Unannounced Care Inspection Report
12 April 2017

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 Manor took place on 12 April 2017 from 09.40 to 17.30 hours.

The inspection sought to assess progress with any issues raised 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.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies and staff training and development. Staff were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. A general inspection of the home confirmed that the premises and grounds were well maintained. Areas for improvement were identified in relation to the system for checking the settings of pressure relieving mattresses to ensure their effective use; the completion of risk assessments and care plans for bedrails use; and the arrangements for embedding the new regional operational safeguarding policy and procedures. Three recommendations were made to drive improvements in these areas.

Is care effective?

Systems were in place to enable good communication amongst staff in the home. Patients and relatives spoken with were confident in raising concerns with the manager and staff. A review of care records confirmed that a range of risk assessments were generally undertaken on a regular basis; care plans were created to prescribe care. New areas for improvement were identified during this inspection in relation to the lack of meaningful statements in care plan evaluations; and the need for registered nurse's oversight of patients' bowel records. Two recommendations have been made in this regard.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding issues affecting them. Patients spoken with commented positively in regard to the care they received. There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

There was a clear organisational structure evidenced within Culmore Manor and staff were aware of their roles and responsibilities. A review of care observations confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide. Staff spoken with were knowledgeable regarding the line management structure and who they would escalate any issues or concerns to. However, some of the responses received on the returned questionnaires indicated that some patients were unsatisfied with the management and leadership of the home. This information has been shared with senior management representatives within Larchwood for their consideration and actions, as deemed appropriate.

Monthly quality monitoring visits were carried out in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. Although there were no new areas for improvement identified in the well led domain during this inspection, consideration must be given to the two requirements and three recommendations that have been stated for the second time.

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	*2	*8

*The total number of requirements and recommendations above includes two requirements and three recommendations that have 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. Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 28 November 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. 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.

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 Maximum of 46 in category NH-I and 10 in category NH-PH	**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.

A poster was prominently displayed in the home, inviting feedback from patients and their representatives. 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 seven patients, three care staff, two registered nurses, six 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
- six patient care records
- staff training records for 2016/2017
- accident and incident records
- care records and falls audits
- records relating to adult safeguarding
- one staff recruitment record
- complaints received since the previous care inspection
- staff supervision and appraisal records
- records pertaining to NMC and NISCC registration checks
- minutes of staff', patients' 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.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 28 November 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be followed up during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 28 November 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 15 (2) (a) **Stated:** Second 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**	**Met**
	Action taken as confirmed during the inspection: A review of patient care records confirmed that pain assessments were completed for patients who were prescribed regular analgesia. The outcomes of the pain assessments were reflected in the patient care plans.	
Requirement 2 **Ref:** Regulation 13 (1) (a) **Stated:** First time	The registered persons must ensure that the settings of pressure relieving mattresses are monitored and recorded, to ensure their effective use.	**Partially Met**
	Action taken as confirmed during the inspection: Although there was evidence that a system was in in place to monitor and record pressure mattress settings, this system was not sufficiently robust to ensure that corrective action would be taken in a timely manner. This recommendation was partially met. A new recommendation has been made in this regard. Refer to section 4.3 for further detail.	
Requirement 3 **Ref:** Regulation 12 (1) (a) **Stated:** First time	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.	**Partially Met**

	Action taken as confirmed during the inspection: Discussion with staff and a review of care records evidenced that staff were monitoring patients' skin integrity, particularly in relation to areas which were identified as being at risk of pressure damage. However, a review of patient care records did not evidence that specific directions in relation to the use of hand splints/skin protectors were included in the care plans. This requirement was partially met and has been stated for the second time.	
Requirement 4 **Ref:** Regulation 16 (1) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A review of care records confirmed that a range of risk assessments and care plans were developed within the required timeframe, following admission.	
Requirement 5 **Ref:** Regulation 19 (1)(a) **Stated:** First time	The registered persons must ensure that contemporaneous notes of all nursing provided are maintained. Fluid balance charts must be accurately completed.	**Not Met**
	Action taken as confirmed during the inspection: Although there was evidence that the patients' total fluid intakes were being monitored by registered nurses, the review of the fluid charts evidenced that the records were not accurate. This requirement was not met and has been stated for the second time. Refer to section 4.4 for further detail.	
Requirement 6 **Ref:** Regulation 27 (2) (b) (d) **Stated:** First time	The registered persons must ensure that suitable arrangements are made to ensure that the standard and monitoring of cleanliness throughout the home is maintained.	**Met**
	Action taken as confirmed during the inspection: The home was found to be clean and well decorated throughout. Discussion with patients and their representatives confirmed that the standard of cleanliness was always maintained to a good standard.	

