Unannounced Care Inspection Report
28 November 2016

Culmore Manor Care Centre

Type of Service: Nursing Home
Address: 39 Culmore Road, Londonderry BT48 8JB
Tel no: 02871359302
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Culmore took place on 28 November 2016 from 08.15 to 17.15 hours.

The inspection sought to assess progress with any 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.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	7	10

The total number of requirements above includes one requirement that has been stated for the second time.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 6 June 2016.

There were no further actions required to be taken following the most recent inspection.

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

2.0 Service details

Registered organisation/registered person: Larchwood Care Homes (NI) Ltd. Christopher Walsh	**Registered manager:** Ciaran Burke
Person in charge of the home at the time of inspection: Ciaran Burke	**Date manager registered:** 28 December 2012
Categories of care: NH-PH, NH-I	**Number of registered places:** 56

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with four patients, four care staff, two registered nurses, seven patients' representatives and one visiting professional.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- nine patient care records
- accident and incident records
- audits in relation to care records and falls
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 6 June 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector. There were no further actions required to be taken following the most recent inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 25 April 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 15 (2) (a) **Stated:** First time	The registered persons must ensure that pain assessments are completed (if applicable) for all patients requiring regular or occasional analgesia. This assessment should review the effectiveness of the analgesia and the outcome should be reflected in the patients' care plans. The pain assessment tool to be used must be commensurate with the patient's ability to communicate. **A recommendation has been stated on two previous occasions.**	**Not Met**
	Action taken as confirmed during the inspection: There was evidence that some patients had pain assessments completed; however, the review of care records identified that one patient did not have their pain assessment updated from 2 June 2016. Although the care plan had been evaluated on a regular basis, the care plan did not specify how the patient's pain was being managed. This requirement was not met and has been stated for the second time.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 36.2 **Stated:** Second time	The registered persons should ensure that the following policies and guidance documents are developed and made readily available to staff: A policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines which* should include the out of hours procedure for accessing specialist equipment and medication and the referral procedure for specialist palliative care nurses. **The above policies should be submitted to RQIA with the returned QIP**	**Met**
	Action taken as confirmed during the inspection: The above policies had been updated in line with best practice.	
Recommendation 2 **Ref**: Standard 40.2 **Stated:** First time	The registered persons should ensure that all staff who are delegated the responsibility of conducting supervisions and appraisals, should have the necessary training provided.	**Met**
	Action taken as confirmed during the inspection: A review of training records confirmed that training had been provided to all staff who undertook supervisions and appraisals with staff.	
Recommendation 3 **Ref**: Standard 22.10 **Stated:** First time	The registered persons should ensure that the audit of accidents and incidents is further developed, to aid in identifying patients who fall most frequently. An action plan should also be developed to evidence follow-up on identified patterns and tends.	**Met**
	Action taken as confirmed during the inspection: A review of the falls audit confirmed that it had been further developed, since the last inspection. Although there was no formal action plan, there was evidence that the registered manager had oversight of the falls that occurred in the home and the audit clearly identified the patients who had fallen most frequently.	

Recommendation 4 **Ref**: Standard 46.3 **Stated:** First time	The registered persons should ensure that any deficits identified in infection prevention and control audits are evidently followed up on.	**Met**
	Action taken as confirmed during the inspection: A review of the infection prevention and control audits evidenced that this recommendation had been met, as stated; however, observations on the day of the inspection identified that particular areas in the home were not maintained to an acceptable standard. Refer to section 4.3.4 for further detail.	
Recommendation 5 **Ref**: Standard 48.1 **Stated:** First time	The registered persons should ensure that patients' personal safety risk assessments include the level of assistance required by each patient, in the event of an emergency. A system of centralising the personal emergency evacuation plans (PEEPs) alongside the fire management plans should also be put in place, in line with best practice. A recommendation has been made in this regard.	**Met**
	Action taken as confirmed during the inspection: Each patient had a Personal Emergengcy Evacuation Plan (PEEP) in place that provided important information about their mobility and any equipment needed to evacuate them safely. It was concerning that two registered nurses were unaware of the location of the PEEP's folder. The registered manager provided assurances that this would be addressed with staff.	

