The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
22 May 2017

Brookmount

Type of service: Nursing Home
Address: 4 Lower Newmills Road, Coleraine, BT52 2JR
Tel no: 028 7032 9113
Inspector: Aveen Donnelly

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Brookmount took place on 22 May 2017 from 09.20 to 17.00 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?

There were areas of good practice identified throughout the inspection in relation to staff recruitment practices; staff induction, training and development; adult safeguarding arrangements; infection prevention and control practices; and risk management.

No new areas for improvement were identified during this inspection; however, consideration must be given to one requirement that has been stated for the second time, in relation to monitoring the settings of pressure relieving mattresses, to ensure their effective use.

Is care effective?

There were examples of good practice found throughout the inspection in relation to the care records, review of care delivery and some communication systems.

Areas for improvement were identified in relation to timely follow up on recommendations made by dieticians; timely communication of patient falls with the relevant bodies/persons; and the urinary catheter care records.

Is care compassionate?

Areas of good practice were found throughout the inspection in relation to the culture and ethos of the home, treating patient with dignity and respect. A number of comments from the consultation process and the returned questionnaires are included in the main body of the report.

No areas for improvement were identified during the inspection.

Is the service well led?

There was evidence of good practice identified in relation to the governance and management arrangements; management of complaints; and most of the quality improvement processes. There was evidence that action had been taken to improve the effectiveness of the care; the majority of requirements and recommendations made at the previous care inspection had been met.

Areas for improvement were identified in relation to the falls audit; and the management of Chief Nursing Officer (CNO) alerts regarding staff who have sanctions imposed on their employment by professional bodies.

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	*1	5

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

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

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 24 January 2017. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

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

2.0 Service details

Registered organisation/registered person: Apex Housing Association Mr Gerald Kelly	**Registered manager:** Mrs Ann Bannister
Person in charge of the home at the time of inspection: Mrs Ann Bannister	**Date manager registered:** 19 May 2014
Categories of care: NH-LD(E), NH-I Category NH-LD(E) for 1 identified individual only.	**Number of registered places:** 48

3.0 Methods/processes

Prior to inspection we analysed the following information:

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

A poster was displayed in the home, inviting feedback from patients and their representatives. During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with six patients, five care staff, three registered nurses, one kitchen staff, two domestic/laundry staff and five patients' representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- six patient care records
- staff training records for 2016/2017
- accident and incident records
- audits in relation to care records and falls
- records relating to adult safeguarding
- one staff recruitment and selection record
- complaints received since the previous care inspection
- records pertaining to NMC and NISCC registration checks
- minutes of staff', patients' and relatives' meetings held since the previous care inspection
- annual quality report
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- the system for managing urgent communications, safety alerts and notices.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 24 January 2017

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

4.2 Review of requirements and recommendations from the last care inspection dated 24 January 2017

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 15 (2) (a) **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: Where a patient had a wound, there was evidence of regular wound assessments and review of the care plan regarding the progress of the wound. A review of the patient care records evidenced that the dressing had been changed according to the care plan. Wound care records were supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines.	
Requirement 2 **Ref:** Regulation 13 (1)(a) **Stated:** First time	The registered persons must ensure that the settings of pressure relieving mattresses are monitored and recorded, to ensure their effective use.	**Partially Met**
	Action taken as confirmed during the inspection: Although there was a system in place to monitor and record the settings of pressure mattress settings, in one unit, this had not been completed from 15 May to the day of the inspection. This requirement was not met and has been stated for the second time.	

Requirement 3 **Ref:** Regulation 14 (2) (c) **Stated:** First time	The registered person must ensure that any chemicals used within the home are labelled correctly and stored securely in accordance with COSHH regulations. **Action taken as confirmed during the inspection**: All cleaning chemicals were observed to be stored securely. The registered manager and a review of records confirmed that all domestic staff had received COSHH training following the last inspection.	**Met**
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 22.4 **Stated:** Second time	The registered persons should ensure that the falls risk assessment is reviewed in response to patients' falls. **Action taken as confirmed during the inspection**: A review of the accident and incident records confirmed that the falls risk assessments and care plans were generally completed following each incident.	**Met**
Recommendation 2 **Ref**: Standard 4 **Stated:** Second time	The registered persons should ensure that care plans are developed in response to acute infections. **Action taken as confirmed during the inspection**: Where patients were prescribed antibiotic medication, there was evidence that a care plan had been developed; this was reviewed when the treatment was completed.	**Met**

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 15 May 2017 evidenced that the planned staffing levels were generally adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels and observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. Although a number of staff commented in relation to the staffing levels, all staff spoken with stated that the patients' needs were always met. 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.

