Unannounced Care Inspection Report
5 July 2016

Deanfield

Type of Service: Nursing Home
Address: 19 Deanfield, Limavady Road, Londonderry BT47 6HY
Tel No: 02871344888 / 02871341754
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Deanfield took place on 5 July 2016 from 09.30 to 16.45 hours. The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

The daily staffing levels for the home were subject to regular review to ensure the assessed needs of the patients were met. Staff were observed assisting patients in a timely and unhurried way. Communication was well maintained between all grades of staff. Newly appointed staff completed a structured orientation and induction programme at the commencement of their employment and all staff expressed that they received good support and guidance in their practice. However, weaknesses were identified in the recruitment and selection processes; the verification of staff registrations with the relevant professional bodies; mandatory training requirements; the reporting of incidents in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005; the safe storage of cleaning chemicals in keeping with COSHH legislation; and the accurate completion of accident and incident reports. Five requirements and two recommendations have been made to secure compliance and drive improvement.

Is care effective?

Care plans had been developed with input from patients and/or their representatives, if appropriate, and there was evidence of regular communication with patient representatives within the care records. There was evidence of effective team working and good communication between patients and staff. Meetings were held on a regular basis with staff, patients and relatives and all those consulted with expressed confidence in raising concerns to the registered manager. Patients were repositioned according to their care plans and there was evidence that patients' fluid intake had been monitored. Patients risk assessments and care plans were generally reviewed on a regular basis, with the exception of those pertaining to patients who were either newly admitted or readmitted to the home following a period of hospitalisation. Weaknesses were also identified in the completion of wound care documentation; and care plan development and training. One requirement and two recommendations have been made to secure compliance and drive improvement.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. Patients were praiseworthy of staff and a number of their comments are included in the report. Staff interactions with patients were observed to be compassionate, caring and respectful. Patients were afforded choice, privacy, dignity and respect. All patients spoken with were complementary regarding the staffs' attitude and attentiveness to detail. There was evidence of patient, representative and staff consultation. There were no requirements or recommendations made in this domain.

Is the service well led?

The home was evidenced to be operating within its registered categories of care and there was a clear organisational structure within the home. The policies and procedures of the home were available and subject to regular review and safety alerts and notices were actioned appropriately. Any 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 and all those consulted expressed confidence that any concerns raised would be taken seriously. Monthly monitoring visits were conducted in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. However, there was no action plan developed in response to the Regulation 29 monitoring visit; and deficits were also identified in the auditing processes. Two recommendations have been made to secure compliance and drive improvement. Given that two requirements have also been stated for the second time and that requirements have also been made in the safe and effective domains, this would impact on the well led domain.

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	8	6

*The total number of requirements and recommendations above includes two requirements and one recommendation that have been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with the 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 announced estates inspection undertaken on 15 April 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

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

2.0 Service details

Registered organisation/registered provider: Loughview Homes Ltd Michael Curran Paul Steele	**Registered manager:** Joy McLaughlin
Person in charge of the home at the time of inspection: Joy McLaughlin	**Date manager registered:** 13 December 2007
Categories of care: NH-I	**Number of registered places:** 29

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

Care delivery/care practices were observed and a review of the general environment of the home was undertaken. During the inspection the inspector spoke with six patients individually and greeted others in small groups, three care staff, one registered nurse and four relatives.

In addition questionnaires were provided for distribution by the registered manager; Ten for relatives and staff respectively; and five for patients.

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
- accident and incident records
- audits
- records relating to adult safeguarding
- complaints received since the previous care inspection
- recruitment and selection records
- staff induction, supervision and appraisal records
- staff, patients' and relatives' meetings held since the previous care inspection
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a sample of policies and procedures
- NMC and NISCC registration records.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 15 April 2016

The most recent inspection of the home was an announced estates inspection. The completed QIP was returned and approved by the estates inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered providers, as recorded in the QIP will be validated at the next estates inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 29 September 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 15 (2) (a) **Stated:** First time	A pain assessment must be maintained in patients' care records, If applicable. **Action taken as confirmed during the inspection:** A review of care records evidenced that pain assessments had not been consistently completed. This requirement was not met and has been stated for the second time.	**Not Met**