4.3 Inspection findings

4.3.1 Care Practices

Staff interactions with patients were observed to be compassionate, caring and timely. There was evidence that patients were being supervised appropriately. Patients looked well cared for and were appropriately clothed. Patients being nursed in bed looked comfortable; those who were able to provide their views of care and treatment were positive in their comments and no concerns were raised during the inspection. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Overall, the home was calm and well organised.

One patient was being nursed in bed due to having pressure damage to their sacral area. Although the patient only weighed 45 kilograms, the pressure relieving mattress setting was set to the highest setting, which was meant for patients who weighed over 100 kilograms. Too high or too low a pressure setting has the potential to cause pressure damage rather than relieving it. This meant that the mattress was not being effective in reducing the pressure to the affected areas. The registered manager explained that this mattress was temporarily in use whilst another mattress was being repaired. However, there was no evidence that any mattress settings were being monitored or recorded. A requirement has been made in this regard.

The review of one patient's care record identified that they required a hand protector to be used. The patient's care plan specified that the hand protector was not to be used if a wound dressing was in place and there was clear instruction in the care plan regarding this. However, the review of the care records confirmed that the wound had healed on 18 November 2016 and there was no evidence that staff had applied the hand protector from that date. The skin integrity/repositioning charts did not indicate the specific skin areas that had been checked, the care plan also did not include direction on how often the hand protector should be worn and did not provide direction on how often the skin should have been checked. A requirement has been made in this regard.

A sampling of personal hygiene records evidenced gaps in completion. For example, although there was evidence that one identified patient had been assisted to have a bed bath every day, there was no evidence that they had been given a weekly shower, as indicated in their care plan. Given that the patients were observed to be comfortable and appeared well-groomed on the day of the inspection, a recommendation has been made in relation to the accurate recording of care delivery.

Although most of the patients were observed to have their nurse call bells placed within reach, the call bell of one patient was inaccessible to them. When questioned, the patient stated that sometimes it was in reach but not always. The patient's representative also commented that this was a regular occurrence and that often the drinks provided were also placed out of reach of the patient. This was discussed with the registered manager. A recommendation has been made in this regard.

Two staff members consulted with described, difficulties they were having, managing the care of one identified patient who displayed behaviour that might challenge or upset others. The information recorded in the patient's care record was not an accurate reflection of the patient's current mental health needs and did not provide enough guidance about the action the staff should take. Staff consulted with did not know enough about the triggers for the behaviours or the actions to take to diffuse the behaviour. Although training had been provided specifically in relation to the management of this identified patient's care, the staff consulted with stated that they did not feel skilled to work with this patient. The appropriateness of this identified patient's placement was discussed with the registered manager, who explained that the patient's physical needs had greatly lessened following admission to the home and that a care management review had been requested with the relevant health and social care trust. A recommendation has been made that the registered manager should review the management of the identified patient's care, to ensure that the staff are adequately supported to meet the patient's psychological needs.

The staff consulted with also informed the inspector that the identified patient was privileged to confidential information regarding other patients, discussed during the handover reports at the end of shifts. Refer to section 4.3.2 for further detail on the management of confidential information.

4.3.2 Care Records

As discussed in section 4.2, a requirement has been stated for the second time in relation to the completion of pain assessments and care plans for patients who required regular pain relief.

Although there was evidence that most patients' risk assessments and care plans had been reviewed on a regular basis, a review of the care records evidenced that patients' care plans had not been developed within the recommended timeframe of five days.

One patient who had been admitted to the home 19 days, prior to the inspection, did not have any care plans in place, to direct staff on the delivery of care. This patient was also identified as having a high risk of choking due to 'eating very quickly' and required a modified diet. The risk assessment identified that the patient 'needed reminding to slow down', when eating, to reduce the risk of choking; however, there was no care plan in place to address this. Although the patient had been identified as being at a high risk of falling, again there was no care plan in place to identify preventative measures, to mitigate against this risk. Another patient had been identified as having a moderate risk of developing pressure damage and there was no care plan in place, to direct staff on the delivery of care. The registered nurse consulted with was unaware of the recommended timeframe, in which the patients' care plans should be developed. The registered manager confirmed to RQIA by email on 2 December 2016, that the two identified patients' care plans had been completed. A requirement has been made in this regard.

