Unannounced Care Inspection Report
20 and 21 July 2016

Blair House Care Home

Type of Service: Nursing Home
Address: 107 Dakota Avenue, Newtownards, BT23 4QX
Tel No: 028 9182 4450
Inspectors: Dermot Walsh and Norma Munn

1.0 Summary

An unannounced inspection of Blair House Care Home took place on 20 July 2016 from 09.45 to 17.00 hours and 21 July 2016 from 09.15 to 15.05 hours.

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

Is care safe?

Safe systems were in place for monitoring the registration status of current nursing and care staff. Accidents and incidents were appropriately managed and RQIA was suitably informed of notifications. Weaknesses were identified in the delivery of safe care, specifically in relation to compliance with best practice in infection prevention and control (IPC). Weaknesses were also identified with safe working practices and fire safety. Two requirements have been made to secure compliance and drive improvement. One recommendation stated for a second time in the previous QIP relating to compliance with best practice in IPC has now been stated as a requirement following consultation with senior management within RQIA. One recommendation regarding fire safety within the home has been stated for a second time.

Is care effective?

Staff were aware of the local arrangements for referral to health professionals. Communications between health professionals were recorded within the patients' care records and recommendations were adhered too. Patients and staff demonstrated confidence and awareness in raising any potential concerns to the relevant people. One requirement regarding the management of wound care has been stated for a second time and one recommendation relating to the dating and signing of records has been stated for a second time. One recommendation stated for a second time in the previous QIP relating to the accurate completion of repositioning records has now been stated as a requirement following consultation with senior management within RQIA. One recommendation has been made in relation to staff meetings.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. Patients and their representatives were very praiseworthy of staff and a number of their comments are included in the report.

Is the service well led?

Many compliments had been received by the home in relation to the care and compassion provided to patients/relatives and some of these comments are contained within this report. Appropriate certificates of registration and public liability insurance were on display. Three recommendations have been made in relation to the auditing of care records, the management of safety alerts and notices and the monthly monitoring reports within this domain to drive improvement.

Two requirements and one recommendation have also been made in the other three domains. In addition, one requirement and one recommendation have been stated for a second time and two recommendations have been stated as requirements following consultation with senior management in RQIA.

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

For the purposes of this report, the term 'patients' will be used to describe those living in Blair House which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	5*	6*

*The total number of requirements and recommendations made includes one requirement that has been stated for the second time and two recommendations that have been stated for the second time. Two recommendations, stated for the second time in the previous inspection, have been stated as requirements.

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

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

1.2 Actions/enforcement taken following the most recent type e.g. care inspection

The most recent inspection of the home was an unannounced pharmacy inspection undertaken on 24 March 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

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

One recommendation stated for a second time in the previous QIP relating to the accurate completion of repositioning records has now been stated as a requirement following consultation with senior management within RQIA.

2.0 Service details

Registered organisation/registered provider: Priory (Watton) Ltd Caroline Denny	**Registered manager:** Caron Conroy
Person in charge of the home at the time of inspection: Caron Conroy	**Date manager registered:** 3 December 2014
Categories of care: RC-DE, NH-DE, NH-I A maximum of 28 patients in category NH-DE located on the ground floor and a maximum of 28 patients in category NH-I located on the First Floor. A maximum of 25 residents in category RC-DE; 11 accommodated on the Ground Floor and 14 accommodated on the First Floor.	**Number of registered places:** 81

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report and the returned QIP
- pre inspection assessment audit.

During the inspection we met with 28 patients individually and others in small groups, three patient representatives, six care staff, five registered nurses and one ancillary staff.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspectors.

Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff. Nine patient, nine staff and seven patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- three patient care records
- staff training records
- staff induction records
- complaints records
- incidents / accidents records since the last care inspection
- minutes of staff meetings
- a selection of audit documentation
- one recruitment file

- competency and capability assessments for the nurse in charge
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- duty rota for the period 11 – 24 July 2016

