Unannounced Care Inspection Report
21 May 2019

Three Rivers Care Centre

Type of Service: Nursing Home
Address: 11 Millbank Lane, Lisnamallard, Omagh, BT79 7YD
Tel No: 028 8225 8227
Inspector: Jane Laird and Helen Daly

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 56 patients.

3.0 Service details

Organisation/Registered Provider: Zest Care Homes Limited **Responsible Individual:** Philip Scott	**Registered Manager and date registered:** Charlene Parkin Registration pending
Person in charge at the time of inspection: Charlene Parkin	**Number of registered places:** 56
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:** 53

4.0 Inspection summary

An unannounced inspection took place on 21 May 2019 from 09.20 hours to 18.45 hours.

The inspection assessed progress with all areas for improvement identified in the home since the last care and medicine management inspections 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 care inspection, RQIA were concerned that some aspects of the quality of care and service delivery within Three Rivers Care Centre were below the minimum standard expected. A decision was taken to invite the registered person to a meeting with RQIA in relation to post falls management, wound care documentation, record keeping, governance and infection prevention and control (IPC).

This meeting took place on 30 May 2019 at RQIA. During the meeting Claire McKenna, Regional Manager and Charlene Parkin, Manager who were present on behalf of the Responsible Individual, Philip Scott, acknowledged the failings and provided a full account of the actions and arrangements made to ensure the improvements necessary to achieve full compliance with the required regulation and which provided the necessary assurances required.

A further inspection will be undertaken to validate sustained compliance and drive necessary improvements.

Areas requiring improvement were identified as outlined in the quality improvement plan (QIP). Please refer to section 7.0.

In relation to the management of medicines, one area for improvement identified at the medicines management inspection (11 June 2018) pertaining to the management of thickening agents had not been met and is stated for a second time. Five areas for improvement in relation to the storage temperatures for medicines, the management of medicines on admission, distressed reactions, adding medicines to food to assist swallowing and ensuring medicines do not remain in use after their expiry date is reached were identified.

Patients described living in the home as being a good experience. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others/with staff.

Comments received from patients, people who visit them and staff during and after the inspection, are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	*9	*7

*The total number of areas for improvement includes one regulation and two standards which have been stated for a second time.

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

A further inspection is planned to validate compliance and drive improvements.

Enforcement action resulted from the findings of this inspection by way of a meeting at RQIA. Following this meeting a decision was made to take no further enforcement action at this time.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

4.2 Action/enforcement taken following the most recent inspection dated 18 December 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 18 December 2018. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire. A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for care staff from 13 May 2019 to date 26 May 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- one staff recruitment and induction file
- three patient care records
- five patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits/records including medicine management audits
- management of medicines on admission and medication changes
- management of distressed reactions, pain, thickening agents, controlled drugs, antibiotics, warfarin, enteral feeding
- personal medication records, medicine administration records, medicines requested, received and transferred/disposed of
- medicine management audits
- complaints record
- compliments received
- a sample of monthly monitoring reports from March 2019
- RQIA registration certificate

Areas for improvement identified at the last care and medicine management inspections were reviewed and assessment of compliance recorded as either met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of outstanding areas for improvement from previous inspection(s)

Areas of improvement identified at the last care inspection have been reviewed. Of the total number of areas for improvement one was partially met and one was not met. These have been included in the QIP at the back of this report.

Areas of improvement identified at the last medicines management inspection have been reviewed. Of the total number of areas for improvement one was met and one was not met. This has been included in the QIP at the back of this report.

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

We arrived in the home at 09.20 hours and were greeted by the manager and staff who were helpful and attentive. Patients were mainly in their bedroom and staff were attending to their needs. Some patients were seated in one of the lounges in preparation for breakfast whilst others remained in bed, again in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice and staff were observed assisting patients to enjoy their chosen activity and to eat and drink as required.

The manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 13 May 2019 to 26 May 2019 evidenced that the planned staffing levels were adhered to on most occasions. Discussion with the manager further confirmed that contingency measures were in place to manage short notice sick leave when necessary.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients' needs in a timely and caring manner. 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.

Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. Comments included, "I love it here", "Staffing levels have improved" and "Feel supported by management on most occasions". We also sought staff opinion on staffing via the online survey. One response was received which indicated that the staff member was very dissatisfied with the service across all four domains. This information was shared with the manager.

Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Three Rivers. We also sought the opinion of patients on staffing via questionnaires. Unfortunately there was no response in the time frame provided.

Review of one staff recruitment file evidenced that a pre-employment health assessment had been obtained prior to the commencement of employment in line with best practice. Records also evidenced that enhanced AccessNI checks were sought, received and reviewed prior to staff commencing work.

A review of records confirmed that a process was in place to monitor the registration status of registered nurses with the Nursing and Midwifery Council (NMC) and care assistants with the Northern Ireland Social Care Council (NISCC). Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice.

We discussed the provision of mandatory training with staff and reviewed staff training records. The compliance figures for most of the mandatory training were below 50 percent. This was discussed with the manager who stated that they were experiencing difficulties with identified staff members not attending the training and that recent disciplinary action had been commenced. The manager further stated that there was other training that had not been added to the statistics and was unaware of the exact figures. An updated training analysis was forwarded to RQIA following the inspection which provided a greater level of compliance. Training dates were also forwarded for wound care, pressure ulcer prevention and IPC. This is discussed further in 6.6.

We observed the incorrect use of a mobility aid during the transfer of a patient from the day room to the toilet and immediately brought this to the attention of the registered nurse within the unit and then to the manager who stated that this practice had previously been identified and discussed with staff but agreed to address this again to ensure that all moving and handling practices are in accordance with the patients risk assessments and care plans.

We reviewed accidents/incidents records in comparison with the notifications submitted by the home to RQIA which verified that records were maintained appropriately and notifications were submitted in accordance with regulation. However, it was identified that following an unwitnessed fall staff did not record whether or not they had obtained neurological observations. This was discussed with the manager and identified as an area for improvement.

A number of audits were completed on a monthly basis by the manager and/or deputy manager to ensure the safe and effective delivery of care. Falls in the home were monitored on a monthly basis for any patterns and trends which provided the location, time and nature of the fall. IPC, care records, hand hygiene and environment audits were also carried out monthly. However, on review of the issues identified during inspection such as the transportation of clean and unclean linen being shared on the same trolley with no clear segregation, staff wearing nail polish, and patient equipment not effectively cleaned following use, a discussion was held with the manager around the effectiveness of the audits and an area for improvement was identified in relation to IPC. This is discussed further in 6.6.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, the dining room and storage areas. There were numerous areas throughout the home where walls and identified patient equipment were worn or damaged. This was discussed with the manager who submitted an action plan following the inspection detailing all areas of the home that are scheduled for refurbishment with a date for competition. This has been identified as an area for improvement and will be reviewed at a future inspection to ensure that repair work has been initiated and progress made.

We further identified that equipment such as a toaster within one of the dayrooms and kettles within identified bedrooms were unsupervised within the dementia unit and there was no risk assessment carried out to ensure that this equipment was safe to be stored within these areas. This was discussed with the manager who agreed to review the environment and carry out a health and safety risk assessment. This was identified as an area for improvement.

Fire exits and corridors were observed to be clear of clutter and obstruction; however, two identified storage areas were cluttered and untidy with a variety of items such as needles, wound care dressings, plastic bags, catheter equipment, staff coats and handbags. The manager agreed to review the storage space and removed the needles immediately. During the meeting an action plan was provided detailing that a lock had been installed to both storage areas.

Within the dementia unit we observed a store room door open and a spray chemical bottle evident inside. Toiletries were also easily accessible within the patients' bedroom ensuite areas and washing detergent was identified within the smaller dayroom in the dementia unit. It was further identified that a spray bottle containing liquid was on the domestic trolley and the identity of the chemical was unknown as there was no label on the bottle. This was discussed with the manager and assurances were received that keys had recently been purchased for cupboards in all patient ensuite rooms to ensure that toiletries are stored safely and staff have been educated regarding the safe storage/labelling of all chemicals. This was identified as an area for improvement.