Further review of the care records identified that although falls risk assessments were reviewed on a regular basis, they had not been reviewed after a patient had fallen. A recommendation has been made in this regard.

Patients who had been prescribed antibiotics to treat acute infections, did not have care plans developed. A recommendation has been made in this regard.

Supplementary care records were reviewed. These included repositioning records, food and fluid intake charts and records of skin integrity checks and personal care delivery. Although a review of the patient care records evidenced that patients' daily fluid intakes were being monitored and recorded in the daily progress notes, the amounts recorded were not accurate because they did not include the drinks offered/taken after the evening meal. Patients consulted with stated that they received a hot drink at 'supper' time; however, these drinks were not recorded on the fluid charts. Supplements provided to patients, as appropriate, were also not included in the fluid charts. A requirement has been made in this regard.

Supplementary care records were observed stored in a lounge area on the first floor of the home. Discussion with staff identified that they had not recognised how access to the records could potentially infringe the patients' rights to privacy and dignity. It was concerning that anyone using this room could have access to the content of these charts and that the staff were not maintaining confidentiality with regards to the patients' personal care records. This was discussed with the registered manager during feedback. A recommendation has been made to ensure that consideration is given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times. Consideration should also

be given to the location of the handover report on the ground floor, to ensure that any patient seated in the area is not privileged to confidential information regarding other patients.

4.3.3 Consultation

During the inspection, we met with four patients, four care staff, two registered nurses, seven patients' representatives and one visiting professional. Some comments received are detailed below:

Staff

"The care is mostly very good".
"We work well as a team, everyone helps out".
"We do the best that we can do".
"The care is pretty good".
"Happy enough with everything".

On the day of the inspection the staff were observed assisting patients in a timely and unhurried way. Patients and relatives consulted with also did not have any concerns regarding staffing levels. One staff member commented to the inspector that when staff shortages occurred due to illness, the patients only received the minimum of care. This comment was relayed to the registered manager to address.

Two staff members spoke with the inspector at length regarding difficulties they had in managing the care of one patient who displayed behaviour that might challenge or upset others. Refer to section 4.3.1 for further detail.

Patients

"I am grand here".
"I am extra-well looked after".
"It is not too bad here".

One patient stated that the home was sometimes 'tight on staff'; however, they felt that they could approach the registered manager at any times with their concerns and that they would be addressed.

Patients' representatives

"'I have no concerns".
"All is fine here".
"Our (relative) is not here long, but everything seems great".
"It is alright".
"Everything seems to be fine".
"The home is always clean, we have no complaints".

One patients' representative informed the inspector that the call bell and drinks that had been provided were not always within the patient's reach. Refer to section 4.3.1 for further detail.

Visiting Professionals

"No concerns here".

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. Six staff, five patients and five relatives had returned their questionnaires, within the timeframe for inclusion in this report. Some comments received are detailed below:

Staff: Four respondents indicated that they were either 'satisfied' or 'very satisfied' that the care was safe, effective and compassionate; and that the home was well-led. However, one staff member, indicated that they were 'very unsatisfied' with the leadership of the home and answered 'no' to every question asked under the well-led domain. One other respondent indicated that the patients did not get the right care at the right time with the best possible outcome for them. Written comment included 'we do the best we can, but there (are) times we get held up which can leave us behind'.

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

Relatives: four respondents indicated that they were either 'satisfied' or 'very satisfied' that the care received was safe, effective and compassionate; and that they found the home was well-led. However, one respondent indicated that they were 'unsatisfied' that the care was safe and answered 'no' where asked, if the staff had enough time to care for their relative. Written comments related to improvements needed, in regards to nail care and oral hygiene; and adherence to the recommendations made by occupational therapists.

Two respondents answered 'no', where asked, if their relative got the right care, at the right time, with the best possible outcome for them. Written comment included 'sometimes, my (relative) has to wait a long time before a carer answers the buzzers, to allow (them) to go to the bathroom'. Other comments related to the outcomes of care reviews not being followed up; the care plan not being readily shared with the family members; and dissatisfaction with the portion sizes of meals. Although one respondent indicated that they were 'satisfied' that the care was compassionate, examples were given where the care provided did not meet the patient's individual needs. Following the inspection, these matters were raised with the registered manager, to address.