The registered manager explained there were currently one registered nurse and four care staff vacancies. These vacancies were being filled by agency staff or permanent staff working additional hours. Some care staff had been recruited and were going through the appropriate checks before starting in post.

In 2016, RQIA validated that Apex Housing Association had recruitment processes in place which were in line with legislative requirements; the required information was held in the home in the form of a recruitment matrix. The review of the recruitment matrix identified that it captured most of the information required in Schedule 2 of the Nursing Home Regulations (Northern Ireland) 2005. However, when one application form was reviewed, it was evident that there had been gaps in employment and there was no evidence that these had been explored; this information was not identified on the recruitment matrix. Information regarding the candidates' reasons for leaving their current /most recent post was also not consistently recorded; this information should be sought for all positions where candidates have worked with children or vulnerable adults. Following the inspection the registered manager confirmed to RQIA by email on 23 May 2017 that this information had been explored as part of the candidate's interview process. RQIA was satisfied that the recruitment processes were robust.

Discussion with staff evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Agency staff also received a three day induction to the home. Staff consulted with confirmed that there were systems in place to monitor their performance and to ensure that they were supported and guided in their practice; this included supervisions, annual appraisals; and competency and capability assessments.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records 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 prevention and protection from harm. Overall compliance with training was monitored by senior management within the organisation and by the registered manager. The registered manager retained a copy of agency staff' profiles, which evidenced that they also had received the required training.

Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Observation of the delivery of care evidenced that training had been embedded into practice.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC).

Staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. There had been no safeguarding incidents reported from the last care inspection. Discussion with the registered manager confirmed that they were knowledgeable regarding the regional safeguarding protocols and the home's policies and procedures. Arrangements were in place to embed the new regional operational safeguarding policy and procedure into practice. The registered manager had been identified as the safeguarding champion for the home and this was displayed on the noticeboards on both floors of the home.

Review of patient care records evidenced that a range of validated risk assessments were generally completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. As discussed in section 4.2, a review of the accident and incident records confirmed that the falls risk assessments and care plans were generally completed following each incident. Refer to section 4.5 for further detail.

Where bedrails were assessed as being unsafe to use, less restrictive measures were put in place.

A review of the home's environment was undertaken and included observations of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout.

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

Areas for improvement

No new areas for improvement were identified during this inspection; however, consideration must be given to one requirement that has been stated for the second time, in relation to monitoring the settings of pressure relieving mattresses, to ensure their effective use.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

The home used an electronic system for assessing, planning and evaluating patients' care needs. Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

As discussed in section 4.2, there was evidence that wound care was well managed. Other areas of good practice were also identified within the care records. For example, where patients were prescribed antibiotic medication for acute infections, care plans had been developed and were reviewed when the treatment was completed. Patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans. There was a system in place to monitor patients' weights and discussion with the kitchen staff confirmed that they were aware of the patients who required high/low calorific diets. Patients who had diabetes, had care plans in place which included signs of low and high blood sugars; monitoring of the patients' blood sugars was also undertaken in line with the care plan.

A review of supplementary 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 that the registered nurses had oversight of the patients' bowel records and a review of the daily progress notes evidenced timely action taken in response to any concerns.

However, areas for improvement were identified in relation to other aspects of patient care. For example, where a recommendation had been made by the dietician, there was a lack of evidence within the care record that this had been followed up with the general practitioner in a timely manner. When this was brought to the attention of the registered nurse on the day of the inspection, this matter was followed up immediately. This was discussed with the registered manager; a recommendation has been made in this regard.

Although there was evidence within the patient care records, that falls risk assessments and care plans were generally completed following each incident, the review of the records did not evidence that the patient's next of kin or care management had been consistently informed of all incidents. This was discussed with the registered manager; a recommendation has been made in this regard.