Requirement 2 **Ref**: Regulation 29 **Stated:** First time	The registered person must ensure that a visit to the home as outlined in Regulation 29 is undertaken at least once a month. A written report of the visit must be completed and retained for inspection. The report should reflect all aspects of quality monitoring in sufficient detail as to the standard of care being provided including the actions to be taken when deficits have been identified.	**Met**
	Action taken as confirmed during the inspection: A review of the Regulation 29 reports confirmed that monitoring visits had been conducted on a regular basis.	
Requirement 3 **Ref**: Regulation 27 (4) (b) **Stated:** First time	Precautions must be in place that minimise the risk of fire and protect patients, staff and visitors in the event of a fire. This refers specifically to the observed practice of fire doors being propped open. 27 (4) (b)	**Not Met**
	Action taken as confirmed during the inspection: Two bedroom doors were observed to be wedged open during the inspection and one bedroom door was also wedged open despite there being an automatic door closure mechanism in place. 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:** First time	The following policies and guidance documents should be developed and made readily available to staff: • A policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) Breaking Bad News which should include the procedure for breaking bad news in the event of a sudden or unexpected death. • 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 procedure for managing shared rooms and the local arrangements that are in place for accessing palliative care teams, district nursing teams, GP out-of-hours or pharmacists, if required.	**Met**
	Action taken as confirmed during the inspection: The review of the above policies evidenced that they had been reviewed in line with this recommendation.	
Recommendation 2 **Ref**: Standard 32.1 **Stated:** First time	End of life arrangements for patients should be discussed and documented as appropriate, and include patients' wishes in relation to their religious, spiritual and cultural needs.	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that end of life care arrangements had been discussed, as appropriate.	

Recommendation 3 **Ref**: Standard 4.9 **Stated:** First time	Where a nursing assessment is made to monitor a patient's daily fluid intake, then the patients daily (24hour) fluid intake must be recorded in their daily progress record to evidence that this area of care is being properly monitored and validated by the registered nurse.	**Met**
	Action taken as confirmed during the inspection: A review of patients' care records confirmed that patients' total fluid intakes were consistently recorded in the daily progress notes.	
Recommendation 4 **Ref**: Standard 46.1 **Stated:** First time	The registered manager 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.	**Not Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and observation on the day of inspection evidenced that the role of the identified infection prevention and control nurse requires to be further developed.	

4.3 Is care safe?

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 26 June 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients, relatives and staff evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way.

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 staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Staff consulted confirmed that they received induction; and shadowed experienced staff until they felt confident to care for the patients unsupervised. 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.

Discussion with the registered manager confirmed that there were systems in place for the recruitment and selection of staff. A review of two personnel files evidenced that one staff member had commenced employment prior to having the relevant checks completed. For example, the enhanced criminal records check and employment references had been received after one staff member had commenced employment; and another staff member's employment references did not include one from their most recent employer. A requirement has been made in this regard.

Although the registration status of registered nurses was checked with the Nursing and Midwifery Council (NMC) during the recruitment process, discussion with the registered manager confirmed that ongoing checks were only conducted on an annual basis. A requirement has been made in this regard.

A review of the staff training records did not evidence that compliance with mandatory training requirements had been actively managed. For example, six staff had attended training in adult safeguarding on 8 October 2015; and 19 staff had attended training in moving and handling practices on 24 March 2016. The registered manager stated that records pertaining to the training that had previously been provided had been archived and were not available for inspection. Records were available in relation to fire training; however the available records did not confirm that all staff members had attended this. Infection prevention and control training had also not been undertaken by staff since October 2013. This was discussed with the registered manager and advice was given in relation to the development of a training matrix that would improve oversight of compliance levels. A requirement has been made in this regard.

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.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. Discussion with the registered manager and a review of notifiable events submitted since the previous care inspection evidenced that any safeguarding concern had been managed appropriately and in accordance with the regional safeguarding protocols. The registered manager described that records were maintained in the patient's daily progress notes and electronic copies of the relevant local Healthcare Trust and RQIA notifications were maintained. Advice was given in regards to implementing a system to maintain all safeguarding records centrally.

