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Unannounced Care Inspection
of
Brookmount

21 May 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 21 May 2015 from 10.15 to 18.15 hours.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern. However, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 21 May 2015.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	5	10

The total number of requirements and recommendations above includes both new and those that have been ‘restated’.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the deputy manager as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Gerald Kelly	**Registered Manager:** Ann Bannister
Person in Charge of the Home at the Time of Inspection: Moira McGuinness	**Date Manager Registered:** 5 April 2012
Categories of Care: NH-LD (E), NH-I	**Number of Registered Places:** 48
Number of Patients Accommodated on Day of Inspection: 45	**Weekly Tariff at Time of Inspection:** *£618*

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

4. Methods/Process

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

Prior to inspection the following records were examined:

- 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 (QIP) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre-inspection assessment audit.

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with three patients, four care staff, three nursing staff and two patient's visitors/representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- the staff duty rota
- five patient care records
- staff training records
- policies for death and dying; and palliative and end of life care
- policy on breaking bad news.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 27 January 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the last Care Inspection on 27 January 2015.

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 16 (2) (b) **Stated:** Third time	Where a nursing assessment is made to monitor a patient's daily fluid intake, then the patients daily (24hour) fluid intake should be recorded in their daily progress record in order to show that this area of care is being properly monitored and validated by the registered nurse. Given that this requirement has been stated for the third time, enforcement action was considered in discussion with the Head of Nursing. It was concluded that enforcement action would not be taken at present. The requirement is assessed as moving towards compliance and has been stated for the third and final time.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed in three care records, that fluid intake was monitored and validated by the registered nurse.	

Requirement 2 **Ref**: Regulation 20 (1) (a) **Stated:** Second time	The registered person must continue to monitor the dependency levels of patients using the Rhys Hearn (1970) dependency tool, to ensure that staffing provision and care hours provided meets the needs of the patients accommodated.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed that the dependency levels of patients were reviewed monthly.	
Requirement 3 **Ref**: Regulation 16 (2)(b) **Stated:** First time	The registered person must ensure the development of care plans as follows: • Care plans regarding continence management must be person-centred. • Care plan evaluations must reflect information documented in progress notes and bowel records. • Care plans regarding fluid intake management must contain the patients' fluid target and this target must be entered onto the fluid recording record.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed that care plans were person-centred and reflected information documented in progress notes and bowel records. A review of three care records confirmed that fluid targets were recorded in the patients' care plans and on the fluid recording charts. A review of the regulation 29 visit report confirmed that fluid monitoring was reviewed during this visit.	
Requirement 4 **Ref**: Regulation 15 (2)(a)&(b) **Stated:** First time	The registered person must ensure that bowel function, reflective of the Bristol Stool Chart should be recorded on admission as a baseline measurement and thereafter in patients' care plans and daily progress records.	**Not Met**
	Action taken as confirmed during the inspection: Inspector confirmed in two care records that baseline measurement of bowel function was not recorded, in line with the Bristol Stool Chart. This information was recorded daily. However, the care plans did not accurately reflect this. This requirement is made for the second time.	

Requirement 5 **Ref**: Regulation 20(1)(a) **Stated:** First time	The registered person must ensure that a dedicated individual to organise and co-ordinate a programme of activities and events, is appointed to ensure patients' individual needs are fully met and their quality of life in the home enhanced A record must be maintained to evidence the decision making process regarding the provision of activities and events for patients accommodated in the nursing home. This record should include the level of participation and enjoyment and the activities provided to patients who cannot or do not wish to partake in group activities.	**Not Met**
	Action taken as confirmed during the inspection: Inspector confirmed that there was no dedicated individual appointed to co-ordinate activities. Care staff were assigned to carry out a range of activities, which were displayed on each unit. Three staff consulted stated that they did not have the time to carry out activities. The planned activities, such as watching movies, listening to music and religious services did not involve much staff interaction. Personal care interventions, such as hand/nail care, and hairdressing were also included as activities. This was discussed with the deputy manager, who stated that additional activities were also provided by a patient's relative and that this was not recorded. The inspector noted that this informal arrangement was not sufficient to meet the patients' needs. The records pertaining to the provision of activities were inadequate and did not record the level of patient participation in sufficient detail. A review of the regulation 29 visit report identified that the registered manager was reviewing the activity provision to determine the hours required per week across both floors. There was no evidence that this was being progressed. This requirement is stated for the second time.	