Whilst all the relatives who responded, indicated that they found the home to be well-led, one respondent provided negative comments in relation to the management of the home. Following the inspection, these matters were shared with the responsible person, who agreed to address the concerns raised.

4.3.4 Infection Prevention and Control

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. Although the areas reviewed were generally found to be clean, reasonably tidy, well decorated and warm throughout, a number of shower rooms and sluice rooms were not cleaned to an acceptable standard and equipment was stored inappropriately in these rooms.
For example, the following issues were identified and posed risk of cross-contamination of infection:

- toilet brush holders were in need of replacement
- a soiled basin was observed in one bathroom sitting on top of a commode
- the wall in one toilet was stained and in need of cleaning
- continence products which had been removed from their packaging were openly stacked on linen trolleys
- paper signage was observed to be un-laminated in the sluice room
- paint splashes were evident on the sink and floor in the sluice room
- a soiled bedpan was observed sitting on a shower chair, that was covered in talcum powder
- cushions that were in need of cleaning were placed in a storage area
- One fall out mat was worn and was in need of repair/replacement
- foam backing to one toilet seat riser had been temporarily repaired and had the foam exposed
- plastic basins, bedpans and lids were stored on the floor in the bathroom
- the extractor fan and the wall in the smoking room required cleaning
- sealant around one sink was cracked and in need of replacement.

These areas of concern were discussed with the registered manager and a requirement has been made to ensure that the standard and monitoring of cleanliness throughout the home is maintained. A recommendation has also been made to ensure that there is an identified nurse with day-to-day responsibility for monitoring compliance with infection prevention and control procedures and that the role and responsibility of this person is reviewed, to address the issues identified.

Cleaning chemicals were also stored on the cistern in one bathroom. This posed a potential risk to patients. This was discussed with the registered manager, who provided assurances that this would be addressed with the staff. A requirement has been made in this regard.

4.3.5 Governance and Management Arrangements

All those consulted with knew who the registered manager and other members of the senior management team were and stated that they were available at any time if the need arose. Patients' representatives commented that the registered manager 'seemed very good' and described them as being very approachable.

It was evident that some action had been taken since the last inspection, to improve the effectiveness of the care. However, one requirement made in relation to the completion of validated pain assessments was not met and has been stated for the second time. This was concerning, given that a recommendation had already been stated twice in this regard. 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; however we were not assured about the effectiveness of the audits, given the number of requirements and recommendations made during this inspection. A recommendation has been made that the auditing processes are further developed and implemented, to ensure that the issues identified during this inspection are identified. This relates specifically to the auditing of patients' care records; supplementary care records; and the overall cleanliness of the home.

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. However, there were inaccuracies in the content of the monthly quality monitoring report. For example, the most recent quality

monitoring report stated that fluid records were examined and 'were up to date and signed, the fluid intake meets regional guideline recommendations'. The report also included a statement that 'all documentation was up to date and clearly reflected patient need'. There was no traceability in relation to which specific care records had been reviewed. There was also no action plan completed by the person delegated with the responsibility of conducting the visit and therefore no indication as to who was responsible for implementing the required improvements and by when. A recommendation has been made in this regard.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately.

Copies of the complaints procedure were displayed prominently throughout the building, including in patients' bedroom; however, the complaints procedure required updating, to include the telephone contact details of the relevant representatives from the organisation; the Patient Client Council; the Regulation and Quality Improvement Authority (RQIA); the Northern Ireland Ombudsman; and the relevant health and social care trusts. A recommendation has been made in this regard.

Areas for improvement

A requirement has been made that the settings of pressure relieving mattresses are monitored and recorded, to ensure their effective use.

A requirement has been made that where patients require specialist equipment to be used, this is provided and the specific instructions for its use are included in the care plan. Records in relation to skin integrity checks should be maintained accordingly.

A recommendation has been made that the provision or refusal of weekly showers is recorded, in accordance with best practice guidance, care standards and legislative requirements.

A recommendation has been made that training is provided to staff on the importance of placing call bells and drinks within patients' reach. Records of this training, in whatever format provided, must be retained in the home for inspection.

A recommendation has been made that the management of one identified patient's care is reviewed to ensure that the staff are adequately supported to meet the patient's psychological needs.