Requirement 7 **Ref:** Regulation 14 (2) (c) **Stated:** First time	The registered persons must ensure that any chemicals used within the home are stored securely in accordance with COSHH regulations.	**Met**
	Action taken as confirmed during the inspection: There was no evidence that cleaning chemicals were stored inappropriately.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 4.9 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A review of personal hygiene records confirmed that records were maintained in line with best practice.	
Recommendation 2 **Ref**: Standard 39 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Discussion with patients and their representatives confirmed that call bells and drinks were always left within patients' reach. This matter had been included in the minutes of the recent staff meeting.	
Recommendation 3 **Ref**: Standard 4 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager confirmed that a care review had taken place in relation to the identified patient's care. Strategies had been put in place to ensure consistency of approach in relation to meeting the patient's psychological needs. No concerns were identified by staff in this regard.	

Recommendation 4 **Ref**: Standard 22.4 **Stated:** First time	The registered persons should ensure that the patients' falls risk assessments are completed following each fall.	**Not Met**
	Action taken as confirmed during the inspection: Although there was evidence that falls risk assessments were reviewed on a regular basis, the review of the care records confirmed that risk assessments had not been updated every time patients had fallen. This recommendation was not met and has been stated for the second time.	
Recommendation 5 **Ref**: Standard 4 **Stated:** First time	The registered persons should ensure that care plans are developed in response to acute infections patients may have.	**Not Met**
	Action taken as confirmed during the inspection: A review of two patient care records confirmed that care plans were not in place for acute infections. This recommendation was not met and has been stated for the second time.	
Recommendation 6 **Ref**: Standard 6 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Observation on the day of the inspection confirmed that supplementary care records were stored securely. Discussion with staff confirmed that patients were not present during the shift handover report.	
Recommendation 7 **Ref**: Standard 46.1 **Stated:** First time	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.	**Met**

	Action taken as confirmed during the inspection: Discussion with the registered manager and staff confirmed that infection prevention and control audits were completed by an identified nurse. As discussed under requirements six and seven above, the home was clean and cleaning chemicals were stored appropriately.	
Recommendation 8 **Ref**: Standard 35.4 **Stated:** First time	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.	**Partially Met**
	Action taken as confirmed during the inspection: Although there was evidence that audits were conducted on a regular basis, in relation to the care records, there was no evidence that supplementary care records had been reviewed as part of this process. Given that deficits continued in relation to the accuracy of the fluid intake records; completion of care plans for acute infections and falls risk assessments, this recommendation was partially met and has been stated for the second time.	
Recommendation 9 **Ref**: Standard 35.7 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: The monthly quality monitoring report provided a comprehensive overview of areas that were meeting standards and areas where improvements were required. An action plan was generated to address any areas for improvement.	
Recommendation 10 **Ref**: Standard 16 **Stated:** First time	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.	**Met**

	Action taken as confirmed during the inspection: A review of the complaints procedure evidenced that it had been reviewed to include the above information.	

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 for week commencing 3 April 2017 evidenced that the planned staffing levels were generally adhered to. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. Discussion with patients, representatives and staff evidenced that the staffing levels met the assessed needs of the patients.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained. Advice was given in relation to the need for the registered manager to record whether or not the enhanced criminal records certificate received was clear or not.

All those consulted with confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. 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.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. Overall compliance with training was monitored by the registered manager and this information informed the responsible persons' monthly quality monitoring visit in accordance with regulation 29.

Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

A review of records evidenced that the arrangements for monitoring the registration status of nursing staff were appropriately managed in accordance with NMC. Similar arrangements were also in place to ensure that care staff were registered with the Northern Ireland Social Care Council (NISCC).

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. However, following discussion with the registered manager, it was evident that the arrangements to implement the new regional operational safeguarding policy and procedures had not been fully embedded into practice. For example, it had not yet been clarified whether or not there would be one adult safeguarding champion within each home of the organisation; or how local information would be fed into the annual safeguarding position report. A recommendation has been made in this regard.

Discussion with the registered manager and a review of documentation confirmed that any potential safeguarding concerns were reported appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

A review of patient care records evidenced that a range of validated risk assessments were generally completed as part of the admission process and reviewed as required. Refer to section 4.2 and 4.4 for further detail. However, one patient required bedrails to be used. The review of the care record did not evidence that formal consent had been obtained for their use. A bedrail risk assessment or care plan had not been developed and the review of the supplementary care records did not evidence regular safety checks of the bedrails, whilst in use. This is discussed with the registered manager. Given that all other patients had the appropriate documentation in place in relation to bedrail use, a recommendation has been made to drive improvement in this area.

Following the last inspection, a system was put in place to monitor and record the settings of pressure relieving mattresses; however, the system was not sufficiently robust to ensure that corrective action would be taken in a timely manner. The frequency of mattress checks was discussed with the registered manager. A recommendation has been made in this regard.

Patients/representatives/staff spoken with were complimentary in respect of the home's environment. Although a review of the home's environment evidenced that the bedrooms, bathrooms, lounges and dining rooms were warm, well decorated, fresh smelling and clean throughout, storage areas in the home were limited. Linen trolleys, commodes and bedpans were stored in a number of bathrooms. Although RQIA acknowledges that the items stored in these rooms were clean, the matter was discussed with the registered manager, who agreed to continually review the storage arrangements for such items, within the home.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to.

Areas for improvement

A recommendation has been made that arrangements are put in place to embed the new regional operational safeguarding policy and procedures.

A recommendation has been made that where bedrails are required, risk assessments are undertaken, to ensure their safe use, and care plans are developed accordingly. Records of safety checks when bedrails are in use must also be maintained.

A recommendation has been made that the system in place to monitor the settings of pressure relieving mattresses is further developed, to ensure that settings are recorded on a daily basis.

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

4.4 Is care effective?

A review of seven patient care records evidenced that a range of validated risk assessments were generally completed as part of the admission process and reviewed as required. The majority of risk assessments were reflected in the care plans; however, one swallowing assessment was not retained in the patient care record.

This was discussed with the registered manager on the day of the inspection, who agreed to follow this up with the speech and language therapist.

Although there was evidence that the patient care plans were reviewed on a regular basis, the entries in the care plan evaluations were in the main meaningless. For example, evaluation statements such as 'care continues as per care plan' were evidenced in many of the care plans reviewed. This was discussed with the registered manager. A recommendation has been made in this regard.

Supplementary care records were reviewed. Where patients were identified as being at risk of developing pressure damage to their skin, the review of the repositioning records evidenced that they were repositioned in accordance with the care plan.

All patients consulted with confirmed that they received tea or coffee at supper time. However, as discussed in section 4.2, the review of the total fluid intake charts evidenced that the supper time drinks were generally not included on the fluid intake records. This was discussed with the registered manager and a recommendation made in this regard has been stated for the second time.

A review of the patient's bowel charts evidenced that although patients' bowel motions were consistently recorded, records of when patients did not have bowel movements were not recorded. There was also no evidence that registered nurses had oversight of the bowel records. In one bowel record reviewed, a gap of seven days was identified. Given that entries were only recorded when patients' bowels moved, we were not assured about the accuracy of the records. This was discussed with the registered manager. A recommendation has been made in this regard.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift.

Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition. Staff meetings were held on a regular basis and records were maintained. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Staff stated that there was effective teamwork; each staff member 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. Patient and relatives' meetings were held on a regular basis and all those consulted with expressed their confidence that the registered manager would address any concerns raised.