Satisfactory systems for the following areas of the management of medicines were observed: the management of the management of medication changes; antibiotics; pain; the majority of medicine records and the management of medicines via the enteral route.

We reviewed the management of medicines on admission for three patients. Written confirmation of current medication regimens was available for patients who were admitted from hospital. However, written confirmation of current medication regimens was not requested from the general practitioner when patients were admitted from their own home. This is necessary to ensure that patients are being administered their medicines in accordance with their most recent prescription. An area for improvement was identified.

The management of medicines prescribed for administration on a "when required" basis for the management of distressed reactions was reviewed for four patients in the Drumragh unit. Care plans directing the use of these medicines were in place for only two of the patients. The reason for and outcome of each administration were not routinely being recorded. It was acknowledged that the reason and outcome for the administration of these medicines was being recorded in the Strule unit. An area for improvement was identified.

Medicines were being added to food to assist swallowing for a number of patients. This had not been authorised by the prescribers and the suitability of adding the specific medicines to food had not been checked with a pharmacist. Care plans were not in place. This is necessary as the medicines may be being administered outside the terms of their product licences. An area for improvement was identified.

The majority of medicines were stored safely and securely and in accordance with the manufacturers' instructions. Satisfactory recordings were observed for the temperature of the treatment rooms and the medicine refrigerator in the Drumragh unit. However, the temperature of the medicine refrigerator on the Strule unit was frequently outside the accepted range (2^{o}C -

8^{o}C). Medicines must be stored at the manufacturers' recommended temperature to ensure their effectiveness. An area for improvement was identified.

A small number of out of date medicines which were prescribed for administration 'when required' were observed at the inspection. In addition, as had been discussed at the last medicines management inspection, the date of opening had not been recorded on all insulin pens. This is necessary to facilitate audit and disposal at expiry. An area for improvement was identified.

The registered manager advised via email (22 May 2019) that both treatment rooms were tidied following the inspection, all clutter had been removed and that dressings from the store cupboards had been relocated to the treatment rooms.

The home's medicines management auditing systems were reviewed. Running stock balances were maintained for the majority of medicines and registered nurses advised that any anomalies were highlighted to the manager. The community pharmacist completed monthly medication audits and the findings were discussed with the manager and an action plan put in place. The audits completed at the inspection indicated that the majority of medicines had been administered as prescribed. Some small discrepancies were discussed with the manager for ongoing vigilance. It was agreed that the areas identified for improvement at this inspection would be included in the monthly audits.

One registered nurse advised that she would like additional training on the use of syringe drivers. This was discussed with the manager who advised that training had been planned.

We reviewed the management of thickening agents. Care plans and speech and language assessment reports were in place. Staff were knowledgeable about each patient's recommendations. Records of prescribing were maintained. However, records of administration by registered nurses were incomplete and care assistants were not maintaining records of administration. This had been identified as an area for improvement at the last medicines management inspection and is stated for a second time.

The management of warfarin was reviewed for two patients. Care plans were in place and records of administration, which included daily running stock balances were maintained. For one patient a copy of the current warfarin regimen was available on the medicines file.
For the second patient, the current dosage directions had been received via telephone call on the day before the inspection. The telephoned directions had not been witnessed by a second nurse and the transcription had not been signed. The registered nurse on duty advised that this was not the usual practice and written directions were requested from the prescriber during the inspection. The manager advised via email that the directions had been received (via email from the prescriber) following the inspection. The management of warfarin had been identified as an area for improvement at the last medicines management inspection. Due to the action taken and the assurances provided this area for improvement was assessed as met.

We reviewed the medication administration records in both treatment rooms and there was no evidence that medicines were being omitted due to patients being asleep. The manager and registered nurses advised that any on-going non-administration of medicines would be referred to the prescriber for review.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment and induction. Further areas of good practice were identified in relation to the standard of maintenance of the personal medication records, the management of antibiotics and the administration of medicines via the enteral route.

