unlocked and oxygen was not securely stored in two areas of the home. The importance of ensuring that all areas of the home are hazard free was discussed with the management team and an area for improvement was identified.

Review of a sample of bedrooms identified that wardrobes were not secured to walls. The potential risks regarding free standing furniture were discussed in detail with the management team who agreed to have all wardrobes and free standing furniture reviewed and secured where necessary. This was identified as an area for improvement.

There were systems and processes in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases and that any outbreak of infection was reported to the Public Health Agency (PHA).

Whilst there was a good supply of Personal Protective Equipment (PPE) and hand sanitising gel in most areas of the home, a specific type of glove used in the delivery of personal care was not available within one of the units. Staff advised that this type of glove and selection of sizes were not always available within the identified unit. This was discussed with the management team who agreed to review this and to ensure that an adequate supply is available throughout the home going forward.

Staff use of PPE and hand hygiene was regularly monitored by management and records were kept. The Manager also said that any issues observed regarding infection prevention and control (IPC) measures or the use of PPE was immediately addressed.

Observation of staff practices evidenced that they were not consistently adhering to IPC measures, including inappropriate storage of patient equipment/toiletries within communal bathrooms; incontinence pads outside of packaging; unclean linen in trolleys uncovered within corridor areas; a number of light pull cords stained/uncovered and non-availability of liquid soap in two communal bathrooms. Details of these and any other IPC issues identified during the inspection were discussed with the management team who acknowledged that these findings were not in keeping with IPC best practice. An area for improvement was identified.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV. Patients confirmed that they could remain in their bedroom, go to a communal room or outdoors as desired.

Observation of life in the home and discussion with staff and patients established that staff engaged with patients individually or in groups; patients were afforded the choice and opportunity to engage in social activities, if they wished.

During the inspection, a number of patients were enjoying a Christmas carol service in the main reception area of the home. Other patients were observed engaged in their own activities such as; watching TV, resting or chatting to staff. Patients appeared to be content and settled in their surroundings and in their interactions with staff.

Patients commented positively about the food provided within the home with comments such as; “The food is perfect”, “Good food”, “Plenty of choice” and “The food is great”.

Visiting arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

Since the last inspection there has been a change of ownership to Dunluce Healthcare Bangor Ltd and the Responsible Individual is Mr Ryan Smith. Mr Caine McGoldrick remains as the home manager. The manager said they felt well supported by senior management and the organisation.

A review of the records of accidents and incidents which had occurred in the home evidenced that these were notified, if required, to patients’ next of kin, their care manager and to RQIA. However, two notifiable events had not been reported to RQIA and an area for improvement was identified. Following the inspection, both notifications were submitted retrospectively.

The home was visited each month by a representative of the Responsible Individual to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed and available for review by patients, their representatives, the Trust and RQIA.

There was evidence that a system of auditing was in place across various aspects of care and services provided by the home to monitor the quality of care. Whilst the manager confirmed that care record audits were identifying deficits these had not been addressed in a timely way and further discrepancies as mentioned above in section 5.2.2 were identified during the inspection. This area for improvement has therefore been stated for a second time.

During feedback the management team discussed the recent challenges around staffing and the impact that this has had on maintaining quality governance particularly around record keeping. The Responsible Individual confirmed the actions being taken to address the above deficits, including the recruitment of additional registered nurses and management support to enhance the overall governance.

RQIA were satisfied that the appropriate action had been taken at this time to address the immediate issues identified with ongoing monitoring by management to address all other actions.