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 24 March 2016

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

4.2 Review of requirements and recommendations from the last care inspection dated 24 February 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 18 (2)(j) **Stated:** First time	The registered person must ensure that malodours are managed within the home.	**Met**
	Action taken as confirmed during the inspection: No malodours were detected during a review of the environment.	
Requirement 2 **Ref:** Regulation 19 (1) (a) Schedule 3 (1) (a) (b) (3) (K) **Stated:** First time	The registered person must ensure that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance.	**Not Met**
	Action taken as confirmed during the inspection: Records in relation to wound management for an identified patient had not been maintained appropriately. Please see section 4.4 for further clarification. This requirement has not been met and has been stated for the second time.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 32 **Stated:** Second time	The registered person should ensure that a protocol for timely access to any specialist equipment or drugs is developed. A system to implement the protocol should confirm that all relevant staff have read the document with evidence of staff signature and date.	**Met**
	Action taken as confirmed during the inspection: A protocol for timely access to any specialist equipment or drugs was readily available to all staff. Staff consulted with were aware of this protocol.	
Recommendation 2 **Ref:** Standard 46 Criteria (1) (2) **Stated:** Second time	The registered person should ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection.	**Not Met**
	Action taken as confirmed during the inspection: During a review of the environment, it was observed that compliance with best practice in infection prevention and control had not been met. Please see section 4.3 for further clarification. This recommendation has not been met and has now been stated as a requirement following consultation with senior management in RQIA.	
Recommendation 3 **Ref:** Standard 4 Criteria (9) **Stated:** Second time	The registered person should ensure that supplementary care records are completed in full, in a timely manner and a system is put in place to monitor this.	**Not Met**
	Action taken as confirmed during the inspection: A review of four repositioning charts confirmed that poor and/or conflicting information was recorded. Please see section 4.4 for further clarification. This recommendation has not been met and has now been stated as a requirement following consultation with senior management in RQIA.	

Recommendation 4 **Ref:** Standard 4 Criteria (1) (7) **Stated:** First time	It is recommended that patients' continence assessments and care plans are fully completed to include the specific continence products required by the patient.	**Met**
	Action taken as confirmed during the inspection: A review of three patient care records confirmed this recommendation has been met	
Recommendation 5 **Ref:** Standard 47 **Stated:** First time	The registered person should ensure a magnetic lock is applied to the identified kitchen door to facilitate safe and healthy working practices within the home.	**Not Met**
	Action taken as confirmed during the inspection: A review of the identified kitchen door evidenced a magnetic lock had not been applied and the door remained open through a fault in the flooring. Please see section 4.3 for further information. This recommendation has not been met and has been stated for the second time.	
Recommendation 6 **Ref:** Standard 4 Criteria (5) (6) (11) **Stated:** First time	It is recommended that care records should evidence patients and/or their representatives' involvement in the assessment; planning and evaluation of the patients' care to meet their needs. If involvement is not possible, then the reason why should be clearly documented within the patient's care record.	**Met**
	Action taken as confirmed during the inspection: Patient and/or representative involvement was evidenced within three patient care records reviewed.	
Recommendation 7 **Ref**: Standard 37 **Stated:** First time	The registered person should ensure that staff date and sign any record they create in accordance with best practice and professional guidance.	**Partially Met**
	Action taken as confirmed during the inspection: Records reviewed contained evidence of date and signature. However, one alteration made in one record did not include either. This recommendation has not been met and has been stated for the second time.	

4.3 Is care safe?

The registered 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 11 July 2016 to 24 July 2016 evidenced that the planned staffing levels were adhered to. Two staff consulted on inspection were of the opinion that the dependency tool used to determine staffing levels did not accurately reflect patient dependency needs. The registered manager had confirmed that a new dependency tool has commenced to review patient dependency levels and staffing levels would be reviewed following a review of the results from the new dependency tool.

Discussion with patients and representatives evidenced that there were no concerns regarding staffing levels. One respondent from staff questionnaires was of the opinion that the housekeeping department had 'insufficient staffing levels' leading to some units within the home 'frequently without a housekeeper.' Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

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.

Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training. The registered manager would review training records monthly and a daily 'Foundations For Growth' (FFG) status report would be submitted to the home's head office. The registered providers aim for a 97 percent compliance level with training completed within their homes. The registered manager confirmed the current compliance in training for Blair House was 98.4 percent completion.

Competency and capability assessments of the nurse in charge of the home in the absence of the manager had been completed appropriately. The completed assessments had been signed by the registered nurse and verified by the registered manager as successfully completed.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC). NMC and NISCC checks were monitored monthly and evidenced within a file.

A review of the recruitment process evidenced a safe system in practice. Relevant checks and interviews had been conducted prior to the staff member commencing in post.

Discussion with two staff demonstrated a lack of knowledge of their specific roles and responsibilities in relation to adult safeguarding. Discussion with the registered manger confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. Compliance with completed safeguarding training for all staff members was at 85.6 percent. The registered manager confirmed that updated safeguarding training would be completed with all staff.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. There was evidence that risk assessments informed the care planning process.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since 24 February 2016 confirmed that these were appropriately managed. However, two separate falls had been recorded within one accident report. This was discussed with the registered manager and it was agreed that each fall should have been recorded separately. The manager agreed to bring this to the attention of staff.

A review of the home's environment was undertaken. This included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. Rooms and communal areas were clean and spacious. Fire exits and corridors were observed to be clear of clutter and obstruction.

The following issues were identified which were not managed in accordance with best practice guidelines in IPC:

- inappropriate storage in identified rooms
- kitchenette requiring a deep clean
- pull cords in use without appropriate covering
- rusted shower and commode chairs
- commode/shower chairs not effectively cleaned after use
- signage attached to wall with adhesive tape
- inappropriate hand hygiene
- pressure cushions in disrepair

The above issues were discussed with the registered manager and an assurance was provided that these areas would be addressed with staff and measures taken to prevent recurrence. A recommendation was made during a previous inspection on 7 September 2015 that management systems are put in place to ensure compliance with best practice in infection prevention and control. This recommendation had been stated for a second time at the most recent inspection on 24 February 2016 and following the findings of this inspection and in consultation with senior management in RQIA this has now been stated as a requirement.

During a review of the environment, four doors were observed to be wedged or propped open. This would pose a serious risk to patients should a fire break out. A requirement has been made. It was also required that the wedging or propping open of doors must cease with immediate effect. The registered manager agreed to monitor this. A recommendation had been made in the previous inspection regarding the fitting of a magnetic lock to facilitate safe passage through an identified kitchen door when serving meals. The magnetic lock had not been fitted and the door was maintained open due to a fault in the flooring. This was discussed with the registered manager and the flooring was repaired on day two of the inspection. The recommendation was stated for a second time.

One fire door was blocked from closure by a heated food trolley. The trolley was used to keep food warm prior to and during the serving of meals to patients in a lounge/dining area. The heated trolley was unsupervised for periods of time and as the surface of the trolley was very hot, this posed as a potential burn hazard to any patient who came into contact with it. Four doors which should have been locked to promote the health and safety within the home were observed to have been unlocked. These rooms were a sluice, two rooms containing open accessible electrical boxes and a domestic store containing numerous chemicals accessible to anyone who accessed it.

A patient was observed by the inspectors entering the unlocked sluice. The inspectors immediately intervened to prevent any harm coming to the patient and alerted staff who escorted the patient from the room. These issues were discussed with the registered manager and a requirement was made to ensure that the health and safety of patients was maintained within the home.

A refurbishment programme was in progress in the home. All carpeting had been removed from downstairs bedrooms and the flooring replaced. Downstairs lounges, corridors and 30 bedrooms had been repainted. The registered manager confirmed the redecorating programme was ongoing throughout the home.

The outside garden area was reviewed on inspection. The garden area was enclosed with two key padded gates at each end. Seating was provided and filled flower boxes were situated around the garden. The garden area was observed to be very well maintained. The door leading to the garden from the home was alarmed. The alarm had been triggered by inspectors opening the door. It was concerning that after approximately three minutes the alarm had not been responded too and the inspectors had to actively seek staff to turn the alarm off. This was discussed with the registered manager who agreed to review the response times of alarms.

Areas for improvement

It is required that the practice of wedging doors open ceases with immediate effect.

It is required that the home is conducted in a manner which protects the health and welfare of patients in that the identified doors remain locked when not in use and that action is taken over the use of the heated food trolley to prevent harm/injury to patients.

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

4.4 Is care effective?

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. Care plans had been personalised to meet the individual needs of the patients and had been reviewed monthly.

Staff demonstrated an awareness of patient confidentiality in relation to the storage of records. Records were stored securely in nursing stations requiring keypad access. However, as discussed previously doors had been observed to be propped open.

A review of repositioning charts evidenced that they had not been completed in accordance with best practice guidelines. Repositioning charts were recorded inconsistently with regards to evidencing skin checks at the time of repositioning. Repositioning charts reviewed did not make reference to the actual pressure areas or wounds identified. The frequency of repositioning was not recorded on the charts. A requirement has been made (see section 4.2).