Areas for improvement

The following areas were identified for improvement in relation to post falls management, environment, risk management, infection prevention and control (IPC) and control of substances hazardous to health (COSHH).

In addition to the repeated area for improvement, pertaining to the management of thickening agents, five areas for improvement in relation to the storage temperatures for medicines, the management of medicines on admission, distressed reactions, adding medicines to food to assist swallowing and ensuring medicines do not remain in use after their expiry date is reached, were identified.

	Regulations	Standards
Total number of areas for improvement	7	3

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of three patient care records evidenced that care plans were in place to direct the care required and generally reflected the assessed needs of the patient. We reviewed the management of nutrition, patients' weight, management of infections and wound care. There was evidence of regular communication with representatives within the care records. A system was also in place to audit patient care records and each patient had a key worker. A daily record had been maintained to evidence the delivery of care and there was evidence that the care planning process included input from patients and/or their representatives, if necessary.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, general practitioners (GPs), speech and language therapists (SALT) and dieticians. Supplementary care charts such as, repositioning records and elimination records evidenced that contemporaneous records were maintained on most occasions. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), SALT or the dietician. Patients were routinely assessed against the risk of reduced nutrition using a recognised Malnutrition Universal Screening Tool (MUST).

On review of the three fluid intake records it was identified that there was no set fluid intake targets or dates of entry documented within the recording charts and the 24 hour fluid intake was not consistently recorded within the daily evaluation notes for identified patients. This was an area for improvement that was identified at the previous care inspection and has been stated for a second time. We reviewed a sample of repositioning records and identified that there were gaps within the charts where patients had not been repositioned as per their care

plan and the condition of their skin was not documented on all occasions. It was further identified that there was no care plans for identified wounds and when wounds had been dressed they were not consistently recorded within the patients' daily evaluation notes. The manager acknowledged the shortfalls in the documentation and agreed to review all patients care plans regarding wounds and pressure area care and to discuss with the registered nurses the importance of accurately documenting the daily events within patients care records. This was identified as an area for improvement.

It was further identified that a patient who had several wounds was referred to the TVN and advice was given to reposition the patient two hourly, there was no evidence that this had not been implemented into practice and was not included within the care plan. This was identified as an area for improvement at the previous care inspection in relation to ensuring that records are updated following professionals recommendations and has been stated for a second time.

A further patient was identified as being at risk of pressure damage and was noted to be nursed on pressure relieving equipment. However, records failed to record the need for such equipment and the pressure relieving mattress weight setting was not set appropriately for the patient's current weight. This meant that the mattress was not able to function correctly and therefore was ineffective. This was discussed with the manager who agreed to review all pressure relieving equipment and care plans following the inspection and an area for improvement was stated.

We observed the serving of the lunchtime meal. The dining room was presented with condiments and drinking glasses at each table. Lunch commenced at 12.30 hours. Patients were assisted to the dining area or had trays delivered to them as required. Staff were observed assisting patients with their meal appropriately. A staff nurse was overseeing the mealtime and was observed to encourage patients with their meals in an unhurried manner. Staff wore the appropriate aprons when serving or assisting with meals and patients wore clothing protectors as required. A range of drinks were offered to patients and they appeared to enjoy the mealtime experience. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes. The menu was on display within the dining area and offered a choice of two main meals.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other health care professionals. Staff also confirmed that if they had any concerns, they could raise these with the manager or the nurse in charge.

All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other health care professionals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication between patients, staff and other key stakeholders.

Areas for improvement

The following areas were identified for improvement in relation to record keeping and pressure area care.

	Regulations	Standards
Total number of areas for improvement	1	1

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

Cards and letters of compliment and thanks were displayed in the home. Some of the comments recorded included:

- "A massive thankyou to all the staff at Three Rivers"
- "Thank you for the excellent nursing care"

Consultation with 13 patients individually, and with others in small groups, confirmed that living in Three Rivers was a positive experience.

