Unannounced Care Inspection Report
1 June 2017

Ardlough

Type of Service: Nursing Home
Address: 2 Ardlough Road, Drumahoe, Londonderry, BT47 5SW
Tel No: 028 7134 2899
Inspector: Aveen Donnelly

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 44 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare **Responsible Individual:** Dr Claire Royston	**Registered Manager:** Ms Anne Martina Mullan
Person in charge at the time of inspection: Ms Anne Martina Mullan	**Date manager registered:** 13 February 2014
Categories of care: Nursing Home (NH) DE – Dementia. MP – Mental disorder excluding learning disability or dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. PH – Physical disability other than sensory impairment.	**Number of registered places:** 44 comprising: 28 -NH-MP and MP(E) (including 1 identified patient in category NH-PH) 16 -NH-DE

4.0 Inspection summary

An unannounced inspection took place on 1 June 2017 from 09.00 to 15.15 hours.

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 Care Standards for Nursing Homes 2015.

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

Evidence of good practice was found in relation to staff recruitment practices; staff induction, training and development; adult safeguarding arrangements; infection prevention and control practices; risk management; the care records and care delivery and effective communication systems. The culture and ethos of the home promoted treating patient with dignity and respect. There was also evidence of good practice identified in relation to the governance and management arrangements; management of complaints and incidents; quality improvement processes and maintaining good relationships within the home.

Areas requiring improvement were identified in relation to the recording of urinary catheter care in keeping with best practice and in relation to ensuring that the displayed menus were correct.

Patients said that they were satisfied with the care and services provided and described living in the home, in positive terms.

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	0	2

Details of the Quality Improvement Plan (QIP) were discussed with Martina Mullan, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the most recent inspection dated 29 November 2016

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 29 November 2016. There were no further actions required to be taken following the most recent inspection.

5.0 How we inspect

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing.
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection the inspector met with five patients, four care staff, three registered nurses, one kitchen staff, one domestic staff and one patients' representative. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

The following records were examined during the inspection:

- staffing arrangements in the home
- one staff recruitment and selection record
- staff induction, supervision and appraisal records
- staff training records for 2016/2017
- accident and incident records
- records relating to adult safeguarding
- patient register
- annual quality report
- compliments records
- RQIA registration certificate
- certificate of public liability
- audits in relation to care records and falls
- a selection of policies and procedures

- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- emergency evacuation register
- four patient care records
- two patient care charts including food and fluid intake charts and repositioning charts
- complaints received since the previous care inspection
- minutes of staff' and relatives' meetings held since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as 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 areas for improvement from the most recent inspection dated 29 November 2016

The most recent inspection of the home was an unannounced medicines management. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 13 April 2016

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 37.1 **Stated:** First time	Consideration should be given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times.	**Met**
	Action taken as confirmed during the inspection: Observations confirmed that patient information was maintained appropriately.	

6.3 Inspection findings

6.4 Is care safe?

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

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the week commencing 22 May 2017 evidenced that the planned staffing levels were generally adhered to. For example, there were two twilight shifts that had not been covered in the period examined. Advice was given to the registered manager in relation to recording the efforts made to replace staff.

Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. Discussion with patients and their representatives evidenced that there were no concerns regarding staffing levels. Two staff members stated that they felt under pressure and that they would like to spend more time with the patients. However, all those spoken with confirmed that the patients' needs were always met. These comments were relayed to the registered manager during feedback

The planned staffing levels were based on the patients' dependency levels, which were assessed using the Care Home Equation for Safe Staffing (CHESS) assessment tool, developed by Four Seasons Healthcare. The registered manager explained that this was reviewed on a regular basis and that the staffing levels could be adjusted as required. The registered manager explained there were currently two registered nurse vacancies; these vacancies were being filled by agency staff or permanent staff working additional hours. Recruitment of staff was in progress.

Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

Discussion with the registered manager and a review of one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Where nurses and carers were employed, their registrations were checked with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC), to ensure that they were suitable for employment. The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI and satisfactory references had been sought and received, prior to the staff member starting their employment. For agency staff, their profile was maintained, which included information on the Access NI check and NMC/NISCC checks; the validity of the registration details provided were also checked by the registered manager.

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

The registered manager had also signed the record to confirm that the induction process had been satisfactorily completed. Discussion with staff and a review of records confirmed that agency staff; and staff from other homes within the organisation, also received an induction to the home.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, undertook competency and capability assessments and completed annual appraisals. Individual supervisions were also conducted with staff in response to learning that was identified from the governance audits. For example, where deficits were identified in the hand hygiene audits, there was evidence that an individual supervision had been undertaken with the identified staff members, to ensure that they adhered to best practice.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and records were kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. The records reviewed confirmed that 100% of staff had, so far this year, completed their mandatory training. This was commended by the inspector. For agency staff, the registered manager also received a profile which included information on their compliance with mandatory training requirements.