Areas for improvement

A recommendation has been made to ensure that care plan evaluations are meaningful and reflect the effectiveness of the care provided.

A recommendation has been made that registered nurses review patients' bowel records on a daily basis and record any actions taken in the patients' daily progress notes.

Entries should also be made when there have been no bowel movements, to ensure the accuracy of the records.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with seven 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. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

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. We observed the lunch time meal being served in the dining room. The atmosphere was quiet and tranquil and patients were assisted to eat their meals, as required. Tables were set with tablecloths and specialist plate guards and cups were available to help patients who were able to maintain some level of independence as they ate their meal. The lunch served appeared very appetising and patients spoken with stated that it was always very nice. Menus were displayed in each dining room and were correct on the day of inspection. The location of the menus were discussed with the registered manager were discussed with the registered manager to ensure that they would be more prominently displayed, for patients to see what meals were planned for the day.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. A dedicated staff member was employed to provide activities in the home. A list of activities was displayed and there was evidence that a range of activities were provided in the home. On the day of the inspection, the patients were brought together in the large sitting room, to have an 'Easter supper'. Consultation with patients' relatives confirmed that these types of events were a regular occurrence in the home. There were systems in place to obtain the views of patients, their representatives and staff on the running of the home. Patients and their representatives had been invited to participate in the annual quality survey in April 2016; however the annual quality report was not available in the home on the day of the inspection. This meant that we were unable to determine whether consideration had been given to any suggestions for improvement. This was discussed with the registered manager. Following the inspection, the annual quality report was submitted to RQIA by email on 24 April 2017.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. During the inspection, we met with seven patients, three care staff, two registered nurses, six patients' representatives and one visiting professional. Some comments received are detailed below:

Staff

"We give top quality care here, it is a very good home".
"The care here is exceptional, everyone does their best".
"The care is quite good, we aim to cater for the patients' needs, we do our best".

"We can be proud of the care, I have no concerns".
"The care is very good".

Patients

"I am getting on very well".
"It is very good, nothing is too much bother for them".
"It is very good".
"I am treated very naturally by all the staff, they are all very good".
"They go above and beyond the call of duty, it is just excellent".
"It is all very good, they work very hard".
"This place couldn't be better".

Patients' representatives

"'It is all very good".
"Excellent care, I couldn't say a word against them".
"All ok, we have no concerns".
"It is grand here".
"It is all fine".

One relative commented that the care in the home can sometimes be rushed and that they would like the staff to have a bit more time to interact with the patients. This comment was relayed to the registered manager to address.

Visiting Professionals

"They are all very good here, very supportive of the patients".

We also issued ten questionnaires to staff and relatives respectively; and eight questionnaires were issued to patients. Four staff, seven patients and two relatives had returned their questionnaires, within the timeframe for inclusion in this report. The majority of staff' and relatives' responses indicated that the care in the home is safe, effective and compassionate; and that the home was well-led. However; some of the responses received from patients indicated that they were unsatisfied with the management and leadership of the home. This information has been shared with senior management representatives within Larchwood for their consideration and actions, as deemed appropriate.

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 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.

There was a clear organisational structure within the home; the registered manager was supported in their role by two clinical lead nurses. Patients consulted with were aware of the roles of the staff in the home and whom they should speak to if they had a concern. All those consulted with were aware who the registered manager was and stated that they 'walked the floor regularly'. Staff described good working relationships within the home and that management were responsive to any suggestions or concerns raised. Comments included 'he is fabulous' and 'we have no problem approaching him for anything'.

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. Patients were aware of who the registered manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. The recently updated complaints procedure was displayed in all the bedrooms.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

Although there were systems in place to monitor and report on the quality of nursing and other services provided, the deficits identified during this inspection meant that we were not assured of the effectiveness of the audits. For example, the audit of accidents which occurred in the home had not identified that falls risk assessments had not been completed after every fall; and the auditing processes did not include any review of the supplementary care records. A recommendation that was previously made has been stated for the second time in this regard. Refer to section 4.2.

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.

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.