Patient comments:

- "Staff are very good"
- "I feel safe"
- "Very well looked after"
- "Staff are lovely and very kind"
- "Couldn't be better"
- "Staff are always nice"

Representatives' comments:

- "Care standards drop at the weekends"
- "I feel there is good communication here. No concerns"
- "Great communication from staff"

During the inspection we met with four patient representatives. We also sought relatives' opinion on staffing via questionnaires. There was no response in the time frame allocated.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the manager for their information and action as required.

Patients' bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences. A variety of methods were used to promote orientation, for example, appropriate signage, photographs and the provision of clocks and prompts for the date. Patients and staff spoken with were complimentary in respect of the home's environment whilst acknowledging that there were further improvements to be made.

Discussion with patients and staff and review of the activity programme evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. On the day of the inspection the activity schedule was on display within each unit. The activity coordinator discussed the provision of activities and the current arrangements within the home to facilitate patient involvement. The patients appeared to enjoy the interaction between the staff and each other.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to listening to and valuing patients and their representatives and taking account of the views of patients.

Areas for improvement

No areas for improvement were identified during the inspection within this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Since the last inspection a deputy manager has been employed to support the manager with the overall governance of the home. Ms Charlene Parkin has applied for registered managers position and is awaiting registration. Discussion with staff/patients/representatives evidenced that the manager was not visible on the unit to support effective engagement with patients, their representatives and staff. This was discussed with the manager during the meeting who acknowledged that this was an important part of her role and agreed to complete a daily walk around of the home to effectively engage with patients, patient representatives and staff.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed, however, it was identified that there were two complaints recorded by a registered nurse within a patients care records which were not within the homes complaint register. This was discussed with the manager who was unaware that these complaints had been made and therefore unsure if the complainant was satisfied with the outcome and agreed to follow this up. Following the inspection the manager had a meeting with registered nurses to discuss the importance of communicating all complaints to the manager even if the complaint has been resolved.

A number of governance audits were reviewed as outlined in 6.3 in relation to the environment, IPC and care records which did not capture the issues identified during inspection. This was discussed with the manager and an area for improvement was identified.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed on a monthly basis and copies of the report were available for patients, their representatives, staff and trust representatives. Although the reports documented that audits had been carried out they failed to identify the issues that were evident during the inspection in relation to the environment and deficits in IPC practices. This was discussed at the meeting and a robust action plan was provided detailing the refurbishment plan, training dates and review of auditing systems. Assurances were provided that the future monitoring visits would review the content of the audits and establish appropriate action plans where necessary.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to maintaining good working relationships.

Areas for improvement

The following areas were identified for improvement in relation to quality assurance audits.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Charlene Parkin, manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** Second time **To be completed by:** Immediate effect	The registered person shall ensure that accurate records for the administration of thickening agents are maintained. Ref: 6.3
	Response by registered person detailing the actions taken: Charts detailing the SLT prescribed fluid consistency for all residents prescribed thickening agents has previously been implemented and is available in all unit serverys and the main kitchen to act as a checklist for all staff involved in assisting with fluid intake. These will be further developed to bring into line with IDDSI classifications. All thickened fluids consumed by residents are to be recorded on QR8001.34 Fluid intake/output charts and/or QR8001.51 Nutritional intake charts as appropriate and an additional annotation made alongside the amount to denote the consistency given e.g. T1 = Thickened to Stage 1 consistency. All MARs and kardexes should also have the consistency stage noted alongside the prescribed thickening agent. To ensure these previously implemented actions are being adhered to Nursing staff have been instructed to review Fluid and Nutritional charts twice daily. These will further be monitored for compliance by review of a sample selection during the Managers Daily Inspection. Further clincal supervision on the accurate completion of these charts and the standards expected for record keeping as per NISCC/NMC are currently being delivered. Training on record keeping and the surrounding legalities will be provided by Rosemary Wilson, Legal health & social care education consultant on 24/10/19 and all staff will be encouraged to attend. Those staff identified as not adhereing to the measures implemented will receive counselling as a first step in the Company disciplinary process and progress further if needed.
Area for improvement 2 **Ref**: Regulation 27 **Stated:** First time **To be completed by:** Immediate effect	The registered person shall ensure that the environmental and infection prevention and control issues identified during this inspection are urgently addressed. Ref: 6.3

