Unannounced Care Inspection Report
18 October 2016

Brookmount

Type of Service: Nursing Home
Address: 4 Lower Newmills Road, Coleraine, BT52 2JR
Tel no: 0287032 9113
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Brookmount took place on 18 October 2016 from 08.45 hours to 17.15 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. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. A general inspection of the home confirmed that the home was clean and well maintained.

Areas for improvement were identified in relation to the staffing arrangements in the home; inductions of agency staff members; staff training in adults safeguarding; competency and capability assessments of the registered nurses who have the responsibility of being in charge of the home, in the absence of the registered manager; frequency of the staff's registration with the Nursing and Midwifery Council (NMC); falls risk assessments; the reporting of any head injuries sustained in the home to RQIA; and the need to replace one identified patient's bedroom carpet. Four requirements and four recommendations have been made in this domain.

Is care effective?

The systems and processes in place, to ensure that care delivery was effective, were reviewed. A review of care records confirmed that a range of risk assessments and care plans were completed on admission and as required thereafter. We examined the systems in place to promote effective communication between staff, patients and relatives.

Areas for improvement were identified in relation to wound care management; the need for care plans to be developed in response to acute infections. We were also not assured that the methods available for engagement with patients and relatives were effective. One requirement and two recommendations have been made.

Is care compassionate?

Consultation with patients and their representatives evidenced that patients were treated with dignity and respect and a number of positive comments received have been included in the report. There was evidence that patients were encouraged with their meals and assistance provided, as required. There was a range of activities available, for patients to choose from. Comments were received from staff, both verbally and on the returned questionnaires, in relation to the staffing levels and how this impacted upon the care delivery being hurried. These comments support the requirement that has been made in the safe domain. There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

The systems and processes, in place to ensure that the home was well led, were reviewed. There was a clear organisational structure evidenced within the home 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; this included the reporting arrangements when the registered manager was off duty. There were systems were in place to monitor and report on the quality of nursing and other services provided.

Areas for improvement were identified in relation to the need for wound audits to be completed; and for the monthly quality monitoring report to be returned to the registered manager in a meaningful timeframe. Two recommendations have been made.

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	5	8

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 unannounced medicines management inspection undertaken on 13 September 2016.

Enforcement action resulted 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: Apex Housing Association Gerald Kelly	**Registered manager:** Ann Bannister
Person in charge of the home at the time of inspection: Ann Bannister	**Date manager registered:** 19 May 2014
Categories of care: NH-LD(E), NH-I	**Number of registered places:** 48

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 five patients, five care staff, two registered nurses and seven patients' representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- ten patient care records
- staff training records for 2015/2016
- accident and incident records
- audits in relation to care records and falls
- records relating to adult safeguarding
- one staff recruitment and selection record
- staff induction 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
- complaints received since the previous care inspection

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 13 September 2016

The most recent inspection of the home was an unannounced medicines management inspection.

Enforcement action resulted from the findings of this inspection.

The completed QIP was returned and approved by the pharmacist inspector. There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 4-5 January 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 35.3 **Stated:** First time	A system of robust auditing should be implemented, to ensure that care records meet regulatory and professional standards. Traceability of the identified records and follow up on identified areas should be evident.	**Met**
	Action taken as confirmed during the inspection: A review of care record audits and discussion with the registered manager confirmed that there was a system in place to review the care records. The registered manager utilised an electronic dashboard, which identified all areas that required attention. Hard copy records of audits were also reviewed and there was evidence that follow up action had been taken to address any shortfalls identified. The registered manager agreed that she would increase the frequency with which these audits would be completed.	

Recommendation 2 **Ref**: Standard 41.1 **Stated:** First time	The registered manager should evidently review the staffing levels in the home, taking into account the dependency levels of patients, the deployment of staff and the layout of the building.	**Not Met**
	Action taken as confirmed during the inspection: Although there was evidence that staffing levels had been increased from 16.00 hours to 22.00 hours, consultation with staff and observations on the day of the inspection evidenced that there continued to be delays in meeting patients' needs, due to the dependency levels of patients and the layout of the building. Given the length of time from when this recommendation was first made, a requirement has now been made. Refer to sections 4.3 and 4.6 for further detail.	