Discussion with the registered manager confirmed that risk assessments should be completed as part of the admission process and reviewed as required. However, deficits were identified in the completion of risk assessments and care plans. Refer to section 4.4 for further detail.

A review of the accident and incident records confirmed that there was a low incidence of falls in the home. A review of one patients care record identified that the care plan had been reviewed following a fall, however, two falls risk assessments which had been completed; were not dated. Therefore, we could not be assured that the risk assessments had been completed in response to the patient's falls. The review of the accident and incident records also identified gaps in completion. For example, the section pertaining to the notification of care management and the patients' representative was not consistently completed. This was discussed with the registered manager who advised that this information would be recorded in the patients' progress notes. A recommendation has been made in this regard.

Further review of the incident and accident records also identified an incident had occurred, wherein a patient had sustained a head injury, RQIA had not been notified, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. A requirement has been made in this regard.

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. In general, the areas reviewed were found to be clean, reasonably tidy, and warm throughout. However, the sluice room on the ground floor and the first floor were not clean to an appropriate standard. When the registered manager was made aware of this issue, this was addressed immediately. Further detail regarding cleaning schedules and infection prevention and control audits is discussed in section 4.6.

Cleaning chemicals were also stored openly in the sluice rooms, which were unlocked. A requirement has been made in this regard.

As discussed in section 4.2, two bedroom doors were observed to be wedged open and one bedroom door was wedged open despite there being an automatic door closure mechanism in place. This was discussed with the registered manager who removed the door wedges on the day of inspection. The propping open of fire doors is a management issue and is contrary to NI HTM 84 fire safety precautions. A requirement has been stated for the second time in this regard.

Areas for improvement

A requirement has been made to ensure that staff members do not commence employment until an enhanced criminal record check with AccessNI has been completed and employment references have been received.

A requirement has been made to ensure that a robust system is implemented, to ensure that registered nurses' registration with the Nursing and Midwifery Council (NMC) is checked on a regular basis.

A requirement has been made to ensure that staff receive mandatory training and other training appropriate to the work they perform.

A recommendation has been made to ensure that staff fully complete accident and incident reports, in line with good practice.

A requirement has been made to ensure that RQIA is notified of any serious injury to a patient in the home.

A requirement has been made to ensure that all cleaning chemicals are securely stored in keeping with COSHH legislation, to ensure that patients are protected from hazards to their health.

Number of requirements	**5**	**Number of recommendations**:	**1**

4.4 Is care effective?

As discussed in section 4.2, a review of patient care records identified that pain assessments were not consistently completed and a requirement has been stated for the second time in this regard. A review six patient care records evidenced deficits in the completion of risk assessments and care plans, particularly in relation to patients who had been recently admitted to the home. For example, one newly admitted patient did not have risk assessments completed in relation to the risk of poor nutrition; moving and handling; continence; risk of falling; and use of bedrails. Another patient who had been recently been readmitted following a period of hospitalisation did not have their risk assessments and care plans consistently reviewed on return to the home. Given that all other assessments and care plans had been reviewed on a regular basis, a recommendation has been made specifically in relation to the completion of care records of newly admitted patients and those who have been readmitted following periods of hospitalisation.

A review of wound care documentation also identified that registered nurses were not completing wound assessments or reviewing the care plans, in line with best practice. For example, although the care plan indicated that a wound dressing required to be changed every three to four days, there were gaps of up to 18 days identified in the completion of wound assessments. The daily dressing chart, which also should have been completed at every dressing change had gaps in completion, of up to 21 days. This was discussed with the registered manager. A requirement has been made in this regard.

Other weaknesses were identified in relation to the completion of care plans. For example, one patient was identified as being at risk of dehydration and although there was evidence in the daily progress notes that this was being monitored, a care plan had not been developed in this regard. A patient who resisted assistance with personal care needs did not have this information included in their care plan. A number of care plans were unsigned and two falls risk assessments were undated. Staff also recorded the month that care plans were reviewed, rather than the specific date that this was undertaken. This is not in line with NMC guidelines on records and record keeping. These matters were discussed with the registered manager, who confirmed that no formal training in care planning or recordkeeping had been provided to registered nursing staff. A recommendation has been made in this regard.