	Response by registered person detailing the actions taken: A full review of the homes environment was undertaken by the Acting Home Manager and the Regional Manager following the date of inspection. A redecoration calendar was formulated and commenced, identifying priority works and this is running to schedule. Other required works which included repairs and replacements in the interests of infection prevention and control have been addressed. Trainng in this area has been made available to all staff on 18/6/19 and 5/7/19. The current monthly infection control audit has been increased to weekly and guidance on the detail of scrutiny required within it and any resulting action plan will be provided by the Regional Manager.
Area for improvement 3 **Ref:** Regulation 14 (2) (a) (b) and (c) **Stated:** First time **To be completed by:** Immediate effect	The registered person shall ensure that cleaning chemicals are suitably labelled and stored in accordance with COSHH regulations. Ref: 6.3
	Response by registered person detailing the actions taken: All domestic staff were met with following the inspection and have been advised that on all occasions any chemicals used must be correctly labelled. Additionally, correct storage of chemicals was also discussed. A new folder with the most recent COSHH Data sheets has been provided for reference. During the Managers Daily Inspection cleaning trolleys are checked and any actions required are addressed immediately.
Area for improvement 4 **Ref:** Regulation 13 (1) (b) **Stated:** First time **To be completed by:** Immediate effect	The registered person shall ensure that all unwitnessed falls are managed in line with current best practice and that neurological observations are obtained. Ref: 6.3
	Response by registered person detailing the actions taken: The adapted SHSCT Falls Tool Kit has been implemented providing guidance for both witnessed and unwitnessed falls. This clearly outlines the procedure to follow, documentation to be completed and all persons to be informed in the event of a fall. Use of this toolkit was covered during recent care file workshops delivered on 10/7/19. Further clinical supervision for all nursing staff is ongoing where the management of falls is discussed on an individual basis. Completed accident/incident forms are forwarded to the Home Manager upon completion and reviewed for accuracy of documentation and course of action taken. A checklist 'yellow slip' identifying any incomplete documents/actions is returned to the responsible nurse highlighting areas for improvement needed.

Area for improvement 5 **Ref:** Regulation 14 (2) (a) (b) and (c) **Stated:** First time **To be completed by:** 21 June 2019	The registered person shall ensure that as far as reasonably practicable unnecessary risks to the health or safety of patients is identified and so far as possible eliminated. This is in relation to the unsupervised use of kettles and a toaster within the dementia unit. Ref: 6.3 **Response by registered person detailing the actions taken:** The kettle identified in a bedroom on the day of inspection had been provided by relatives for their perosnal use during visits, this has since been removed upon request. The dining room were the toaster was located has now been fitted with keypad entry to minimise risk to residents when the room is unattended. All other toasters and kettles are only in servery areas which have a keypad facility. Geezers have been ordered for both units which will further eliminate the need for kettes in all areas.
Area for improvement 6 **Ref**: Regulation 27 **Stated:** First Time **To be completed by:** 21 June 2019	The registered person shall ensure that a refurbishment plan is implemented to include the repair or replacement of identified patient equipment and the refurbishment of walls in multiple rooms. Ref: 6.3 **Response by registered person detailing the actions taken:** A full review of the homes environment was undertaken by the Acting Home Manager and the Regional Manager following the date of inspection. A redecoration calendar was formulated and commenced, identifying priority works and this is running to schedule. Other required works identified during the comprehensive environmental audits have been completed with the exception of some furniture replacements which are on order for estimated arrival early September 2019.
Area for improvement 7 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate effect	The registered manager shall ensure that written confirmation of current medication regimens is obtained for all admissions/re-admissions to the home. Ref: 6.3