6.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	6	8*

* The total number of areas for improvement includes two standards that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Caine McGoldrick, Manager and Mr Ryan Smith, Responsible Individual, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 19 (1) (a) (3) (a) (b) Schedule 3 **Stated:** First time **To be completed by:** 17 January 2023	The registered person shall ensure that care records are maintained in accordance with legislative requirements. Ref: 5.2.2
	Response by registered person detailing the actions taken: The Hillcrest Nursing and Dunluce Health Care Group Senior Management Team continue to undertake cyclic reviews of all care documentation records in accordance with the legislative requirements. To ensure that the home have adopted much more robust and transparent evidence of all measures relating to care documentation records that underpin the evidence for quality of care delivery within the home environment, the following steps have also been taken following on directly from the last inspection: 1. A task and finish group was established internally comprised of managerial and nursing staff from Hillcrest and a Senior Manager from the Dunluce Area Management team. This group was facilitated by a senior nurse and Specialist Lecturer from Ulster University with a comprehensive background in academia and Gerontological nursing care and research. The purpose of this group was to undertake and complete a fundamental review and analysis of all care records commensurate with a Corporate identity for Dunluce Health Care Group. 2. This task and finish group completed a compressive review and critical analysis of all existing Dunluce Health Care records in a timely manner. 3. This has resulted in a new Corporate Standard for all Care Documentation records within Dunluce Health Care aligned closely with the Roper, Logan & Tierney Model of Nursing, The PACE (NIPEC) Person-Centred Framework Standards, and the McCormack et al., Person Centred Care Framework philosophy. 4. All Care Documentation records will have two discrete sections moving forwards with Section 1 of all care note documents detailing 1-10 specific sub-sections which will articulate multiple interconnected components of the patient's care quality. Section 2 of the care note documents will follow the specified 12 Activities of Daily Living Approach to Care Delivery operationalising an eclectic approach therein to the development

	of care planning and evaluation methodologies. 5. A new notes filing system has been operationalised internally as a direct result of this review for all existing care documentation to ensure a consistent and strategic approach to care quality provision. 6. The operational plan internally has set specific internal dates for completion of all existing documents to the new Corporate Identity records. 7. All new admissions to the Home will be immediately admitted using the comprehensive documentation records. 8. As new care record files have been operationalised, a new records filing cabinet system to maintain confidentiality of such records has been ordered and will be in place as soon as possible.
Area for improvement 2 **Ref:** Regulation 27 (4) (a) (b) **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall take adequate precautions against the risk of fire. With specific reference to ensuring that fire doors are not propped open. Ref: 5.2.3
	Response by registered person detailing the actions taken: The Home took urgent and immediate steps to rectify the issues identified herein during the monitoring visit. The Home also recognise the critical importance of such potential breaches within the Regulations and have also operationalised the following steps as a direct result: 1. The Home have consulted with Western Emergency Skills Training Limited who have provided a Specialist Lecturer in Fire Safety Awareness (whom was a Crew Commander with the NIFRS & a qualified EMT) Training to undertake an urgent review and re-assessment of the current Fire Risk Assessments and protocols. 2. This Fire Safety Lecturer has completed walk around inspections of the entire home and conducted a review of current fire safety awareness, fire procedures & fire risk assessment documentation. 3. This has resulted in the Home providing additional Fire Safety Awareness Practical Training to all staff to augment their existing on-line mandatory training with the first session being delivered on the 7th February 2023. Other training sessions will be planned and staff will be required to attend this additional mandatory training. 4. The Home Manager will implement any potential revised Fire Safety Awareness Drills cognisant of any recommendations provided by the Specialist Fire Lecturer from Western Emergency Skills Training. .

Area for improvement 3 **Ref:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure as far as reasonably practicable that all parts of the home which patients have access are free from hazards to their safety. Ref: 5.2.3
	Response by registered person detailing the actions taken: All hazards identified during the inspection process where rectified immediately. The Home management team recognise the critical importance of ensuring that, as far as is reasonably practical, that the home is free from any and all such hazards so as to promote patient safety. Taking due cognisance of these issues the following steps have also been taken to address this issue in a robust and transparent manner: 1. The Home Management team will ensure that at all Staff meetings they will reinforce the crucial nature of ensuring that all hazards within the environment are removed so as to maximise on patient safety and to prevent potential harm. 2. The Home Management team will conduct daily walk around inspections on all floors and units at least twice during each shift to ensure full compliance with this issue. 3. Any deviations observed during this walk around will be addressed immediately and accordingly with staff to ensure the environment is free from any potential hazards for patients, visitors and staff.
Area for improvement 4 **Ref:** Regulation 27 (2) (t) **Stated:** First time **To be completed by:** 10 January 2023	The registered person shall ensure that a risk assessment is completed on all wardrobes and free standing furniture and secured for safety as necessary. Ref: 5.2.3
	Response by registered person detailing the actions taken: 1. A risk assessment has been completed within the home for all free standing furniture. 2. An action plan is in place with respect to ensuring a collaborative and consultative risk assessment procedures for patients is completed and evidence of same is documented within the revised Care Records.
Area for improvement 5 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that the IPC issues identified during the inspection are addressed. Ref: 5.2.3
	Response by registered person detailing the actions taken: All IPC issues where practical were addressed immediately during the inspection process. However, the Management team have also taken the following steps related to IPC issues to ensure that this situation does not arise again.