Whilst there was evidence that patients' who had urinary catheters in place had care plans developed to direct staff of the management of their care, the review of the care records did not evidence when the catheter bags had been changed. All staff consulted with confirmed that the catheter bags were routinely changed when the patients were showered; however the review of the patient records did not evidence this. The registered manager explained that the electronic system did not allow this to be recorded on the 'touch' system, which care staff used to record care intervention; and agreed to follow this up with the IT support team. A recommendation has been made in this regard.

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

All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Consultation with staff evidenced that nursing and care staff attended a handover meeting at the beginning of each shift; and that this provided the necessary information regarding any changes in patients' condition.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained. Staff stated that there was effective teamwork; and if they had any concerns, they could raise these with their line manager and/or the registered manager.

Patients' and relatives' meetings were also held on a regular basis. Minutes were available. All patients and representatives spoken with expressed their confidence in raising concerns with the home's staff/management. Patients and representatives were aware of who the registered manager was.

Areas for improvement

Areas for improvement were identified in relation to timely follow up on recommendations made by dieticians; timely communication of patient falls with the relevant bodies/persons; and the urinary catheter care records.

Number of requirements	0	Number of recommendations	3

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients consulted with stated that they were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

There was evidence of a variety of activities in the home and discussion with patients confirmed that they were given a choice with regards to what they wanted to participate in. Various photographs were displayed around the home of patients' participation in recent activities. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

We observed the lunch time meal being served in two dining rooms. The atmosphere in the dining room was quiet and tranquil and the staff, particularly on the first floor were observed to be happy as they prepared the dining room for lunch. The staff were observed singing to and with the patients and the patients really enjoyed this. This evidenced that staff viewed the mealtime experience as a positive opportunity to engage with patients.

Patients were encouraged to eat their food and assistance was provided to patients in a discreet manner. Tables were set in advance of the patients taking their seats; and specialist cups and plate guards were available to help patients who were able to maintain some level of independence as they ate their meal. The menus were displayed and were correct on the day of the inspection. The lunch served in both units appeared very appetising and patients spoken with stated that it was always very nice.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. For example, a resident survey had been undertaken in October 2016, which evidenced that the patients were mostly satisfied with the care and services provided. The registered manager explained that the outcomes of the satisfaction survey had been discussed at a relatives' meeting and that suggestions for improvements were also taken from that forum.

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 included praise for the 'fantastic care' given.

The care plans detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for patients, as appropriate. 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. At the time of the inspection no one was receiving end of life care.

During the inspection, we met with six patients, five care staff, three registered nurses, one kitchen staff, two domestic/laundry staff and five patients' representatives. Some comments received are detailed below:

Staff

"The care is of a very good standard".
"We all work together for the patients' overall wellbeing".
"There is a high standard of care with good continuity and patient/relative involvement".
""I have no problems".
"Communication is good and the nurses are very knowledgeable".
"I can't fault the care here; everyone is good at their jobs".

Two staff members commented in relation to the staffing levels. Given that discussion with patients evidenced that there were no concerns regarding staffing levels; and observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty, these comments were relayed to the registered manager to address.

Patients

"It is very good".
"You couldn't get better".
"All is ok".
"I am very happy; maybe even too happy here".
"They are dead on here".
"I am happy with the care".

Patients' representatives

"'I have no problems, the very best".
"I am very pleased with everything".
"We find it very good, very cosy indeed".
"It is very good, no complaints whatsoever".

One relative consulted with expressed dissatisfaction in relation to the hospitality of staff; explaining that they felt the staff did not check on their relative, whilst they were visiting. They also expressed concerns that visitors did not always sign-in to the visitors' book and that this caused them concern. This comment was relayed to the registered manager to address.

We also issued ten questionnaires to staff and relatives respectively; and eight questionnaires were issued to patients. No patients' questionnaires were returned. Six staff and four relatives had returned their questionnaires, within the timeframe for inclusion in this report. Comments and outcomes were as follows:

Relatives: respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. Written comments included, 'I'd love them to have more time to interact with my relative' and 'the staff are very good at listening and understanding and acting'.

Staff: respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. Written comments included, three written comments received related to the lack of a handover at the start of their shifts. Following the inspection, this was relayed to the registered manager, who confirmed that the handover report had been discussed at a recent staff meeting and that no concerns had been raised with them, in this regard. Assurances were provided that the effectiveness of the handover report would be monitored on an ongoing basis.