Requirement 6 **Ref**: Regulation 20(1)(a) **Stated:** First time	The registered person must ensure that the recruitment plan is provided to RQIA with the returned QIP and no later than 1 April 2015.	**Met**
	Action taken as confirmed during the inspection: The recruitment plan was provided to RQIA and was deemed to be appropriate.	
Requirement 7 **Ref**: Regulation 12 (4)(a)(b) **Stated:** first time	The registered person must review the serving of meals to ensure that: • meals are served in a timely manner to meet patients' needs • meals are served at a temperature which is in accordance with the nutritional guidelines • staff provide appropriate supervision to patients during mealtimes The deployment of staff at mealtimes and issues in relation to respect and dignity, when assisting patients to eat, must be included in this review.	**Not Met**
	Action taken as confirmed during the inspection: The mealtime experience was observed. There was a change made to the menu on the day of inspection. This change was only indicated on one side of the table menus. The menu did not correspond with the four-weekly menu that was displayed in the dining room. Discussion with kitchen staff confirmed that a three-weekly menu planner was being implemented. Four meals, covered in cling film, were observed being transported to patients' bedrooms. We observed one uncovered meal plate being delivered to a patient's bedroom. The desert was not kept hot and was observed on an unheated trolley, covered with tin-foil, whilst the main meal was being served. Patients were wearing disposable bibs. Staff were present during the serving of the meal but did not appear to anticipate patients' needs. This was evident where one patient was eating the meal with a knife for some time, until eventually assisted by a staff member. Staff were observed using terminology, such as 'softs' and 'pureeds', when discussing patients' needs. This requirement is made for the second time.	

Requirement 8 **Ref**: Regulation 13 (1)(b) **Stated:** First time	The registered persons must ensure that patients' weights are monitored on a regular basis and appropriate action taken when significant decreases/increases are identified.	**Not Met**
	Action taken as confirmed during the inspection: A review of five patient care records confirmed that patients' weights were monitored on a regular basis. However, discrepancies were identified in two patients' weights. One discrepancy was not identified for 11 days and another discrepancy was not identified for 30 days. The evidence indicated that weights were reviewed, in line with the care plan reviews; however, there was no system in place to identify immediate action taken, when a significant decrease in weight was recorded at the time patients were being weighed. This requirement is made for the second time.	
Requirement 9 **Ref**: Regulation 13 (4)(b) **Stated:** First time	The registered persons must ensure that thickening agents are not used for patients, for whom they have not been prescribed.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed that thickening agents were used for patients, for whom they had been prescribed.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 19.2 **Stated:** First time	The policy for continence should be further developed to include catheter and stoma care. The following guidelines should be made available to staff and used on a daily basis: • British Geriatrics Society Continence Care in Residential and Nursing Homes • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence	**Not Examined**
	Action taken as confirmed during the inspection: The policy on continence was unavailable. The deputy manager confirmed that this was in the process of being updated by the continence link nurse. This recommendation is carried forward for examination at future inspection.	
Recommendation 2 **Ref**: Standard 17.6, 17.10 & 17.16 **Stated:** First time	The registered manager should record the outcome of all complaints. A process should be developed, to ascertain and record the complainant's satisfaction with actions taken. Information should also be provided to complainants with regards to their rights if they remain dissatisfied with the outcome of the complaints procedure.	**Partially Met**
	Action taken as confirmed during the inspection: A review of the complaints register identified that the registered manager had reviewed the complaints, however there was no outcome recorded. The inspector was unable to validate the process for ascertaining complainants' level of satisfaction with actions taken or that information had been provided to those who remained dissatisfied. This recommendation has been stated for the second time.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating with patients and relatives, however this did not reflect current best practice, including regional guidelines on Breaking Bad News. Discussion with three staff confirmed that they were knowledgeable regarding this policy and procedure.