	1. Appropriate gloves are available in all units 2. New linen trolleys have been purchased 3. New light pull coverings have been ordered (awaiting delivery) 4. All staff have been reminded about the importance of returning personal toiletries and other such affects to the patient's own private and personal rooms following any assistance with this ADL. 5. Additional IPC face to face training to augment the online training platforms has already been provided to staff covering all critical areas related to IPC standards and procedures within the home during the month of January. 6. Additional face to face IPC training will be provided and is scheduled as mandatory for all staff within the home. 7. A new IPC Corporate Observational Managerial Audit detailing a total of six core IPC areas has been developed by the Nurse Managers and the Dunluce Senior Management team. This observational audit is to be completed at a minimum daily by the manager, deputy manager or clinical leads. Where any IPC issues are identified this will necessitate the deployment of a comprehensive action plan with review dates.
Area for improvement 6 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that all notifiable events are submitted to RQIA without delay. Ref: 5.2.5
	Response by registered person detailing the actions taken: The Home have recognised the critical nature of this issue and have taken the following steps to ensure immediate rectification of this issue and to prevent any possible reoccurrence of same in the future: 1. Two new clinical nurse leads have been appointed to assist the Nursing Management team with all clinical and governance procedures within the home. Both clinical leads will receive further in-house training and supervision with respect to Care Standards and Care Regulations and the importance of Regulation 29 Monitoring reports. 2. The Dunluce Senior Management team have adopted a revised Reg 29 Monthly Monitoring Report which is an adaptation of the Appendix 2 Schedule from RQIA and this will ensure that a much more robust focus on notifiable events are submitted to RQIA without delay. 3. Team meetings which are held monthly will have a fixed agenda item to review all such notifiable events and the Reg 29 Monthly Monitoring Reports. 4. Internal managerial audits continue to be completed which will focus on such notifiable events also and will be revised to reflect that a notifiable event has been reported immediately to RQIA.

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** 27 December 2022	The registered person shall ensure that care records are accurately maintained throughout all relevant documentation. With specific reference to the patients recommended daily fluid target Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: The Hillcrest Nursing and Dunluce Health Care Group Senior Management Team continue to undertake cyclic reviews of all care documentation records in accordance with care standards. To ensure that the home have adopted much more robust and transparent evidence of all measures relating to care documentation records that underpin the evidence for quality of care delivery within the home environment, the following steps have also been taken following on directly from the last inspection: 1. A task and finish group was established internally comprised of managerial and nursing staff from Hillcrest and a Senior Manager from the Dunluce Area Management team. This group was facilitated by a senior nurse and Specialist Lecturer from Ulster University with a comprehensive background in academia and Gerontological nursing care and research. The purpose of this group was to undertake and complete a fundamental review and analysis of all care records commensurate with a Corporate identity for Dunluce Health Care Group. 2. The revised care documentation records will place significant emphasis on critical observations for the patient that are ongoing daily, which include the critical nature of daily fluid balance monitoring. This will be clearly identified within an appropriate Care Plan and Care Evaluation Records and evidenced within the ADL 4 Eating & Drinking aspect of care records. 3. Additional staff training on the importance of recording accurate observations continuously within all aspects of care documentation records in accordance with Care Standards and the NMC Guidance has been provided in the month of January to all Registered Nurses. This mandatory training placed detailed focus on the critical application of observations for patients and the critical application of theories and models of care within the cyclic process from assessment to evaluation of same. 4. The two clinical leads will be directly responsible for disseminating and cascading this training further to any Registered Nurse who was not able to attend the training session. 5. Additional training is currently being planned for all care staff within the home who are involved in data entry onto all daily