There was evidence within the care records that referrals had been made, as appropriate, to healthcare professionals, such as the tissue viability nurse specialist (TVN), speech and language therapist (SALT), dieticians and other multidisciplinary professionals.

Care plans had been developed with input from patients and/or their representatives, if appropriate, and there was evidence of regular communication with patient representatives within the care records.

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 and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored. There was also evidence within the care records that the patients' total fluid intakes were being monitored on a daily basis.

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. 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.

Discussion with the registered manager and review of records evidenced that patients and/or relatives meetings were held on a regular basis and records were maintained. Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management.

Areas for improvement

A recommendation has been made that all relevant risk assessments and care plans are completed/updated within five days of admission/readmission to the home.

A requirement has been made to ensure that the patient's care plan is kept under review in relation to wound care. The wound must be reassessed at each dressing change and this assessment documented in accordance with best practice guidelines. Wound care records should also be supported by the use of photography in keeping the National Institute of Clinical Excellence (NICE) guidelines.

A recommendation has been made to ensure that staff receive training and support in respect of care planning so as their understanding of providing individualised care and support is enhanced and staff understand their responsibility and accountability regarding this area of care.

Number of requirements	**1**	**Number of recommendations**:	**2**

4.5 Is care compassionate?

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.

One patient was identified as having a visual impairment. Consultation with the staff confirmed that they felt they have the necessary skills to communicate effectively with the patient and

consistently described meals and items of clothing, in order for the patient to be able to make a choice in relation to what to eat or what to wear. The patient stated that the staff knew them so well, she had full confidence that they would chose something nice on her behalf.

Menus were displayed clearly in the dining room and were correct on the day of inspection. The midday meal was observed, being served in the dining room. The atmosphere was quiet and tranquil and patients were encouraged to eat their food and tables were set prior to the patients entering the room.

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. There was a list of planned activities displayed at the front entrance in order to assist patients to choose which to participate in. Discussion with staff also confirmed that the opportunities for patients to attend external activities were also provided. Consultation with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

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. Views and comments recorded were analysed and areas for improvement were acted upon.

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 manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment from the relative of a recently deceased patient stated that the patient 'felt the warmth of (the staffs') attention in her last days'.

During the inspection the inspector spoke with 6 patients individually and greeted others in small groups, three care staff, one registered nurse and four relatives. All comments received were positive. Some comments received are detailed below:

Staff

'"the care is very good, we work our best and know we give good personal care".
"The care is fantastic, couldn't be better. All needs are met to a high quality standard".
"The care is great. We all get on fantastic".
"Excellent. All the patients get 1:1 care and time spent with them, that you don't find in other places".

Patients' representatives

"It is first class. We have no concerns. Very happy".
"The staff are fabulous".
"I would give them 100 percent and we know what care is like in other nursing homes".

Patients

"It's very good here. The staff are very kind".
"It is like a home from home. The staff are lovely".
"I am happy. I get what I need".
"I am getting on very well. The staff know me well".
"It's all good. I am very happy".
"The staff are polite".

In addition to speaking with patients, relatives and staff RQIA provided questionnaires. At the time of writing this report 10 relatives, three patients and four staff had retuned their questionnaires. All respondents indicated a high level of satisfaction with care under the four domains.

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?

The registered manager confirmed 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.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff 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. All staff consulted with spoke very highly of the registered manager. Comments included that she was 'fantastic' and all staff expressed confidence in her approachability and responsiveness to any concerns raised.

There was a system in place to systematically review the home's policies and procedures on a three yearly basis and staff confirmed that they had access to the home's policies and procedures. There were also 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 were had sanctions imposed on their employment by professional bodies.

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.

Discussion with the registered manager and review of records evidenced that monthly 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 was 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. Given the number of requirements and recommendations made in the safe and effective domains of this report and that two requirements have been stated for the second time, advice was given in relation to the use of the provider visit template, which is available on the RQIA website. A recommendation has also been made to ensure that requirements and recommendations made in Quality Improvement Plans are reviewed as part of the monitoring visit.