A review of training records evidenced that staff had not completed training in relation to communicating effectively with patients and their families/representatives. However, communication was included in the induction training programme.

Is Care Effective? (Quality of Management)

There was evidence within five records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs, however individual needs regarding the end of life care were not addressed.

Two registered nurses consulted demonstrated their ability to communicate sensitively with patients and/or representatives when breaking bad news. When the need for breaking of bad news was raised, two care staff felt that they would refer relatives to the registered nurses.

Is Care Compassionate? (Quality of Care)

Discussion was undertaken with seven staff, including three registered nurses who had responsibility of being in charge of the home, regarding how staff communicates with patients and their representatives. All staff appeared to have a good awareness, relevant to their role, of the need for sensitivity when communicating with patients and/or their representatives.

Staff spoken with emphasised the importance of developing good relationships with patients and/or their representatives.

We consulted three patients and two patient representatives during the inspection who confirmed that patients were treated with respect and dignity at all times. Both patient representatives spoken with, stated that the staff were very supportive, patients were treated with respect and dignity and that the care was of a high standard

There were a number of compliments recorded which indicated that patient representatives were appreciative of the care provided to a patient who was recently deceased.

Areas for Improvement

The policy and procedure for delivering bad news to patients and their families should be developed in line with best practice, such as DHSSPSNI (2003) *Breaking Bad News*.

Number of Requirements:	**0**	**Number of Recommendations:** * One recommendation is made under standard 32 below.	**0***

5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

Policies and procedures on the management of palliative and end of life care and death and dying were available in the home. The policies included religious observances, last offices and the management of the deceased person's belongings and personal effects. The policies did not reflect best practice guidance such as the GAIN Palliative Care Guidelines, November 2013.

Training records evidenced that care staff were not all trained in the management of death, dying and bereavement. However, the deputy manager confirmed that there was an e-learning module on end of life care scheduled to commence in September 2015. A number of registered nurses had attended palliative care training. This provided those who attended with the opportunity to have discussion around end of life care issues more comfortably. Course material reviewed confirmed that the care of the deteriorating patient, pain relief, the palliative care register and advanced care planning was included in the training. Registered nursing staff were aware of and able to demonstrate knowledge of the GAIN Palliative Care Guidelines, November 2013.

Discussion with three nursing staff confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the deputy manager, two nursing staff and a review of five care records evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

A protocol for timely access to any specialist equipment or drugs was not in place. However two registered nurses and the deputy manager confirmed their knowledge of the procedure to follow. The need for a protocol in this regard is incorporated into a recommendation regarding policy development.

There were no patients requiring the use of a syringe driver on the day of the inspection. A review of training records confirmed that training in the use of syringe drivers had been provided. Discussion with the deputy manager confirmed that update training would be sought form the local healthcare trust link nurse at the time of a patient's admission, if such specialist equipment was required. Current guidelines for the use of the McKinley syringe driver were available.

Is Care Effective? (Quality of Management)

A review of five care records evidenced that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration, nutrition and symptom management. However, two identified patients who required transdermal pain relief did not have Abbey Pain Scores recorded. The care plans for pain did not include the use of the transdermal patch or the management of breakthrough pain.

Staff consulted demonstrated an awareness of patients' needs and wishes regarding end of life care, however in five care records reviewed, there was no evidence of care plans relating to this. The care records did not evidence discussions between the patient, their representatives and staff in respect of death and dying arrangements. The deputy manager identified a reluctance of some family members to discuss this issue.