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. However, a review of the staffing rota for the week commencing 10 October 2016 evidenced that the planned staffing levels were not consistently adhered to. For example, there were four days on which the number of registered nurses fell below the planned levels. The home was also below the planned staffing levels on the day of the inspection. This was discussed with the registered manager, who advised that the home was having difficulty recruiting registered nurses and that these absences occurred, when the nursing agencies employed were unable to provide replacement staff.

The majority of patients required two members of staff to assist them with their personal care needs. This meant that when two staff were busy attending to patients in their bedrooms and in other areas of the home, other patients had to wait for attention. Although discussion with patients did not evidence that there were concerns regarding staffing levels, we observed call bells not being answered promptly on two separate occasions. When brought to the attention of staff, both patients had their needs attended to immediately. Consultation with staff evidenced that due to one identified patient's care requirements, they needed three members of staff to assist them. This meant that when the staff were delivering personal care, they could not hear the nurse call bell sounding. All staff consulted with stated that additional staff were required due to the high dependency levels and stated informed the inspector, that although patients' needs were being met, that care was provided later than planned and in a hurried manner. This was discussed with the registered manager. As discussed in section 4.2, a recommendation that was previously made in relation to staffing levels, had not been met. A requirement has now been made in this regard. Refer to section 4.6 for further detail.

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.

One completed induction programme was reviewed. Although the induction record included a list of the areas completed, we were unable to examine what level of information had been included in each subject area. Induction records and staff profiles were also not consistently maintained for agency staff employed in the home. These matters were discussed with the registered manager. A recommendation has been made in this regard.

Although all staff consulted with, stated that training had been provided in all mandatory areas, up to date staff training records were not available on the day of the inspection. Discussion with the registered manager confirmed that staff completed e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult safeguarding. Following the inspection, the registered manager submitted the training records to RQIA, by email on 20 October 2016. The review of the training records evidenced that these were not consistently updated. For example, the records only evidenced that fire safety training had been provided to 35 out of the 48 staff. The records reviewed also evidenced that training in adults safeguarding had only been provided to 39 out of the 48 staff members; and one staff member had not received training since August 2011. Given that the records were not up to date, we were not assured that compliance with all mandatory areas had been met. This was discussed with the registered manager, by telephone on 20 October 2016. 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 and completed annual appraisals. Although discussion with the registered manager and staff confirmed that a competency and capability assessment was completed with all registered nurses who were given the responsibility of being in charge of the home, we were unable to review the competency assessment document, as this was not available on the day of the inspection. A recommendation has been made in this regard.

Discussion with the registered manager evidenced that all relevant pre-employment checks were completed prior to commencement of employment; however, these records were not maintained in the home, in line with the organisation's policies and procedures. The registered manager explained that the Human Resources function for the home was managed centrally at their headquarters in Londonderry. The requested information was made available for review on the day of the inspection. A checklist was also in place, which indicated that all the relevant documents had been received for each member of staff; however, there was no record of the dates that the enhanced criminal records checks, with ACCESSNI, had been completed and the date received was also not recorded. This information was confirmed to RQIA by email, on 19 October 2016. The registered manager confirmed that this information would be retained on file for future inspection.

Where nurses and carers were employed, their PIN numbers were checked, pre-employment, with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), to ensure that they were suitable for employment. The registered manager explained that the organisation reimbursed the professional fees, to the registered nurses; however this system is not sufficiently robust, to ensure that registrations have been renewed. The records evidenced that the NMC register had not been between 29 July 2016 and 21 September 2016. Although, all registered nurses' registrations were confirmed on the day of the inspection, a review of the records identified that two registered nurses had renewed their registrations during this period. A requirement has been made in this regard.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. Consultation with the registered manager and staff confirmed that there had been no safeguarding incidents in the home since the last inspection and the all those consulted with were knowledgeable regarding the regional safeguarding protocols and the home's policies and procedures.

Validated risk assessments were completed as part of the admission process and were reviewed as required. These risk assessments informed the care planning process.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were generally updated on a regular basis; however, the review identified that the assessments and care plans were not reviewed following each incident. A recommendation has been made in this regard.

The review of the accident and incident records also evidenced that a patient had sustained a head injury as a result of a fall. Although appropriate action had been taken at the time and care management and patients' representatives had been notified, 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, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. We observed that odour management was problematic in one identified patient's bedroom. A pervading incontinence odour existed in the bedroom and although the patient stated that the bedroom was cleaned every day, it was evident that the carpet required to be replaced. The registered manager provided assurances that plans were in place to change the floor covering in this room. A recommendation has been made in this regard.

Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction. Personal evacuation plans had been completed for each patient taking into account their mobility and assistance level. These plans were reviewed monthly to ensure that they were up to date.

Areas for improvement

A requirement has been made that the staffing arrangements in the home are reviewed, taking into account the dependency levels of patients, the deployment of staff and the layout of the building.

A recommendation has been made that agency staff inductions are completed and records retained in the home. Agency staff profiles, which evidence the training and competency level achieved, should also be retained.

A requirement has been made that training on adults safeguarding is provided to all staff. Current records of staff attendance must also be retained in the home, to evidence compliance with mandatory training requirements.

A recommendation has been made that competency and capability assessments are completed on an annual basis, for registered nurses who have the responsibility of being in charge of the home, in the absence of the registered manager.

A requirement has been made 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 recommendation has been made that the falls risk assessment is reviewed in response to patients' falls.

A requirement has been made that any head injuries sustained in the home are notified to RQIA, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

A recommendation has been made that the identified resident's bedroom carpet is replaced.

Number of requirements	4	**Number of recommendations**	4

4.4 Is care effective?

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. With the exception of wound care, all other assessments were reviewed on a regular basis. There was also evidence that risk assessments informed the care planning process.

Although the review of the care records evidenced that wound dressings were reviewed in line with the patients' care plan, there was no evidence that a wound assessment had been updated since 15 May 2016 and the care plan had also not been updated since 5 August 2016. The review of the daily progress notes confirmed that the wound dressing had been changed; however, the entries made in relation to the dressing changes did not include sufficient descriptions of the wound progress and there was no evidence that wound measurements had been recorded. Wound care records were also not supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines. This was discussed with the registered manager. A requirement has been made in this regard.

Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day. Referrals were made to relevant health care professionals, such as GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of the patient's poor nutritional intake.

Patients who were identified as requiring a modified diet, had the relevant choke risk and malnutrition risk assessments completed and patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans. However, the review of care records identified that care plans had not been consistently updated when patients had been prescribed antibiotics for acute infections. A recommendation has been made in this regard.

There was evidence that the care planning process included 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.

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 and that any concerns, could be raised with their line manager and /or the registered manager.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The most recent staff meeting was held on 22 August 2016. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities.

Patients and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. The registered manager explained that patients' and/or relatives' meetings were held on a regular basis; however, she explained that attendance at meetings were generally poorly attended, if at all. The most recent meeting, which was attended by patients, was held on 23 September 2015 and no relatives attended the meeting which had been scheduled for 18 February 2016. This was discussed with the registered manager. A recommendation has been made in this regard.

Areas for improvement

A requirement has been made that patients' needs are assessed and that a treatment plan is developed, implemented accordingly and recorded to evidence all care provided, with particular reference to wound care. Wound care records should also be supported by the use of photography in keeping with the home's policies and procedures and the NICE guidelines.

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

A recommendation has been made that the methods available for engagement with patients and relatives to ensure they are effective.

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

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate and caring. 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 were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

We observed the lunch time meal in two dining rooms. We saw that the atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set in advance of patients taking their seats and specialist cutlery was available to help patients who were able to maintain some level of independence as they ate their meal. The lunch served in both units appeared very appetising and patients spoken with stated that it was always very nice

Patients consulted with also confirmed that they were able to maintain contact with their families and friends.

A list of activities was displayed on the ground and first floors that included armchair exercises; rhythm and music; arts and crafts; nail care and massage; reading and movies. Activities were provided in the afternoon from 14.00 hours to 16.00 hours. One patients' representative consulted stated that her relative always missed the planned activities because he returned to bed in the afternoon. This was brought to the registered manager's attention to address.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. Religious services were also provided on a weekly basis.

The care plan detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for patients, as required. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the quality of the service provided. A report entitled 'You Said; We Did' detailed the results of the patient satisfaction survey, conducted in February 2016. 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 registered 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 praised the staff for their 'exemplary nursing and caring skills' and for the 'empathy shown to the family members' when their loved one was receiving end of life care.

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

Staff

"The care is very good. I take my hat to all the staff because it is heavy work".
"The care is very good. We do our best".
"The care is pretty good, we get good feedback from Doctors and visitors".