A requirement has been made that nursing care plans are prepared in consultation with the patient or their representative as to how the patient's needs in respect of their health and welfare are to be met.

A recommendation has been made that the patients' falls risk assessments are completed following each fall.

A recommendation has been made that care plans are developed in response to acute infections patients may have.

A requirement has been made that contemporaneous notes of all nursing provided are maintained. Fluid balance charts must be accurately completed.

A recommendation has been made that consideration is given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times. This should also include the location of the handover report on the ground floor, to ensure that patients seated in the area are not privileged to confidential information regarding other patients.

A requirement has been made that suitable arrangements are made to ensure that the standard and monitoring of cleanliness throughout the home is maintained.

A recommendation has been made that there is an identified nurse with day-to-day responsibility for monitoring compliance with infection prevention and control procedures and that the role and responsibility of this person is reviewed, to address the issues identified.

A requirement has been made that any chemicals used within the home are stored securely in accordance with COSHH regulations.

A recommendation had been made that there are robust systems in place to discharge, monitor and report on the delivery of nursing care, in particular, the auditing processes in relation to care records; including supplementary care records; and the cleanliness of the home.

A recommendation has been made that the content of the monthly quality monitoring report accurately reflects the quality of the care provided in the home.

A recommendation has been made that the complaints procedure is updated, to include the telephone contact details of the relevant representatives from the organisation; the Patient Client Council; the Regulation and Quality Improvement Authority (RQIA); the Northern Ireland Ombudsman; and the relevant health and social care trusts.

Number of requirements	6	**Number of recommendations**	10

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ciaran Burke, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

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

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

5.1 Statutory requirements

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

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

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

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

Quality Improvement Plan

Statutory requirements

Requirement 1 **Ref**: Regulation 15 (2) (a) **Stated:** Second time **To be completed by:** 26 January 2017	The registered persons must ensure that pain assessments are completed (if applicable) for all patients requiring regular or occasional analgesia. This assessment should review the effectiveness of the analgesia and the outcome should be reflected in the patients' care plans. The pain assessment tool to be used must be commensurate with the patient's ability to communicate. **A recommendation has been stated on two previous occasions.** **Ref: Section 4.2 and 4.3.1**
	Response by registered provider detailing the actions taken: Pain Assessments are completed for all relevant residents.
Requirement 2 **Ref:** Regulation 13 (1) (a) **Stated:** First time **To be completed by:** 26 January 2017	The registered persons must ensure that the settings of pressure relieving mattresses are monitored and recorded, to ensure their effective use. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: Pressure relieving mattress settings are checked and recorded to ensure most effective use. Mattresses are set in accordance with residents' weights as appropriate.
Requirement 3 **Ref:** Regulation 12 (1) (a) **Stated:** First time **To be completed by:** 26 January 2017	The registered persons must ensure that where patients require specialist equipment to be used, this is provided and the specific instructions for its use are included in the care plan. Records in relation to skin integrity checks should be maintained accordingly. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: The specialist equipment is in use for the identified resident. Clear instruction on its use are detailed in the care plan. The care plan has also been updated to include frequency of use. Skin integrity checks are recorded appropriately.
Requirement 4 **Ref:** Regulation 16 (1) **Stated:** First time **To be completed by:** 26 January 2017	The registered persons must ensure that nursing care plans are prepared in consultation with the patient or their representative as to how the patient's needs in respect of their health and welfare are to be met. **Ref: Section 4.3.2**

	Response by registered provider detailing the actions taken: The care plans for the two identified residents have been completed. This was confirmed by email to RQIA on 02.12.16.