Any comments from patient representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

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

There was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. Patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

It was evident that action had been taken to improve the effectiveness of the care; most of the requirements and recommendations made at the previous care inspection had been met. Discussions with staff confirmed that there were good working relationships and that they were confident that the registered manger was responsive to any suggestions or concerns raised. Comments included that the registered manager 'answered on everything' and was 'very inclusive'.

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. All those consulted 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.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents. Good practice was identified in relation to the care record audits, where there was evidence of follow up action taken, when shortfalls had been identified.

However, areas for improvement were identified in relation to the falls audits. For example, the electronic system in use in the home produced a report which included all the information pertinent to falls management. In discussion with the registered manager and staff, there was little evidence that the results of the falls audit had been analysed or that appropriate actions had been taken to address any identified patterns or trends. Furthermore, whilst there was evidence that falls' risk assessments and care plans had been developed in response to patients' falls; we would have expected the falls audit to have identified that care management

and patients' representatives had not been consistently informed of all falls. Refer to section 4.4 for further detail. Advice was given to the registered manager in relation to the purpose of the falls audit; 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. Advice was given in relation to how the registered manager could be more proactive in checking the various websites for relevant alerts and notices. However, the system in place to manage Chief Nursing Officer (CNO) alerts regarding staff that had sanctions imposed on their employment by professional bodies, was not sufficiently robust. This was discussed with the registered manager. A recommendation has been made in this regard.

Discussion with the registered manager and review of records evidenced that monthly quality monitoring visits were completed in accordance in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. An action plan was generated to address any areas for improvement.

Areas for improvement

Areas for improvement were identified in relation to the falls audit; and the management of Chief Nursing Officer (CNO) alerts regarding staff who have sanctions imposed on their employment by professional bodies

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 Ann Bannister, 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 13 (1)(a) **Stated:** Second time **To be completed by:** Immediate from the day of the inspection.	The registered persons must ensure that the settings of pressure relieving mattresses are monitored and recorded, to ensure their effective use. **Ref: Section 4.2** **Response by registered provider detailing the actions taken:** The settings of pressure relieving matresses are monitered and recorded every night
Recommendations	
Recommendation 1 **Ref**: Standard 21 **Stated:** First time **To be completed by:** 19 July 2017	The registered persons should ensure that recommendations made by dieticians are followed up in a timely manner. **Ref: Section 4.4** **Response by registered provider detailing the actions taken:** The nurse on duty will follow up with the residents GP any recommendations made by dieticians after 72 hours if a perscription has not been received.
Recommendation 2 **Ref**: Standard 22 **Stated:** First time **To be completed by:** Immediate from the day of the inspection.	The registered persons should ensure that accident and incident reports are reviewed on a regular basis, to ensure that the sections relating to communication with care management and the patients' next of kin, is consistently recorded. **Ref: Section 4.4** **Response by registered provider detailing the actions taken:** Following an accident or incident in the home the nurse completing the report must document name of care manager and relative informed and date and time informed. If it is during the night or at the weekend / holiday a message should be diaried to complete this task at the first opportunity.This information should then be recorded on the accident form
Recommendation 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 19 July 2017	The registered persons should ensure that records are maintained in relation to the changing of urinary catheter bags, in line with best practice. **Ref: Section 4.4** **Response by registered provider detailing the actions taken:** It is policy within the home to change catheter bags weekly following shower / bath. The day that the catheter bag change is due is now recorded in each residents care plan. An addition has been made to Epicare to facilitate recording of the catheter bag change there also.

Recommendation 4 **Ref**: Standard 22.10 **Stated:** First time **To be completed by:** 19 July 2017	The registered persons should ensure that falls in the home are reviewed and analysed on a monthly basis to identify any patterns or trends and appropriate action is taken. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: A falls audit is completed monthly in order to identify any trends or patterns and is actioned appropriately
Recommendation 5 **Ref**: Standard 35.18 **Stated:** First time **To be completed by:** 19 July 2017	The registered persons shall implement a robust system to manage Chief Nursing Officer (CNO) alerts regarding staff who have sanctions imposed on their employment by professional bodies **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: All CNO alerts are filed in the home and are now being sent to the Personnell Department also

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

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk

@RQIANews

Assurance, Challenge and Improvement in Health and Social Care