All staff consulted with commented regarding the high dependency levels of the patients. Although all staff confirmed that patients' needs were being met, one staff member described the care delivery as being like a 'conveyor belt'. Discussion with the registered manager and staff confirmed that discussions had recently taken place between the staff and representatives from the organisation's head office, where the staff were given the opportunity to discuss their concerns regarding the staffing levels. As discussed in section 4.3 and 4.6, a requirement has been made in relation to staffing levels.

Patients

"It's alright, good really".
"I am treated well, the food is very good".
"They are all polite".
"It's very good".

Patients' representatives

"'Everything is fine".
"It's a very good home, they are very friendly".
"They couldn't be better looked after".
"They get great attention".

One patient's representative stated that the registered nursing staff appear to 'give the pills, then run on'. Another patient's representative stated that there are always delays in getting things fixed in the home. An example was given of a light being broken in an ensuite for over one week, despite having been reported. This was discussed with the registered manager, who agreed to address the matter.

In addition to speaking with patients, relatives and staff RQIA provided questionnaires. At the time of writing this report three relatives, three patients and six staff had returned their questionnaires, within the timeframe for inclusion in this report. Comments and outcomes were as follows:

Patients: respondents indicated that they were either 'satisfied' or 'very satisfied' in relation to all four domains. Comments include "shortage of staff".

Relatives: respondents indicated that they were either 'satisfied' or 'very satisfied' in relation to all four domains. Comments recorded included, "I understand that there are staff shortages which is a common problem in most care facilities" and "on occasions the foyer area could do with air fresheners".

Staff: Although all respondents indicated that they were either 'satisfied' or 'very satisfied' in relation to all four domains, all respondents provided written comment in relation to the staffing levels. Comments recorded included, "Meds are later, residents may be later getting up", "can be understaffed, patient dependency has increased but staffing levels hasn't", "When we are short staffed we don't have any time to spend with the residents", "sometimes the floor can be short staffed, but we do our best to meet the needs of residents", "always need more staffing to ensure 1:1 time with patients", (agency) does not always provide staff when needed". Refer to section 4.3 for further detail.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

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

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. All those consulted with described the registered manager is positive terms and stated that she was 'very approachable' and 'responsive' to any concerns raised.

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
- laundry
- medicines management
- care records
- housekeeping and cleaning
- infection prevention and control
- staff dress code
- food
- Care/Support planning
- Customer service

The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

An audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. An action plan was in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Given that a requirement has been made regarding wound care management, a recommendation has been made that the systems in place to monitor and report on the quality of nursing and other services provided are further developed, to include wound care audits.

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. The monthly monitoring report provided an overview of areas that were meeting standards and areas where improvements were required.

As discussed in section 4.2 and 4.3, a requirement has been made regarding the staffing arrangements in the home. The review of the monthly quality monitoring report identified that the home was operating below the planned levels on the day of the monitoring visit. The report also identified that the Personnel and Training Department were to provide an update regarding the progress of staff requisition. Although an action plan was generated to address the areas for improvement, the report had not been received by the registered manager, until the day of the inspection, when requested by the inspector. This demonstrated that effective actions necessary to address the deficits identified in the quality monitoring report could not have been taken in a timely manner. This was discussed with the registered manager. A recommendation has been made in this regard.

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

Areas for improvement

A recommendation has been made that the systems in place to monitor and report on the quality of nursing and other services provided are further developed, to include auditing of wound care management.

A recommendation has been made that the monthly monitoring reports are received by the registered manager within a meaningful timeframe, to enable the actions identified in the action plan to be addressed in a timely manner.

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 the 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 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 20 (1) (a) **Stated:** First time **To be completed by:** 15 December 2016	The registered persons must ensure that staffing arrangements in the home are reviewed, taking into account the dependency levels of patients, the deployment of staff and the layout of the building. **Ref: Section 4.2, 4.3 and 4.6**
	Response by registered provider detailing the actions taken: Completed An additional 91hrs of Care Assitant hours/week has been authorised and is currently being implemented.
Requirement 2 **Ref:** Regulation 20 (c) (i) **Stated:** First time **To be completed by:** 15 December 2016	The registered persons must ensure that training on adults safeguarding is provided to all staff. Current records of staff attendance must also be retained in the home, to evidence compliance with mandatory training requirements. **Confirmation that all staff have attended adults safeguarding training must be submitted to RQIA with the returned QIP.** **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Agreed All staff will have completed refresher training on Safeguarding & Fire safety by 31/12/16.
Requirement 3 **Ref:** Regulation 20 (1) (c) (ii) **Stated:** First time **To be completed by:** 15 December 2016	The registered persons should 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: Registered Nurses NMC checks are carried out monthly and following renewal of registration
Requirement 4 **Ref:** Regulation 30 (1) (c) **Stated:** First time **To be completed by:** 15 December 2016	The registered persons must ensure that any head injuries sustained in the home are notified to RQIA. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: All Head injuries sustained in the home will be notified to RQIA