	care records and this training will also be mandatory to ensure that all care records are completed properly and in accordance with the prescribed assessment and plan of care.
Area for improvement 2 **Ref:** Standard 35 **Stated:** Second time **To be completed by:** 13 January 2023	The registered person shall ensure that quality governance audits are robust at identifying deficits with a clear action plan, the person responsible for completing the action and follow up. With specific reference to: • care records. Ref: 5.1 and 5.2.5
	Response by registered person detailing the actions taken: The Management team within the Home and the Senior Management Team for Dunluce Health Care recognise the importance of robust quality governance audits to be in place for identifying deficits with a clear actionable plan and person responsible evidenced, and for such a plan to be time bounded. The existing mechanisms in place specifically relating to care records as identified within the inspection report have been significantly revised as a direct consequence of this QIP No 2 and the Regulatory QIP No 1 above. Further to, and in addition to the detailed responses provided at Regulatory QIP No 1 above the Home would point out the following steps have also been taken to address this area for improvement: 1. Additional staff have been appointed within the home. 2. Two experienced staff nurses have been appointed as Clinical Leads for the home and both have received professional supervision from the newly appointed Director of Nursing (DON) regarding transitions to their new roles as Clinical Nursing Leads within Gerontological Nursing. 3. A Senior Nurse at Director of Nursing level has also been appointed for the Dunluce Health Care Group. The new Director of Nursing is an experienced senior nurse, nurse academic and nurse researcher within Gerontological Nursing and will add to the existing quality of Senior Management within Dunluce. The DON will have direct nursing and professional responsibility within all nursing homes within the Dunluce Health Care Group and will be directly working within each care home weekly with all staff..

Area for improvement 3 **Ref:** Standard 35 **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that the manager has oversight of relevant registration checks on care assistants with NISCC and that evidence of these checks is available within the home. Ref: 5.2.1
	Response by registered person detailing the actions taken: Following an ongoing process involving discussions and communications with the Registration Manager at NISCC, they confirmed that the Database Team has this issue resolved on the 21/12/23. The Management team within the home and the Senior Management Team within Dunluce including the Area Manager and the newly appointed DON have direct observational access to these NISCC records, As an additional measure the Dunluce Health Care Group have also implemented the following steps: 1. The Manager will continue to review all aspects of NISCC registrations status on a continuous basis ensuring that staff are compliant with all registration requirements therein. 2. The Area Manager and DON will also have oversight of these records and will continue to present audit reports for the home manager to action within an appropriate time frame. 3. The revised Reg 29 Monitoring Report will place more emphasis on this aspect of continuous monthly monitoring of NISCC registrations.
Area for improvement 4 **Ref**: Standard 23 **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that where a patient requires repositioning the recommended frequency of repositioning is consistent within care plans and recording charts are reflective of the recommendations within care plans. Ref: 5.2.2
	Response by registered person detailing the actions taken: The issue of accurate and detailed recording for all care documentation records have been internally reviewed in a comprehensive and robust manner as detailed above at Regulatory QIP No 1 and Care Standards QIP No 1 and this will directly address this issue immediately. Moreover the following points will enable a more robust and transparent approach to such care records for patients on this daily level of care provision. 1. The addition of two new Clinical Leads will enable a more robust approach to the monitoring of all daily care records for each patient, particularly related to moving and repositioning and that of fluid balance monitoring and application of topical creams and these will be much more consistently aligned to the revised ADL approaches for the provision of individualised patient care. 2. The hand over reports will also specifically focus on the

	critical nature and accuracy of completing these daily monitoring and review charts. 3. Additional focused training will be provided to all care staff who are involved in these daily tasks to ensure that all staff fully understand and value these core aspects of assessed and planned components of care, and the importance of their role therein, particularly related to reporting and recording information accurately. 4. The newly appointed DON will also review care documentation records as part of their audit processes and will develop immediate and actionable plans with all staff accordingly where any deficits are identified
Area for improvement 5 **Ref**: Standard 23 **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that where a patient has been assessed as requiring wound care the following action is taken: • a care plan is implemented with the recommended wound care dressings and frequency of dressing renewal • a separate evaluation is completed for each individual wound following a dressing renewal • the wound is redressed in accordance with the recommended frequency reflected within care plans. Ref: 5.2.2
	Response by registered person detailing the actions taken: The entire process of care documentation and record keeping within the home has been revised and an ongoing process of care records standards has been operationalised for Dunluce Health Care Group. This will clearly address patient wounds under the appropriate ADL's with specific and enumerated care plans and evaluations in place. This will address the deficits identified within the inspection report. Further to this review the additional steps have also been taken: 1. Additional training has been booked and planned with TVN to be run out within the month of February 2023 2. The DON will continue to review and monitor care records and plans to ensure full compliance with care standards and will liaise with the care teams accordingly. 3. The DON will also ensure a cascade approach to provision of additional training in wound care management for the two clinical nurse leads. This will be prioritised and a collaborative and collegiate approach to involving the Trust's Tissue Viability Nurses input into any aspect of complex wound management issues will be sought to enhance the quality of wound care management practices.