Requirement 5 **Ref:** Regulation 19 (1)(a) **Stated:** First time **To be completed by:** 26 January 2017	The registered persons must ensure that contemporaneous notes of all nursing provided are maintained. Fluid balance charts must be accurately completed. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: Fluid balance charts are completed. These records include an accurate record of all fluids taken.
Requirement 6 **Ref:** Regulation 27 (2) (b) (d) **Stated:** First time **To be completed by:** 26 January 2017	The registered persons must ensure that suitable arrangements are made to ensure that the standard and monitoring of cleanliness throughout the home is maintained. **Ref: Section 4.3.4**
	Response by registered provider detailing the actions taken: An audit of all housekeeping and cleaning schedules is completed monthly. Areas identified for improvement are highlighted and actioned by domestic staff. The home manager monitors daily.
Requirement 7 **Ref:** Regulation 14 (2) (c) **Stated:** First time **To be completed by:** 26 January 2017	The registered persons must ensure that any chemicals used within the home are stored securely in accordance with COSHH regulations. **Ref: Section 4.3.4**
	Response by registered provider detailing the actions taken: All chemicals are securely stored in accordance with COSHH Regulations
Recommendations	
Recommendation 1 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 26 January 2017	The registered persons should ensure that the provision or refusal of weekly showers is recorded, in accordance with best practice guidance, care standards and legislative requirements. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: Weekly showers are recorded whether taken or refused in accordance with best practice.
Recommendation 2 **Ref**: Standard 39 **Stated:** First time **To be completed by:** 26 January 2017	The registered persons should ensure that training is provided to staff on the importance of placing call bells and drinks within patients' reach. Records of this training, in whatever format provided, must be retained in the home for inspection. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: The importance of residents having easy access to nurse call system

	and drinks has been highlighted to all relevant staff. This subject has been added to the next scheduled staff meeting agenda and shall be formally addressed & recorded within this forum

Recommendation 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 26 January 2017	The registered persons should ensure that the management of one identified patient's care is reviewed to ensure that the staff are adequately supported to meet the patient's psychological needs. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: Another care review has been requested for the identified resident when all care needs shall be reviewed. Specific staff training has already been carried out in relation to this resident. Staff training needs in this regard are kept under review.
Recommendation 4 **Ref**: Standard 22.4 **Stated:** First time **To be completed by:** 26 January 2017	The registered persons should ensure that the patients' falls risk assessments are completed following each fall. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: Relevant risk assessments are reviewed and updated as requied.
Recommendation 5 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 26 January 2017	The registered persons should ensure that care plans are developed in response to acute infections patients may have. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: Care plans and assessments are reviewed and updated to reflect changes in care needs.
Recommendation 6 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 26 January 2017	The registered persons should ensure that consideration is given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times. This should also include the location of the handover report on the ground floor, to ensure that patients seated in the area are not privileged to confidential information regarding other patients. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: All care records are securely stored when not in immediate use. Handovers are conducted in a manner conducive to the protection of confidential information. Importance of confidentiality shall be included at the next scheduled staff meeting
Recommendation 7 **Ref**: Standard 46.1 **Stated:** First time **To be completed by:**	The registered persons should ensure that there is an identified nurse with day-to-day responsibility for monitoring compliance with infection prevention and control procedures and that the role and responsibility of this person is reviewed, to address the issues identified. **Ref: Section 4.3.4**

26 January 2017	**Response by registered provider detailing the actions taken:** A named nurse has been identified for this role.

Recommendation 8 **Ref**: Standard 35.4 **Stated:** First time **To be completed by:** 26 January 2017	The registered persons should ensure that there are robust systems in place to discharge, monitor and report on the delivery of nursing care, in particular, the auditing processes in relation to care records; including supplementary care records; and the cleanliness of the home. **Ref: Section 4.3.5**
	Response by registered provider detailing the actions taken: There are systems in place within the home to regularly monitor and report. These include a comprehensive range of audits completed monthly and quarterly. The registered manager shall review and update these processes where appropriate.
Recommendation 9 **Ref**: Standard 35.7 **Stated:** Firs time **To be completed by:** 26 January 2017	The registered persons should ensure that the content of the monthly quality monitoring report accurately reflects the quality of the care provided in the home. **Ref: Section 4.3.5**
	Response by registered provider detailing the actions taken: A monthly quality monitoring report is completed. This report accurately reflects the quality of care provided.
Recommendation 10 **Ref**: Standard 16 **Stated:** First time **To be completed by:** 26 January 2017	The registered persons should ensure that the complaints procedure is updated, to include the telephone contact details of the relevant representatives from the organisation; the Patient Client Council; the Regulation and Quality Improvement Authority (RQIA); the Northern Ireland Ombudsman; and the relevant health and social care trusts. **Ref: Section 4.3.5**
	Response by registered provider detailing the actions taken: Complaints procedure documents have been update to include all relevant details.

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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