A key worker/named nurse was identified for each patient approaching end of life care. There was evidence that referrals had been made to the specialist palliative care team and where instructions had been provided, these were evidently adhered to.

Discussion with the deputy manager, seven staff and a review of five care records evidenced that environmental factors had been considered. Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying.

A review of notifications of death to RQIA during the previous inspection year confirmed that all notifications were submitted appropriately.

Is Care Compassionate? (Quality of Care)

A review of five care records evidenced that patients and/or their representatives had not been consulted in respect of their cultural and spiritual preferences regarding end of life care. However, five staff consulted, including three registered nursing staff, demonstrated an awareness of patient's expressed wishes and needs.

Arrangements were in place in the home to facilitate, as far as possible, in accordance with the persons wishes, for family/friends to spend as much time as they wish with the person. An overnight room was available for relatives to use. Staff consulted confirmed that refreshments would be provided to family members during this time.

From discussion with the deputy manager, two registered nursing staff and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives during this time. There was evidence within compliments records that relatives had commended the management and staff for their efforts towards the family and patient.

Discussion with the deputy manager and a review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

Three staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death.

From discussion with the deputy manager and two registered nursing staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included supporting each other and reflecting on how the deceased person's care was managed.

Information regarding support services was available and accessible for staff, patients and their relatives. This information included information leaflets from the HSC Bereavement Network.

Areas for Improvement

Care plans, as discussed previously need to fully reflect consultation with patients and/or their representatives in respect of their needs and wishes. This should include their cultural and/or spiritual preferences regarding death and dying.

Patients who require transdermal patches to manage their pain, should have their pain assessed using a validated pain assessment tool. This should be included in the care plans and reflected in care plan evaluations.

The policy on palliative and end of life care should be should be further developed in line with current best practice guidance, such as GAIN Palliative Care regional guidelines and DHSSPSNI Living Matters : Dying Matters and should include an out of hours protocol for accessing specialist equipment and medication.

Number of Requirements:	**0**	**Number of Recommendations:**	**3**

5.5 Additional Areas Examined

Staffing

Staffing arrangements were reviewed. The total numbers of staff required to meet patient need were in place. A review of the duty roster identified that there were two days where the skill mix was not adequate. This was discussed with the deputy manager, who confirmed that this occurred due to staff absenteeism. Records relating to the efforts made to replace staff were not available. Following the inspection, this was discussed with the registered manager, who agreed to inform RQIA on a weekly basis, when staffing levels fall below appropriate levels. A requirement is made to address this.

Questionnaires

As part of the inspection process we issued questionnaires to staff, patients and their representatives.

Questionnaire's issued to	Number issued	Number returned
Staff	10	8
Patients	6	4
Patients representatives	7	6

All comments on the returned questionnaires were in general positive. Some comments contained within the returned questionnaires and those made directly to the inspector are detailed below:

Staff

'I feel we are compassionate and caring towards residents and families. We are always there to talk to families and offer what support they need'
'We tell visitors that the call bell is there, for them to use also'
'I really like it here. Staffing should be better now that holiday requests are being controlled'
'It is fine here, if everyone shows up for work. If there is one sick call, we are under extreme pressure'
'I have no concerns for patients here'

Patients

Two patients specifically requested full anonymity, in terms of comments made to the inspector. The following statements represent comments made by three patients.

Patient 1:
'All good for me here'
'They just pop their heads in to see if I'm alive. They don't even wait for an answer'

Patient 2:
'Agency staff don't know what they are doing'
'They are often short staffed'
'Staff can be quite rude. I overheard one staff member saying to another patient that they would throw (the breakfast) at them'
'I use hand gestures when talking. One staff member was very rude to me and told me not to point my finger at her'.