	Response by registered person detailing the actions taken: Where a resident is being admitted directly from home a copy of current medications and medical history will be requested from the GP as part of the pre-admission process. Where the resident is being admitted directly from hospital a copy of the same will be requested from the hospital as part of the pre-admission process. Where the resident is returning from a hospital stay and not accompanied by appropriate discharge documentation listing current medications and any changes made whilst inpatient, the nurse-in-charge will liaise directly with the hospital to provide same as a matter of urgency. Such events will be reported to the Trust accordingly.
Area for improvement 8 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate effect	The registered manager shall ensure that medicine refrigerator temperatures are maintained between 2^{o}C - 8^{o}C to ensure that medicines are stored at the manufacturers' recommended temperature. Ref: 6.3
	Response by registered person detailing the actions taken: A new fridge was ordered the day after inspection and installed on delivery to assist with ensuring fridge temperatures are maintained and medicines are stored at the correct manufacturers recommendations.
Area for improvement 9 **Ref:** Regulation 13 (1) (a) **Stated:** First time **To be completed by:** 21 June 2019	The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals. Specific reference to recording charts, care plans and daily records: • Where a patient has been repositioned the frequency should reflect the current care plan, state the condition of the patients skin and the intervention on each repositioning • Wound care documentation must include a care plan for each wound and should be clearly documented within the daily records the wound that has been reviewed Ref: 6.4

	Response by registered person detailing the actions taken: Turning charts have a designated area where the frequency of repositioning as prescribed in the care plan must be recorded. Following repositioning these charts should be recorded timely to reflect the timing, current position, comments on skin condition and check air mattress settings if applicable. To ensure these actions are being adhered to Nursing staff have been instructed to review Turning charts twice daily. The home has purchased timers which are allocated to each resident requiring repositioning and a carer is tasked responsibility for each timer to assist in adhering to prescribed frequency. A weekly audit has been devised to assist management in monitoring compiance and action outcomes as appropriate. All care file documentation is curently being reassessed and restructured to improve flow of information within. Wound documentation now includes an Initial assessment wth photograph, Care plan and Ongoing assessment for each identified wound. Any referrral made to the MDT and any subsequent advice received is filed alongside as supporting documents to the care plan. A wound/pressure ulcer checklist has been implemented to ensure all appropriate actions have been taken and records updated. This checklist is forwarded to the Home Manager upon initial completion and will now also be included in monthly monitoring for review purposes. Wound care workshops and training on pressure area care have been made available to Nursing staff on 13/6/19 and 2/7/19. Awareness sessions on the same topics have been made available to Care staff on 18/6/19 and 5/7/19. These will further be monitored for compliance by review of a sample selection during the Managers Daily Inspection. Further clincal supervision , training and disciplinary progression as outlined in Area for Improvement 1 will take place.
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 4 **Stated:** Second time **To be completed by:** 21 June 2019	The registered person shall ensure that daily fluid intake charts are recorded over a 24 hour period with a set daily fluid intake. Ref: 6.4
	Response by registered person detailing the actions taken: The target fluid intake is identified on each Fluid intake chart for all residents. Charts are totalled by night staff and the input achieved relevant to target is recorded in the daily progress notes. To ensure these charts are being completed correctly and timely Nursing staff have been instructed to review same twice daily. These will further be monitored for compliance by review of a sample selection during the Managers Daily Inspection. Further clincal supervision , training and disciplinary progression as outlined in Area for Improvement 1 will take place.