Review of records pertaining to the management of wounds evidenced that registered nurses were not adhering to regional guidelines and the care planning process. For example, one patient did not have an initial or ongoing assessment of a sacral wound. The sacral wound had been identified previously and referenced within the current repositioning chart as 'break on bottom.' A care plan had not been developed to direct care of the sacral wound. A grade four pressure damage to a patient's heel was identified on a body map recorded on 12 July 2016. A corresponding care plan had not been developed until the 15 July 2016. The care plan referred to grade two pressure damage. The patient's Braden risk assessment had not been updated until eight days following the discovery of the wound. Neither wound had been monitored closely within the patient's daily evaluation. A requirement made in the previous QIP regarding the recording of wound management, has been stated for a second time (see section 4.2).

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. A 'Handover Sheet' which was a booklet containing patient names, mobility, personal care, continence, diet and space for other relevant information was given to, and completed by, each member of staff. Concerns were raised with the registered manager with regards to wound care as, when asked, some staff were unaware of which patients had a wound and/or the location of the wound/s.

Registered nurses were aware of the local arrangements and referral process to access relevant healthcare professionals, for example General Practitioner's (GP), speech and language therapist (SALT), dietician and tissue viability nurse (TVN).

Discussion with the registered manager and a review of records pertaining to meetings confirmed that from the previous care inspection on 24 February 2016, a 'trained staff meeting' had occurred on 13 April 2016. Minutes were also available evidencing a meeting which was conducted in the Dakota Unit on 9 March 2016. Minutes of the meetings were available and maintained within a file that included details of attendees; dates; topics discussed and decisions made. Information sent to RQIA following the inspection evidenced a housekeepers' meeting conducted on 6 May 2016. A recommendation was made to ensure all staff within the home have an opportunity to attend a meeting, or review the meeting minutes, at minimum quarterly.

The registered manager confirmed that an annual survey was sent to all patients' families from the Provider's head office. An operations manager would process and feedback the results to the registered manager who would then develop an action plan to address any shortfalls identified. The registered manager confirmed the results from the survey would be discussed at staff and patient/relatives' meetings.

Patient meetings were conducted monthly and chaired by the Social Activities Leader in the home. A monthly 'Blair House News' newsletter was provided by the home and a 'Weekly Sparkle' was also made available for staff/patients/relatives. Relatives meetings were conducted three monthly. Minutes of these meetings were displayed on a relatives' noticeboard.

The registered manager confirmed that they operate an 'open door policy' and are available to discuss any issues with staff, patients and/or relatives. The registered manager also confirmed that they would undertake a daily walk around the home and would avail of the opportunity to engage with patients and relatives at this time.

Staff consulted knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and/or the registered manager. However, one staff questionnaire respondent was of the opinion that they 'did not always feel that complaints/concerns identified and reported are adequately addressed'. Four staff were unclear of the name and contact details of the management structure above the registered manager. One member of staff was voted by staff in the home to become the representative of Blair House when an 'Amore Care online forum' will be conducted in August 2016 and monthly thereafter. The representative can also contact the provider's human resource team at any stage to raise any concerns staff may have. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Patients and representatives were confident in raising any concerns they may have with the staff and/or management.

Areas for improvement

It is recommended that staff meetings occur at minimum quarterly.

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

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Nine staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. One of the questionnaires was returned within the timescale for inclusion in the report. On inspection five registered nurses, six carers and one ancillary staff members were consulted to ascertain their views of life in Blair House.

Some staff comments were as follows:
"I really enjoy it here."
"I love it here."
"I am very happy working here."
"We work as a team here."

Patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Consultation with 28 patients individually, and with others in smaller groups, confirmed that, in their opinion, the care was safe, effective, compassionate and the service was well led. Nine patient questionnaires were left in the home for completion. One patient questionnaire was returned within the timeframe.

Some patient comments were as follows:
“It’s very good here.”
“It’s fine here.”
“It’s alright here.”
“It’s very nice here.”
“It’s ok.”
“It’s very pleasant here.”

Three patient representatives were consulted on the day of inspection. Seven relative questionnaires were left in the home for completion. Two relative questionnaires were returned. Responses received would indicate a high level of satisfaction with this service.

Some representative comments were as follows:
“The staff are brilliant, I would recommend this place to anyone.”
“The care is good here.”
“The staff take time to talk to you.”

The serving of lunch was observed in the main dining room on the first floor. The mealtime was well supervised. Food was served in an organised manner; when patients were ready to eat or be assisted with their meals. Staff wore appropriate aprons when serving or assisting with meals. A selection of condiments were on the tables and a range of drinks were offered to the patients. The food appeared nutritious and appetising. The mealtime experience was observed to be well organised and pleasurable for the patients.