Patient 3:
'They do their best, but it's all '*go-go'* and they are gone'

These comments were discussed with the deputy manager during feedback and with the registered manager, following the inspection. As stated above, a requirement is made regarding the need for a statutory notification of events form to be submitted to RQIA, when staffing levels fall below appropriate levels. Another requirement is stated for the second time regarding the provision of a dedicated activities coordinator. Refer to inspector comments in section 5.2.

A new recommendation is made for the registered manager to identify staff' training needs, to promote positive relations between patients and staff. A second recommendation is made regarding the need for the negative comments made by patients to be included in the monthly regulation 29 visit reports, conducted by the responsible person.

Patients' representatives

The following statements represent comments made by two patients' representatives and comments included in the returned questionnaires:

'Overall care is very good and staff are great'
'Sometimes, my (relative) has nothing to look at'
''independence would be enhanced by more activities for which a co-ordinator is vital'
'Staff never seem to stop. Although minimum requirements are met, they do seem overworked'
'We are very happy with the overall quality of care, especially the approachable nature of the manager, nurses and most care staff'

'Welcomed on entrance to the home. Extremely happy with current care provision'
'My (relative) is getting the best care possible …. is treated with great respect. As a family, we are very grateful'
'Care is exceptional'
'My (relative's) laundry builds up at weekends and when the laundry staff are on holiday'
'There are no activities, other than the music man. Staff try to do activities. Last summer, the staff were at breaking point'
'I am worried for my relative's safety as the front door is not secured at night time'
'Lack of activities is an issue'.

The identified issues were discussed with the deputy manager during feedback and with the registered manager following the inspection. A recommendation is made regarding the need for the provision of laundry hours to be reviewed, to ensure that there is continuity of service, when staff is on annual leave. As previously discussed, a requirement is made to address the lack of activities in the home.

Environment

Since the previous inspection, RQIA were notified that there was an outbreak of clostridium difficile in the home. A tour of the premises was undertaken. The home presented as comfortable and all areas were maintained to a high standard of hygiene. In all areas of the home, boxes of gloves were observed placed on handrails. This practice was also observed in the previous inspection. A recommendation is made to address this.

One patient representative raised concerns regarding the front door which did not fully close. This was addressed at a recent relatives meeting and there was evidence of additional signage at the front door, to increase user awareness of this matter. However, we observed, in the presence of the deputy manager that the door did not close fully unless concerted effort was made. A recommendation has been made to address this.

On the day of inspection, it was noted that an enforcement order was in the process of being issued from the Northern Ireland Fire and Rescue Service, regarding the home's door closures. This is to be addressed over the next six weeks.

6 Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Moira McGuinness, deputy manager as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.3 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.4 Recommendations

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

6.5 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref**: Regulation 15 (2)(a)&(b) **Stated:** Second time **To be Completed by: 01 August 2015**	The registered person must ensure that bowel function, reflective of the Bristol Stool Chart should be recorded on admission as a baseline measurement and thereafter in patients' care plans and daily progress records. **Response by Registered Person(s) Detailing the Actions Taken:** Bowel Function reflective of the Bristol Stool Chart will be recorded on admission as a baseline for all patients
Requirement 2 **Ref**: Regulation 20(1)(a) **Stated:** Second time **To be Completed by: 01 August 2015**	The registered person must ensure that a dedicated individual to organise and co-ordinate a programme of activities and events, is appointed to ensure patients' individual needs are fully met and their quality of life in the home enhanced A record must be maintained to evidence the decision making process regarding the provision of activities and events for patients accommodated in the nursing home. This record should include the level of participation and enjoyment and the activities provided to patients who cannot or do not wish to partake in group activities. **Response by Registered Person(s) Detailing the Actions Taken:** Monies have been allocated by Apex for the provision of activities. A job description has been developed and the position will be advertised shortly. It is anticipated that the position will be filled bt the end of the summer.