Area for improvement 2 **Ref**: Standard 35 **Stated:** Second time **To be completed by:** 21 July 2019	The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home. • Governance audits in respect of risk assessment and care plan reviews should be improved to ensure that patient's records are updated following professionals recommendations and on return of a patient to the home following an admission to hospital. Ref: 6.4
	Response by registered person detailing the actions taken: Staff have been reminded of the importance of reporting admissions to hospital to the Home Manager. This is recorded on the occupany movement board and further highlighted for action on return from hospital. On readmission the risk assessments and care plans are reviewed and updated as necessary to reflect any new advice. This is checked as complete by the Home Manager. The Care file audit tool further prompts the auditor to examine discharge information from hospital and check risk assessments and care plans reflect this advice. This will be further discussed at the next staff meeting planned for 18th July 2019. Professional visitors continue to be encouraged to speak to either the Home Manager or the Deputy Manager to relay advice or changes that have occurred during their visit. Where this occurs management checks that care plans and risk assessments have been updated accordingly.
Area for improvement 3 **Ref**: Standard 18 **Stated:** First time **To be completed by:** Immediate effect	The registered manager shall review and revise the management of distressed reactions to ensure that care plans are in place and the reason for and outcome of each administration is recorded. Ref: 6.3
	Response by registered person detailing the actions taken: All care file documentation is currently being reassessed and restructured with training and guidance provided as previously mentioned. Those residents who display distressed reactions and have as required medications prescribed will have care plans implemented that will include the nature of the distressed reaction, potential causative triggers, indications for administration of the prescribed medication and any effect of the same on alleviating the distressed reaction. The care file audit tool will be further developed to include reviewing content of care plans for management of distressed reactions.

Area for improvement 4 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 21 June 2019	The registered manager shall review and revise the management of medicines which are added to food to assist swallowing. Ref: 6.3
	Response by registered person detailing the actions taken: All residents who take their medications with food in order to assist swallow and or to prevent choking in the absence of a prescribed alternative drug form have had this noted on the relevant care plan. All care file documentation is currently being reassessed and restructured with training and guidance being provided as previously mentioned. The care file audit tool will be further developed to include reviewing content of care plans for identified needs in relation to swallow difficulties and the use of food to assist in administering medications.
Area for improvement 5 **Ref**: Standard 30 **Stated:** First time **To be completed by:** Immediate effect	The registered manager shall ensure that medicines do not remain in use after their expiry date is reached. Ref: 6.3
	Response by registered person detailing the actions taken: The serving pharmacist assists in the audit of and management of medications and will be advised of this area for improvement so that they are aware to focus on same. Any issues highlighted during the pharmacist's monthly audit are relayed to the Home Manager and an action plan devised. All staff involved in the monthly changeover of medications have again been advised that all PRN medication should have expiry dates checked to inform the ordering process and stock control. All expired items must be disposed of accordingly and where items have not been used for long periods of time consider seeking permission from the GP to discontinue. If medication is due to expire within the current monthly cycle this should be noted and highlighted on the MARs to increase awareness.
Area for improvement 6 **Ref**: Standard 23 **Stated:** First time **To be completed by:** 21 June 2019	The registered person shall ensure that the settings on pressure relieving mattresses are maintained at the correct setting and included in the patients care plan. Ref: 6.4

	Response by registered person detailing the actions taken: Turning charts have been amended to combine required mattress settings and that these are checked on every repositioning. A mattress schedule is now in place and updated monthly to reflect current resident weights, identify the air mattress/pump in use and the correct settings to select. To ensure settings are being monitored and recorded correctly Nursing staff have been instructed to review these charts twice daily. A weekly audit has been devised and implemented to enable the manager to monitor compliance and action outcomes as appropriate. Training on pressure area care has been provided for all staff as previously mentioned.
Area for improvement 7 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 21 July 2019	The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home. • Environmental audits should be sufficiently robust to ensure that any IPC deficits are appropriately identified and actioned • Governance audits in respect of care records should be improved to ensure care plans are maintained as required. Ref: 6.6
	Response by registered person detailing the actions taken: Monthly Infection Control audits have been increased to weekly and any areas for improvement are noted on an action plan with persons responsible for completing and the required rtimescale identified. ICP issues are reviewed on a daily basis during the Manager's daily inspection and corrective action taken immediately as needed. All nursing care files are currently in the process of being rewritten and restructured. Files identified at the time of inspection along with those identified by specialist trust nurses have been prioritised. All files rewritten and restructured will be further reviewed by the Home Manager or Regional Manager. Once all files have been rewritten a further schedule of audit will be devised to ensure governance of all documentation is undertaken in a timely and robust manner. Additionally, staff to whom audit duites are delegated to will be provided with further guidance and training as to the exact level of detail required to ensure that audits are robust and thorough.

Please ensure this document is completed in full and returned via Web Portal

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