Area for improvement 6 **Ref**: Standard 12 **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that care records are accurately maintained with the most up to date SALT recommendations. Ref: 5.2.2
	Response by registered person detailing the actions taken: As identified earlier within the responses and QIP's herein, this is a further important area relating to care documentation and standards therein. The comprehensive review completed and the current approaches to standardisation of all care records will ensure that this issue is immediately rectified. In addition to these approaches the Home have also implemented the following: 1. Care Assessments relating to SALT recommendations will clearly be situated within the ADL 4 care processes with clear Person Centred Care Plans operationalised therein. 2. The new clinical nurse leads will also ensure that effective communication strategies are in place with effective liaison and notifications for all staff to identify SALT recommendations specific to the patient. 3. This will include utilising additional or complimentary assessment tools within the overall care approach as identified within the ADL 4 Care Folder. 4. Current RQIA Care Pathways are exploring issues related to risks of choking and FBOA related issues. This guidance and additional empirical evidence approaches will underpin care planning approaches for all SALT recommendations. 5. Additional emergency First Aid Training related to FBOA procedures aligned to the Resuscitation Councils (UK) algorithm for management of same will be provided to all staff and this training will also be mandatory.
Area for improvement 7 **Ref**: Standard 37 **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that any record retained in the home which details patient information is stored safely in accordance with the General Data Protection Regulation and best practice standards. Ref: 5.2.2
	Response by registered person detailing the actions taken: Ensuring confidentiality of patient care records has been addressed immediately within the home following the inspection. All care records have been comprehensively reviewed and are in the process of being standardised with a Corporate Identity to same. Correlational to this approach the new records will be housed within a new filing system and these will be secured in a new and modern lockable filing cabinet. This has been ordered and will be operationalised soon. In the interim all current records are being secured in accordance with GDPR Data Legislation within the home. The home have also provided

	additional face to face training for all Registered Nurses within the month of January and this training will have emphasised both the GDPR legislation and the NMC requirements relating to confidentiality of records..
Area for improvement 8 **Ref**: Standard 4.1 **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that risk assessments and care plans are completed within the required timeframe following admission/re-admission to the home in accordance with legislative requirements. Ref: 5.2.2
	Response by registered person detailing the actions taken: As detailed within this QIP the need for consistency and standardisation of care records and the approach to same has been clearly recognised with comprehensive plans in place to address any and all potential deficits therein. With respect to Risk Assessments and Care Plans the new approaches being operationalised will ensure that all appropriate Risk Assessments have been completed for the individual patient and multiple additional Risk Assessment Forms have been aligned to ADL 1 – Maintaining a Safe Environment. The following steps have also been taken: 1. The critical nature of consent, or potential issues related to any Deprivation of Liberty will be clearly situated within Section 1 of the new approach to care records and all practitioners will be aware of this approach and the intrinsic nature of consent related to the assessment and management of risk factors. 2. The revised corporate approach to care records and documentation will ensure that all staff complete and adhere to the appropriate time frames therein following admission/readmission to the home. An overview of assessment records to be completed within an allocated time frame will be realigned to the current realignment of the ADL's approaches to care delivery. Staff will be required to complete and sign off on assessment formats operationalised that are directly aligned to risk assessment for the patient. 3. These important changes have also been included within the in-house face to face training on care records, theories and models for effective care provision. 4. The Management team and the Clinical Leads will implement a process of CPD Learning for all newly appointed staff to ensure that they are familiar with all care records and the operationalisation of care plans and evaluations within a specific timeframe..

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