Requirement 3 **Ref**: Regulation 12 (4)(a)(b) **Stated:** Second time **To be Completed by: 01 August 2015**	The registered person must review the serving of meals to ensure that: • meals are served in a timely manner to meet patients' needs • meals are served at a temperature which is in accordance with the nutritional guidelines • staff provide appropriate supervision to patients during mealtimes The deployment of staff at mealtimes and issues in relation to respect and dignity, when assisting patients to eat, must be included in this review.
	Response by Registered Person(s) Detailing the Actions Taken: A review of meals will be conducted by the Catering Manager, Cook and Nurse Manager once the appointment of a cook has been finalised. In the interim existing kitchen staff have been spoken to regarding the need for the menue to correspond with the four weekly menue displayed in the dining room. Meals are no longer to be covered with cling film and are to be served in a timely manner and at the temperature stipulated within the Nutritional Guidelines. Residents with capacity have been consulted regarding wearing either disposable or fabric bibs. Fabric bibs have been purchased for those residents who prefer them.
Requirement 4 **Ref**: Regulation 13 (1)(b) **Stated:** Second time **To be Completed by: 01 August 2015**	The registered persons must ensure that patients' weights are monitored on a regular basis and appropriate action taken when significant decreases/increases are identified.
	Response by Registered Person(s) Detailing the Actions Taken: Patients weights will be monitered monthly and where there is a significant increase / decrease a referral will be made to the Community Dietician as per the MUST tool. This has been emphasised again to all Staff Nurses at a staff meeting
Requirement 5 **Ref**: Regulation 30 **Stated:** First time **To be Completed by: 01 August 2015**	The registered person must ensure that a notifiable events form is submitted to RQIA when staff levels fall below appropriate levels.
	Response by Registered Person(s) Detailing the Actions Taken: A notifiable event form will be submitted to RQIA on the Monday of each week if staff levels fall below the minimum levels.

Recommendations	
Recommendation 1 **Ref**: Standard 19.2 **Stated:** First time **To be Completed by:** **01 August 2015**	The policy for continence should be further developed to include catheter and stoma care. The following guidelines should be made available to staff and used on a daily basis: • British Geriatrics Society Continence Care in Residential and Nursi Homes • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence
	Response by Registered Person(s) Detailing the Actions Taken: The policy for Incontinence is currently being reviewed by the Link Incontinence Nurse and will be completed by the end of July 2015. Nice Guidelines on management of urinary and faecal incontinence and the British Geriatric Society Continence Care in Residential and nursing homes have previously been downloaded and were available for review on the day of inspection. All nurses are now aware of where the guidelines are kept. The guidelines are to be discussed at the next staff meeting and staff will be asked to sign when they have read and understood the same.
Recommendation 2 **Ref**: Standard 17.6, 17.10 & 17.16 **Stated:** Second time **To be Completed by:** **01 August 2015**	The registered manager should record the outcome of all complaints. A process should be developed, to ascertain and record the complainant's satisfaction with actions taken. Information should also be provided to complainants with regards to their rights if they remain dissatisfied with the outcome of the complaints procedure.
	Response by Registered Person(s) Detailing the Actions Taken: The outcome of all complaints will be discussed with the complainant to determine satisfaction with the outcome. A copy of the official complaints form and accompaning official complaints leaflet will be given to complainants who remain dissatisfied. This will be documanted in the complaints book.