Observation of the delivery of care evidenced that training had been embedded into practice. Overall compliance with training was monitored by the registered manager and this information informed the responsible persons' monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

The registered manager and staff also confirmed that training had been provided on the Dementia Care Framework; this included training modules on dementia care; activities and engagement; communication; distressed reactions; and dementia and the law. This training had been provided to all the staff who worked on the dementia unit.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff were appropriately managed in accordance with the NMC. Similar arrangements were in place to ensure that care staff were registered with NISCC.

Staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The staff understood what abuse was and how they should report any concerns that they had. The relevant contact details were available in a folder for all staff to access; and the whistleblowing procedure was also displayed near the front entrance to the home.

Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified. Discussion also evidenced that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures.

Review of patient care records evidenced that validated risk assessments were completed as part of the admission process and were reviewed as required. These risk assessments informed the care planning process.

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

Where patients required bedrails, to maintain their safety whilst in bed, there was evidence that risk assessments had been completed; and that regular safety checks had been carried out, when the patients were in bed. The care plans reflected the assessment outcome and included the reasons why less restrictive measures were not suitable for the patients.

A number of patients had pressure relieving mattresses on their beds, to prevent skin breakdown. The correct mattress settings were indicated on the mattress pumps, to ensure their effective use.

Infection prevention and control measures were adhered to and equipment was stored appropriately. There were processes in place to check that emergency equipment, such as the suction machines, were regularly checked as being in good order and fit for use. This meant that in the event of an emergency the equipment was ready for use.

A review of the home's environment was undertaken which included a number of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items.

Fire exits and corridors were observed to be clear of clutter and obstruction. The emergency evacuation register was up to date and included the details of the last patient admitted to the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

Review of four 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.

There were a number of examples of good practice found throughout the inspection in this domain. For example, registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), Speech and language therapist (SALT), dietician and Tissue Viability Nurse specialists (TVN). Discussion with registered nurses and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Where patients were prescribed antibiotic therapy for the treatment of acute infections, care plans had been developed in relation to this; and patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

A review of wound care records evidenced that wound care was managed in line with best practice. A review of the daily progress notes of one patient evidenced that the dressing had been changed according to the care plan. Wound care records were supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines.

Patients who had been identified as being at risk of losing weight had their weight regularly monitored. This ensured that any weight loss was identified and appropriate action taken in a timely manner. The patients' weights were audited by the registered manager on a monthly basis. Patients who were identified as requiring a modified diet, had the relevant risk assessments completed. Care plans in place were reflective of the recommendations of SALT and care plans were kept under review.

A sampling of food and fluid intake charts confirmed that patients' fluid intake was monitored. The patients' total daily fluid intakes were also recorded in a format which enabled the registered nurses to have an overview of the patients' fluid intake over the previous weeks and months. This is good practice and was commended by the inspector.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans. Advice was given to the registered manager in relation to the need for the frequency of repositioning to be recorded on the personal care booklets, to ensure that new staff were aware of this information.

Patients' bowel movements were monitored by the registered nurses on a daily basis, to ensure that any changes from the patients' usual bowel patterns were identified and timely action taken.

Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005; the registered manager confirmed that the patient register was checked on a daily basis.

Patients who required urinary catheters had care plans in place, to ensure that they were managed in keeping with best practice guidance. The care plan included detail on hygiene care of the catheter; the frequency of tube change; actions to take in case of blockage; and monitoring of fluid intake and output. However, there was no evidence that the care staff recorded when the catheter leg bags were changed. This was identified as an area for improvement.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. Advice was given in relation to recording this, when the care plans were re-written. There was evidence of regular communication with representatives within the care records.

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

Staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The most recent general staff meeting was held on 4 May 2017 and a meeting with the registered nurses was held on 26 April 2017. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities.

All those consulted with confirmed that if they had any concerns, they could raise these with the staff and/or the registered manager. A relatives' meeting had been held on 20 April 2017 and records were available. A review of records evidenced that patients' meetings were not held on a regular basis however, the registered manager obtained feedback from three patients on a weekly basis, to ascertain their views on the home environment and the safety of the care provided. A review of the feedback provided on this system; identified that no concerns had been identified.

There was information available to staff, patients, representatives in relation to advocacy services; and the contact details of the Relatives' and Residents' Association advice line were also displayed. A Family Charter was also available, which outlined how the staff could support relatives to understand and recognise the range of emotions that may be experienced if their loved one was living with dementia.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping; wound care management and oversight of weight loss; audits and reviews; and communication between residents, staff and other key stakeholders.

Areas for improvement

An area for improvement was identified in relation to the recording of when urinary catheter leg bags were changed.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 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 interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care.