Requirement 5 **Ref:** Regulation 15 (2) (a) **Stated:** First time **To be completed by:** 15 December 2016	The registered persons must ensure that patients' needs are assessed and that a treatment plan is developed, implemented accordingly and recorded to evidence all care provided, with particular reference to wound care. Wound care records should also be supported by the use of photography in keeping with the home's policies and procedures and the NICE guidelines. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Patient's needs will be assessed and a treatment plan developed and implemented accordingly to evidence all care provided. All wound care records will be supported by the use of photography. A copy of the Nice Guidelines is available as a resource for all the nurses.
Recommendations	
Recommendation 1 **Ref**: Standard 39.1 and 39.9 **Stated:** First time **To be completed by:** 15 December 2016	The registered persons should ensure that agency staff inductions are completed and records retained in the home. Agency staff profiles, which evidence the training and competency level achieved, should also be retained. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Agreed. Agency staff profiles are now all held on file together with completed induction records
Recommendation 2 **Ref**: Standard 39 **Stated:** First time **To be completed by:** 15 December 2016	The registered persons should ensure that competency and capability assessments are completed on an annual basis, for registered nurses who have the responsibility of being in charge of the home, in the absence of the registered manager. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Competency and capability assessments are completed for all nurses annually
Recommendation 3 **Ref**: Standard 22.4 **Stated:** First time **To be completed by:** 15 December 2016	The registered persons should ensure that the falls risk assessment is reviewed in response to patients' falls. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Falls risk assessments will be renewed and updated in response to all falls.
Recommendation 4 **Ref**: Standard 44.1 **Stated:** First time	The registered persons should ensure that the identified resident's bedroom carpet is replaced. **Ref: Section 4.3**

To be completed by: 15 December 2016	**Response by registered provider detailing the actions taken:** The identified residents carpet was replaced in October 2016
Recommendation 5 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 15 December 2016	The registered persons should ensure that care plans are developed in response to acute infections. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Care plans will be developed in response to every acute infection
Recommendation 6 **Ref**: Standard 7.1 **Stated:** First time **To be completed by:** 15 December 2016	The registered persons should review the methods available for engagement with patients and relatives to ensure they are effective. **Ref: Section 4.5**
	Response by registered provider detailing the actions taken: The home offers an open door policy encouraging residents and relatives to engage with the home manager and staff as required. All relatives are formally invited to a relatives meeting on a yearly basis and coffee afternoons for residents and relatives and friends are held twice yearly. All relatives were invited to a Safeguarding Awareness day in September. Relatives have the opportunity to talk to the Housing with Care Services Manager during her monthly monitoring visit. A suggestion box is in situ and a survey is carried out on a yearly basis. Relatives have the opportunity at yearly care reviews to talk to management and staff. Relatives are invited to participate in activities organised in the home such as the Christmas party and as and when visiting entertainers are performing.
Recommendation 7 **Ref**: Standard 35.4 **Stated:** First time **To be completed by:** 15 December 2016	The registered persons should ensure that the systems in place to monitor and report on the quality of nursing and other services provided are further developed, to include auditing of wound care management. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: The wound care audit tool has been reviewed and an audit of all woundcare will be carried out on a monthly basis. Wound care will be placed on the agenda and discussed at the next staff meeting in December
Recommendation 8 **Ref**: Standard 21 **Stated:** First time	The registered persons should ensure that the monthly monitoring reports are received by the registered manager within a meaningful timeframe, to enable the actions identified in the action plan to be addressed in a timely manner. **Ref: Section 4.6**

To be completed by: 15 December 2016	
	Response by registered provider detailing the actions taken: Monthly monitoring reports will be photocopied and left with the home manager at the end of the visit. The final report will be forwarded to the manager when signed by all relavent parties.

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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