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, the registered manager outlined how the following audits were completed in accordance with best practice guidance:

- accidents and incidents
- medicines management
- care records
- infection prevention and control
- cleaning audit

An audit of patients' falls was completed on a quarterly basis. Although there was a low incidence of falls within the home, there was no evidence that the information on the accident and incident audit had been analysed, to identify potential patterns and/or trends. Advice was given in relation to the required improvements, for example, timing, location, outcome and numbers of patients involved. The registered manager provided assurances that this would be implemented.

Care record audits were completed on a regular basis and there was evidence of follow up action to be taken to address identified shortfalls. However, as discussed in section 4.4, a recommendation has been made to ensure that all relevant risk assessments and care plans are completed/updated within five days of admission/readmission to the home. The registered manager agreed to specifically audit these records to ensure compliance in this area.

The registered manager had not been auditing wound care specifically and a requirement has also been made in section 4.4, in this regard.

As discussed in section 4.3, the sluice rooms were observed to be in need of deep cleaning and decluttering. A review of the cleaning schedules confirmed that these rooms had not been included, therefore there were no records maintained regarding when they had last been cleaned. There was also no traceability in regards to which rooms had been cleaned and there was no records maintained in relation to decontamination of commodes. The infection prevention and control audits and cleaning schedules reviewed also identified that they were not sufficiently robust. The recommendation made during the last inspection in relation to the role of the person with day-to-day responsibility for monitoring compliance with infection prevention

and control procedures had not been fully met, and has been stated for the second time. A recommendation has also been made to ensure that the registered manager reviews the auditing processes, in relation to the deficits identified during this inspection.

Areas for improvement

A recommendation has also been made to ensure that requirements and recommendations made in Quality Improvement Plans are reviewed as part of the monitoring visit.

A recommendation has also been made to ensure that the registered manager conducts audits in relation to wound management; the care records of new admissions/readmissions to the home; cleaning schedules and infection prevention and control; and compliance with staff' mandatory training requirements.

Two requirements have been stated for the second time and requirements have been made in the safe and effective domains, which impact on the well led domain.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the 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 require emends 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 may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to RQIA's office for review by the inspector.

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

Quality Improvement Plan	
Statutory requirements	
Requirement 1 **Ref**: Regulation 15 (2) (a) **Stated:** Second time **To be completed by:** 12 September 2016	A pain assessment must be maintained in patients' care records, if applicable. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Above discussed with RN's at recent staff meeting. Training carried out on care planning/documentation
Requirement 2 **Ref**: Regulation 27 (4) (b) **Stated:** Second time **To be completed by:** 12 September 2016	Precautions must be in place that minimise the risk of fire and protect patients, staff and visitors in the event of a fire. This refers specifically to the observed practice of fire doors being propped open. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Reactive Dorgard placed on specific doors. Staff all made aware of risks'
Requirement 3 **Ref**: Regulation 21 (1) (b) **Stated:** First time **To be completed by:** 12 September 2016	The registered persons must ensure that staff members do not commence employment until an enhanced criminal record check with AccessNI has been completed and employment references have been received. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: This has been addressed with both administration staff and home providers.

Requirement 4 **Ref**: Regulation 20 (1) (a) **Stated:** First time **To be completed by:** 12 September 2016	The registered persons must ensure that a robust system is implemented, to ensure that registered nurses' registration with the Nursing and Midwifery Council (NMC) is checked on a regular basis. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Monthly checks now in place. Home Administrator to carry out + document same.
Requirement 5 **Ref**: Regulation 20 (1) (c) **Stated:** First time **To be completed by:** 12 September 2016	The registered person must ensure that staff receive mandatory training and other training appropriate to the work they perform. The registered manager should provide RQIA (at the time of return of QIP) with the schedule of dates at which these training requirements will be delivered. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Training dates provided. ~~on seperate sheet~~ emm. 2c New training date commenced as recommended by RQIA inspector. INFECTION CONTROL – OCT 2016 SOVA – 12th + 19th Sept. FIRE AWARENESS. 22nd-28th August
Requirement 6 **Ref**: Regulation 30 (1) (c) **Stated:** First time **To be completed by:** 12 September 2016	The registered persons must ensure that RQIA is notified of any serious injury to a patient in the home. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Same noted and new information system in place for reporting to RQIA.
Requirement 7 **Ref**: Regulation 14 (2) (c)	The registered persons must ensure that all cleaning chemicals are securely stored in keeping with COSHH legislation, to ensure that patients are protected from hazards to their health. **Ref: Section 4.3**