In the ground floor residential unit a staff member was observed carrying two biscuits in their hand from a kitchenette to a patient. No side plate was provided to place the biscuits onto beside the patient and tongs were not used to remove the biscuits from the container. This was discussed with the registered manager and it was agreed this practice would cease with immediate effect.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. However, as previously discussed, some staff are unaware of the provider’s management structure above the home’s registered manager. Staff were able to describe their roles and responsibilities.

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

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. The complaints procedure was displayed at reception. The detail in this procedure required amendment and was brought to the registered manager's attention who agreed to review and amend the procedure accordingly. The complaints procedure within the homes' 'Welcome Pack' was accurate.

A compliments file was maintained to record and evidence compliments received. Some examples of compliments received are as follows:

"Sincere thanks shown to our dad for the kindness and care."
"We would like to thank you for the devotion and care shown to … while in your care."
"Many thanks for all the care and attention given to mum while in your care. We also appreciate the care and consideration given to our family."

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, monthly audits were completed in accordance with best practice guidance in relation to wound analysis, care records, accidents, medicines management, complaints, health and safety, kitchen, housekeeping and infection prevention and control.

Four care record audits dated from 2 March 2016 to 10 June 2016 were reviewed. Shortfalls had been identified in all audits reviewed. An action plan had not been developed in two of the audits to address the shortfalls. The action plans which had been developed in the remaining two audits had not been reviewed to ensure the actions had been completed. There was no evidence of any management oversight within the care record auditing process. A recommendation was made.

Safety alerts and notices were reviewed by the registered manager on receipt and, where appropriate, were shared with staff. However, a robust system was not in place to ensure that relevant staff had read the communication or had been notified about it. A recommendation has been made that a safe system and procedure is developed to ensure the effective management of safety alerts and notices.

Discussion with the registered manager and review of records evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. The May 2016 report was reviewed on inspection. There was no indication of who conducted the visit. An action plan was generated within the report to address any areas for improvement. However, a review of the previous action plan was not included within the report. There was no indication of a review of the previous RQIA QIP. Copies of the reports were available for patients, their representatives, staff and trust representatives. A recommendation was made.

As previously discussed issues were identified with the management of infection prevention and control practices, completion of repositioning records, safe working practices, staff meetings, care plan auditing, completion of monthly monitoring report, wound management and the management of urgent communications, safety alerts and notices.

Two requirements and one recommendation have been made in the other three domains. In addition, one requirement has been stated for a second time, two recommendations have been stated for a second time and two recommendations have been stated as requirements following consultation with senior management in RQIA.

In considering the findings from this inspection and the requirements and recommendations have been made/stated for a second time regarding safe, effective and compassionate care, this would indicate the need for more robust management and leadership in the home.

Areas for improvement

It is recommended that the auditing process for care planning contains an action plan to address shortfalls and these actions must be reviewed and validated as complete.

It is recommended that the system to manage safety alerts and notices is reviewed to ensure that these are shared with all relevant staff.

It is recommended that the monthly monitoring report is completed in full to include the person conducting the audit, review of the previous action plan and review of the previous QIP.

Number of requirements	**0**	**Number of recommendations**:	**3**

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Caron Conroy, registered manager, and Karen McElherron, regional manager, as part of the inspection process. The timescales commence from the date of inspection.

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

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

5.1 Statutory requirements

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

5.2 Recommendations

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

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for review by the inspector.

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

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref:** Regulation 19 (1) (a) Schedule 3 (1) (a) (b) (3) (K) **Stated:** Second time **To be completed by:** 25 July 2016	The registered person must ensure that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance. **Ref: Section 4.2, 4.4**
	Response by registered provider detailing the actions taken: All trained nurses have recieved wound care training and guidence form the Tissue Viability Nurse in the local trust. A wound care tracker file have been developed and is updated weekly and returned to the managers office. The manager then will audit the files against the information obtained in the tracker file.Any wounds are now delcared to the company QPI system and red flaged during clinical meetings so all staff are aware of any on going wounds and treatment plans.
Requirement 2 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** 31 July 2016	The registered person must ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. Robust systems must be in place to ensure compliance with best practice in infection prevention and control within the home. **Ref: Section 4.2, 4.3**
	Response by registered provider detailing the actions taken: shower chairs and commonde chairs have been replaced and those no longer fit for purpose have been removed. 2 senior cares have been appointed in each of the nursnig units, they will daily check rooms and bathrooms and sign an audit sheet confirming that all areas are clean and tidy and all infection control risks have been eliminated.
Requirement 3 **Ref:** Regulation 19 (1)(a), schedule 3, (3)(k) **Stated:** First time **To be Completed by:** 31 July 2016	The registered person must ensure that supplementary care records are completed in full, in a timely manner and a system is put in place to monitor this. Particular attention should focus on the accurate completion of repositioning charts. **Ref: Section 4.2, 4.4**
	Response by registered provider detailing the actions taken: The shift report has been ammended to show where the Nurse in charge must sign to confirm they have had sight of and checked the repositiong charts at least twice per shift. The Senior cares also have been delegated to over see the completion of the supplemtary records to ensure accuracy. The supplemtary charts are also randomly audited by the home manager and also by the Regional Manager during her visits.