The monthly quality monitoring report provided a comprehensive overview of areas that were meeting standards and areas where improvements were required. An action plan was generated to address any areas for improvement. Discussion with the manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

Areas for improvement

Although no new areas for improvement were identified during this inspection, the requirements and recommendations stated for the second time must also be considered in the well led domain.

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

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 12 (1) (a) **Stated:** Second time **To be completed by:** 10 June 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. **Ref: Section 4.2 and 4.4**
	Response by registered provider detailing the actions taken: Specialist equipment is in use where required and specific usage instructions are documented in the care plan.
Requirement 2 **Ref:** Regulation 19 (1) (a) **Stated:** Second time **To be completed by:** 10 June 2017	The registered persons must ensure that contemporaneous notes of all nursing provided are maintained. Fluid balance charts must be accurately completed. **Ref: Section 4.2 and 4.4**
	Response by registered provider detailing the actions taken: Accurate records of fluid intake and output are completed each day. A review of staff duties has facilitated contemperaneous records to be maintained.
Recommendations	
Recommendation 1 **Ref**: Standard 22.4 **Stated:** Second time **To be completed by:** 10 June 2017	The registered persons should ensure that the patients' falls risk assessments are completed following each fall. **Ref: Section 4.2 and 4.6**
	Response by registered provider detailing the actions taken: Risk assessments are completed following falls. Home manager conducts monthly documented audit of all falls.
Recommendation 2 **Ref**: Standard 4 **Stated:** Second time **To be completed by:** 10 June 2017	The registered persons should ensure that care plans are developed in response to acute infections patients may have. **Ref: Section 4.2 and 4.6**
	Response by registered provider detailing the actions taken: Care plans are developed for residents who have acute infections. These are reviewed and updated as appropriate.

Recommendation 3 **Ref**: Standard 35.4 **Stated:** Second time **To be completed by:** 10 June 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. **Ref: Section 4.2 and 4.6**
	Response by registered provider detailing the actions taken: A range of monthly audits are conducted to monitor and report on the delivery of care. Supplementary care records are monitored daily by registered nurses and supervised by Clinical Lead Nurse on each floor.
Recommendation 4 **Ref**: Standard 13 **Stated:** First time **To be completed by:** 10 June 2017	The registered persons should ensure that arrangements are put in place to embed the new regional operational safeguarding policy and procedures. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: A new policy has been developed to take account of the new regional operational guidelines. This includes the appointment of an Adult Safeguarding Champion. The new processes in the Company have been published in relevant locations within the Home to inform staff of the arrangements
Recommendation 5 **Ref**: Standard 45 **Stated:** First time **To be completed by:** 10 June 2017	The registered persons should ensure that the system in place to monitor the settings of pressure relieving mattresses is further developed, to ensure that settings are recorded on a daily basis. **Ref: Section 4.2 and 4.3**
	Response by registered provider detailing the actions taken: The monitoring system has been discussed and reviewed. A laminated notice of the required setting shall be in place for each individual mattress.Staff are required to ensure daily monitoring of the settings. A weekly written record of setting checks is also maintained.
Recommendation 6 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 10 June 2017	The registered persons should ensure that where bedrails are required, risk assessments are undertaken, to ensure their safe use, and care plans are developed accordingly. Records of safety checks when bedrails are in use must also be maintained. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Risk assessments and care plans are developed to ensure safe use of bedrails. Checks are carried out and recorded as appropriate.

Recommendation 7 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 10 June 2017	The registered persons should ensure that care plan evaluations are meaningful and reflect the effectiveness of the care provided. Evidence of how this matter is addressed with registered nurses must be retained in the home for inspection. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: A copy of this report and recommendation has been made available to each registered nurse. Staff are required to ensure that entries and evaluations are recorded in a meaningful manner avoiding general terms and focusing on specific description and evaluation of care provided.
Recommendation 8 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 10 June 2017	The registered persons should ensure that registered nurses review patients' bowel records on a daily basis and record any actions taken in the patients' daily progress notes. Entries should also be made when there have been no bowel movements, to ensure the accuracy of the records. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Accurate records of resident bowel movements are maintained. These records are reviewed by registered nurse and actioned appropriately.

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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