Stated: First time **To be completed by:** 12 September 2016	**Response by registered provider detailing the actions taken:** Cleaning staff made aware of COSHH legislation at recent in house training. Notices in place to address same.
Requirement 8 **Ref**: Regulation 16 (2) (b) **Stated:** First time **To be completed by:** 12 September 2016	The registered persons must ensure that the patient's care plan must be kept under review in relation to wound care. The wound must be reassessed at each dressing change and this assessment documented in accordance with best practice guidelines. Wound care records should also be supported by the use of photography in keeping the National Institute of Clinical Excellence (NICE) guidelines. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: New guidelines + documentation in place to ensure all care plans are updated, reviewed and audited. RN's made aware of same. Photographs will now be taken for all wounds.
Recommendations	
Recommendation 1 **Ref**: Standard 46.1 **Stated:** Second time **To be completed by:** 12 September 2016	The registered manager 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 4.2**
	Response by registered provider detailing the actions taken: Delegated RN now in place. New audit systems up + running and all documentation notes in place.

Recommendation 2 **Ref**: Standard 37.5 **Stated:** First time **To be completed by:** 12 September 2016	The registered persons should ensure that staff fully complete accident and incident reports, in line with good practice. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: This was highlighted + addressed with all RN's.
Recommendation 3 **Ref:** Standard 4.1 **To be completed by:** 12 September 2016	The registered manager should ensure that all relevant risk assessments and care plans are completed/updated within five days of admission/readmission to the home. **Ref: Section: 4.4**
	Response by registered provider detailing the actions taken: New formats for both admission + re admission inplace and audits of same carried out RN's aware of this.
Recommendation 4 **Ref**: Standard 39.9 **Stated:** First time **To be completed by:** 12 September 2016	The registered persons must ensure that registered nursing staff receive training and support in respect of care planning so as their understanding of providing individualised care and support is enhanced and staff understand their responsibility and accountability regarding this area of care. **Evidence is to be available in the home that the training and support, <u>in whatever form</u>, has taken place.** **Ref: Section: 4.4**
	Response by registered provider detailing the actions taken: Nurse Manger recently attended update on recording keeping + consent given by Rosemary Wilson. In house training of all RN's has been arranged for 25/8/16 and documentation of same will be made available in the Nursing Home.

Recommendation 5 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 12 September 2016	The monthly monitoring visits should focus on progress made in relation to the requirements and recommendations made in this and subsequent RQIA Quality Improvement Plans. **Ref: Section: 4.6**
	Response by registered provider detailing the actions taken: RQIA template highlighted with registered provider for future use, covering QIP report
Recommendation 6 **Ref**: Standard 35.3 **Stated:** First time **To be completed by:** 12 September 2016	The registered persons should further develop the auditing processes, specifically in relation to: • auditing the care records of patients who have been newly admitted/readmitted to the home following a period of hospitalisation • wound care management • cleaning schedules and infection prevention and control audits • mandatory training requirements **Ref: Section: 4.6**
	Response by registered provider detailing the actions taken: Advice + knowledge taken on auditing. all of the above now ~~date~~ ensure audited monthly + documentation completed.

Name of Registered Manager/Person Completing QIP:	JOY MCLAUGHLIN		
Signature of Registered Manager/Person Completing QIP:	J McLaughlin	**Date completed:**	25/8/16.
Name of Registered Provider Approving QIP:	MICHAEL CURRAN		
Signature of Registered Provider Approving QIP:	M Curran	**Date approved:**	29/8/16
RQIA inspector Assessing Response	J Lamb	**Date:**	28/9/16

REGULATION AND QUALITY
06 SEP 2016
IMPROVEMENT AUTHORITY

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