Requirement 4 **Ref:** Regulation 27 (4) **Stated:** First time **To be completed by:** 21 July 2016	The registered provider must ensure that the home is conducted in a manner which protects the health and welfare of patients. The practice of wedging open doors must cease with immediate effect. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Fire door guards have now been ordered for nurses station doors and also for the small kitchen doors. Key pads have now also been fitted to the store doors, and there is also an ammendment to the shift report for the nurse to sign to confirm that all store dorrs have been checked and are locked during shift.
Requirement 5 **Ref:** Regulation 13 (1) (a) **Stated:** First time **To be completed by:** 21 July 2016	The registered provider must ensure that the home is conducted in a manner which protects the health and welfare of patients: The heated food trolley must be employed in a manner which protects the health and safety of patients. Doors leading to rooms which pose a hazard to patients must remain locked at all times when not in official use. Control of Substances Hazardous to Health (COSHH) regulations must be adhered too at all times. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The heated food trolley for the Scrabo unit now only comes to the unit when staff have rang in the morning to the ktichen when they are in the roomo to serve breakfast. This is to prevent the trolley being left unattended. Key pads have been fitted to the treatment rooms and also to the Domestic Stores. Shift report section and Senior carer checks to make sure that doors are secure and locked.
Recommendations	
Recommendation 1 **Ref:** Standard 47 **Stated:** Second time **To be completed by:** 31 July 2016	The registered person should ensure a magnetic lock is applied to the identified kitchen door to facilitate safe and healthy working practices within the home. **Ref: Section 4.2, 4.3**
	Response by registered provider detailing the actions taken: This has been completed and door guards requested for all nurses stations and small kitchens.

Recommendation 2 **Ref:** Standard 37 **Stated:** Second time **To be completed by:** 31 August 2016	The registered person should ensure that staff date and sign any record they create in accordance with best practice and professional guidance. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Supervision has been completed with all staff re documentation and the NMC Guidelines on record keeping has been requested and will be given to each staff member whcih they will in turn sign for reciept off.
Recommendation 3 **Ref:** Standard 41 Criteria (8) **Stated:** First time **To be Completed by:** 31 August 2016	The registered person should ensure staff meetings take place on a regular basis for all staff to attend and at a minimum quarterly. Records are kept which include: • The date of all meetings • The names of those attending • Minutes of discussions • Any actions agreed **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: A meeting calender has now been drafeted for all the meetings held within the home.A signing in sheet will be completed and minutes and actions agreed recorded and available for all staff.
Recommendation 4 **Ref:** Standard 35 Criteria (16) **Stated:** First time **To be completed by:** 31 August 2016	The registered provider should ensure that the auditing process for care planning contains an action plan to address shortfalls and these actions must be reviewed and validated as complete. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: Care Plan audits that require actions will now have actions plans. These action plans will be given to the named nurse with a specific time frame, the nurse will then return the action plan and attend with the file so the actions can be signed off if seen as completed by the manager and the named nurse. This ensures manager oversight that the actions have been completed.

Recommendation 5 **Ref:** Standard 35 Criteria (17) **Stated:** First time **To be completed by:** 31 July 2016	The registered person should ensure a system is in place to manage safety alerts and notifications. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: Safety alret notices are now printed off and placed in an alert file in each unit with a singing sheet for staff to sign when read. art the monthly SQC meetings an alert file will be taken along to the meeting and the alerts for each month discused and any actions required will be recorded.
Recommendation 6 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 31 August 2016	The registered person should ensure that the monthly monitoring report is completed in full to include the person conducting the audit, a review of previous action plan and a review of previous QIP. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: The new regualtion 29 record form has now a area at the front that discusses any actions from previous visit and the actions achieved and those still outstanding that have been carried forward.

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address*

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Assurance, Challenge and Improvement in Health and Social Care