Patients stated that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and their feedback had been listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

We observed the lunch time meal in two dining rooms. The lunch served appeared appetising and patients spoken with stated that they were satisfied with the meals provided. The atmosphere was quiet and tranquil and patients were encouraged to eat their food; assistance was provided by staff, as required. Tables were set with tablecloths and specialist cutlery and plate guards were available to help patients who were able to maintain some level of independence as they ate their meal. We also observed that menus were displayed in pictorial format to assist in making choices and to provide an awareness of the meal to be served. However, the menus displayed in both dining rooms did not reflect the meal served. This was identified as an area for improvement.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. Two staff members were designated to provide activities in the home. Patients consulted with stated that there were different activities they could participate in. There was evidence of a variety of activities in the home and discussion with patients confirmed that they were given a choice with regards to what they wanted to participate in. There were various photographs displayed around the home of patients' participation in recent activities. There was evidence of regular church services to suit different denominations. Social care plans were in place to provide information to staff to ensure that patients' social care needs were met individually.

The care plans detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for the patients, as appropriate. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met. At the time of the inspection no one was receiving end of life care.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. An annual quality audit had been undertaken in 10 March 2017; views and comments recorded were analysed and areas for improvement had been acted upon.

An electronic feedback system was also situated in the reception area. This was available to relatives and other visitors to give general feedback on an ongoing basis or answer specific questions on the theme of the month. The feedback was summarised automatically by the system and the results were available to the registered manager and the regional manager.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and their relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included praise for the care and attention given to a patient, when receiving end of life care.

During the inspection, we met with five patients, four care staff, three registered nurses, one kitchen staff, one domestic staff and one patients' representative. Some comments received are detailed below:

Staff

"I am proud to say I work here."
"The care is excellent."
"I am happy."
"It is grand, the staff are streets ahead of other places."
"It is alright."
"The care is very good, I have no concerns."
"The care is very good, the patients get more than they need."
"I love it here, it is brilliant."

Two staff members commented in relation to being under pressure and stated that they would like to have more time to spend with the patients. Given that observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty, these comments were relayed to the registered manager to address.

Patients

"It is very good."
"I am treated alright."
"I couldn't say a word against them."
"I get the same as everyone else here."

Patients' representative

"'It is fantastic. I could not say a bad word about them."

We also issued ten questionnaires to staff and relatives respectively and eight questionnaires to patients. Seven staff, eight patients and four relatives had returned their questionnaires, within the timeframe for inclusion in this report. Comments and outcomes were as follows:

Patients: respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. One written comment was received including 'sometimes there are not enough staff on.' Given that there were no concerns identified in relation to the staffing arrangements within the home, this comment is relayed to the registered manager to address.

Relatives: respondents indicated that they were 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. One respondent provided written comment in relation to the staffing levels. Following the inspection, this comment was relayed to the registered manager to address.

Staff: respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. No written comments were received.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients. Mealtimes and activities were well managed.

Areas for improvement

An area for improvement was identified in relation to the accuracy of the displayed menus.

	Regulations	Standards
Total number of areas for improvement	0	1

6.7 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.

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

Discussions with the staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. All those consulted with described the registered manager in positive terms; comments included 'she is very approachable' and 'she's very good'. Staff described how they felt confident that the registered manager would respond positively to any concerns/suggestions raised.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager. The registered nurses also explained that there was a 'senior cover' file, which provided the nurse in charge of the home with the information they needed to manage the home, in the absence of the registered manager.

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 Care Standards for Nursing Homes 2015. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the registered manager was. Discussion was undertaken in relation to the complaints procedure; which needed to include the details for contacting the Patient Client Council. The regional manager agreed to address this matter.

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, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

As a further element of its Quality of Life Programme, Four Seasons Healthcare operate a Thematic Resident Care Audit ("TRaCA") which home managers can complete electronically. Information such as home governance, information governance, housekeeping, resident care and health and safety checks are recorded on various TRaCAs on a regular basis. This information was subject to checks by the regional manager once a month. A review of the "resident care TRaCA" confirmed that when shortfalls had been identified, these were followed up in a timely manner by the registered nurses.

A review of the patient falls audit evidenced that this was analysed to identify patterns and trends, on a monthly basis. An action plan was in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection, confirmed that these were appropriately managed.

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

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. An action plan was generated to address any areas for improvement; discussion with the registered manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships within the home.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Martina Mullan, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager 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.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 29 July 2017	The registered persons shall ensure that records are maintained in relation to when urinary catheter leg bags are changed, in keeping with best practice. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: Supervisions have been carried out with staff to ensure that a record is maintained when urinary catheter bags are changed. A simple form has been put in place for staff to record the date and their signature when the urinary catheter leg bag has been changed. This will be monitored as part of the care file audit process ..
Area for improvement 2 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 29 July 2017	The registered persons shall ensure that the menu displayed is reflective of the meal served. **Ref: Section 6.6**
	Response by registered person detailing the actions taken: Supervisions have been carried out with kitchen staff in relation to displaying the picture menus to reflect the meal being served on a daily basis. The cook is responsible for giving the picture cards to the kitchen assistants to display on the menu boards. This will be monitored daily by the manager or the nurse in charge .

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

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