Recommendation 3 **Ref**: Standard 36.2 & 36.4 **Stated**: First time **To be Completed by: 01 August 2015**	All policies and procedures should be reviewed to ensure that they are subject to a three yearly review. • A policy on communicating effectively should be developed in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.* • A policy on palliative and end of life care should be developed in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines (2013)* and should include an out of hours protocol for accessing specialist equipment and medication. • A policy on death and dying should be developed in line with current best practice, such as DHSSPSNI (2010) Living *Matters: Dying Matters.* The policies and guidance documents listed above, should be made readily available to staff.
	Response by Registered Person(s) Detailing the Actions Taken: The existing Communication Policy requires to be reviewed and added to. Guidance on Breaking Bad News will be encorporated in line DHSSPSNI (2003) Breaking Bad News bt the end of August 2015. A policy on Palliative and end of life care will be developed in line with current best practice and will include an out of hours protocol for assessing specialist equipment and medication. The current policy on death and dying will be reviewed in line with best practice A copy of Living Matters and Dying Matters has been downloaded and made available for staff
Recommendation 4 **Ref**: Standard 4.1 & 4.5 **Stated:** First time **To be Completed by: 01 August 2015**	It is recommended that registered nurses develop care plans, as relevant, on patients requiring end of life care. Care plans should include patients' and or their representatives': • Communication needs and wishes • Cultural, spiritual and religious preferences • Environmental considerations.
	Response by Registered Person(s) Detailing the Actions Taken: An Epicare End of Life care plan will be developed for all patients requiring End of Life care by 1st August 2015.

Recommendation 5 **Ref**: Standard 17.6, 17.10 & 17.16 **Stated:** First time **To be Completed by: 01 August 2015**	It is recommended that Abbey pain scales are used to assess patients' level of pain, as appropriate and this should be reflected in the care plan. This specifically refers to patients who require transdermal pain relief.
	Response by Registered Person(s) Detailing the Actions Taken: An electronic Abbey Pain Scale has been sourced from Epicare and will be implemented by 1st August.
Recommendation 6 **Ref**: Standard 35.7 **Stated:** First time **To be Completed by: 01 August 2015**	It is recommended that the registered persons includes in the regulation 29 monitoring report, comments made by patients about the quality of the service provided and any actions taken by the registered manager. This specifically relates to negative comments expressed by patients about staff attitudes.
	Response by Registered Person(s) Detailing the Actions Taken: Where a patient makes a negative comment about quality of service provided the designated person completing the Regulation 29 monthly report always highlghts any issues for the manager to address. This is documented in the Action Points.
Recommendation 7 **Ref**: Standard 39.4 **Stated:** First time **To be Completed by: 01 August 2015**	It is recommended that the registered manager review the training needs of individual staff, in order to promote positive relations between patients and staff. This specifically relates to negative comments expressed by patients about staff attitudes.
	Response by Registered Person(s) Detailing the Actions Taken: In relation to the patient/patients who made a complaint it is important to conduct an investigation and important to identify individual staff training needs Therefore in the absence of the staff member/patient being identified no investigation can take place.Collectively all staff have been reminded of the importance of respectful communication with all patients at all times.
Recommendation 8 **Ref**: Standard 41 **Stated:** First time **To be Completed by: 01 August 2015**	It is recommended that the provisions of laundry hours are reviewed, to ensure that there is continuity of service, when staff is on annual leave.
	Response by Registered Person(s) Detailing the Actions Taken: The provision of laundry hours has been reviewed. Additional laundry hours have been allocated to ensure continuity of service over a seven day period.

Recommendation 9 **Ref**: Standard 46.2 **Stated:** First time **To be Completed by:** **01 August 2015**	It is recommended that dispensers are provided in identified areas for personal protective equipment such as gloves.
	Response by Registered Person(s) Detailing the Actions Taken: Additional dispensers have been ordered for personal protective equipment
Recommendation 10 **Ref**: Standard 44 **Stated:** First time **To be Completed by:** **01 August 2015**	It is recommended that security measures are reviewed to ensure that unauthorised access is restricted to the home, to protect patients and their valuables. This relates to the front door which is not closing fully.
	Response by Registered Person(s) Detailing the Actions Taken: The front door has now been fixed and is closing fully.

Registered Manager Completing QIP	Ann Bannister	**Date Completed**	26/6/2015
Registered Person Approving QIP	Muriel sands	**Date Approved**	26/06/15
RQIA Inspector Assessing Response	Aveen Donnelly	**Date Approved**	09/07/2015

Please ensure the QIP is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

Please provide any additional comments or observations you may wish to make below: