Unannounced Care Inspection Report
11 May 2017

Templemoyle

Type of service: Nursing Home
Address: 41a Whitehill Road, Eglinton, BT47 3JT
Tel no: 028 7181 1461
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Templemoyle took place on 11 May 2017 from 09.45 to 16.45 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; management of adult safeguarding incidents; infection prevention and control arrangements; and risk management.

Areas for improvement were identified in relation to the arrangements for embedding the new regional operational safeguarding policy and procedure; and the management of malodours in one identified patient's bedroom.

Is care effective?

There were examples of good practice found throughout the inspection in relation to: wound care management; the prevention of pressure sores; the monitoring of patient's food and fluid intakes; and effective communication systems.

Areas for improvement were identified in relation to the review of risk assessments and care plans; and in relation to the accurate recording of bowel records.

Is care compassionate?

There were areas of good practice found throughout the inspection in relation to the culture of the home, treating patients with dignity and respect.

Areas for improvement were identified in relation to the storage of personal care records; and the comprehensiveness of the annual quality audit.

Is the service well led?

There were areas of good practice identified in relation to good working relations which were evident within the home, the home was operating within the categories of care for which the home was registered; and there was evidence that action had been taken to improve the effectiveness of the care following the last care inspection.

Areas for improvement were identified in relation to the management of complaints; the development of the falls audit; and the systems in place for maintaining and checking Chief Nursing Officer (CNO) alerts.

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	3	8

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

Details of the Quality Improvement Plan (QIP) within this report were discussed with Jeya Pratheeksha, 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 31 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: Templemoyle Mrs Elizabeth Kathleen Mary Lisk	**Registered manager:** Mrs Jeya Pratheeksha
Person in charge of the home at the time of inspection: Mrs Jeya Pratheeksha	**Date manager registered:** 9 January 2015
Categories of care: NH-I, NH-PH	**Number of registered places:** 30

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 four patients, four care staff, two registered nurses, two patients' representatives and one visiting professional.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- seven 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
- staff induction, supervision and appraisal records
- records pertaining to NMC and NISCC registration checks
- minutes of staff, patients' and relatives' meetings held since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a selection of policies and procedures.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 31 January 2017

The most recent inspection of the home was an unannounced medicines management 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 providers, 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 16 January 2017

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **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.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of records confirmed that a robust system was in place, to monitor and record the pressure mattress settings.	
Requirement 2 **Ref:** Regulation 12 (a) and (b) **Stated:** First time	The registered persons must ensure that the on-going management of the urinary catheter care is reviewed and monitored, to ensure that patients are not exposed to risks associated with infection or blockage, due to lack of hygiene and routine bag changes.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered nurse confirmed that a system had been put in place to record when catheter bags had been changed.	
Requirement 3 **Ref:** Regulation 13 (1) (a) and (b) **Stated:** First time	The registered persons must ensure that wound care management is reviewed to ensure that care plans are developed to direct staff on the prescribed wound dressing regime; risk assessments are reviewed in response to changes in the patients' skin integrity; and repositioning records are maintained in respect of patients who are deemed at risk of developing skin damage. The care record must also accurately reflect any referrals made to tissue viability nurse specialists (TVN).	**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 daily progress notes, 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 4 **Ref:** Regulation 15 (2) (a) (b) **Stated:** First time	The registered persons must ensure that pain assessments are completed (if applicable) for all patients requiring regular or occasional analgesia. This assessment should review the effectiveness of the analgesia and the outcome should be reflected in the patients' care plans. The pain assessment tool to be used must be commensurate with the patient's ability to communicate.	**Met**
	Action taken as confirmed during the inspection: Patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.	
Requirement 5 **Ref:** Regulation 14 (5) **Stated:** First time	The registered persons must ensure that no patient is subject to restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other patient and there are exceptional circumstances in keeping with best practice. This refers particularly to the completion of risk assessments and care plans for patients who require the use of bedrails.	**Met**
	Action taken as confirmed during the inspection: Where bedrails were required there was evidence that risk assessments had been undertaken for their safe use and this information was included in the care plan.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 12 **Stated:** Second time	The registered persons should review the mealtime experience to ensure that is respectful and the environment is conducive to eating.	**Met**
	Action taken as confirmed during the inspection: Observation of the lunch time meal in two dining rooms confirmed that this recommendation had been met.	

Recommendation 2 **Ref**: Standard 12.1 **Stated:** First time	The registered persons should ensure that the provision of refreshments and snacks throughout the day is reviewed, to ensure that the patients' individual needs and preferences are met. Patients requiring a modified diet should also be offered suitable snacks throughout the day.	**Met**
	Action taken as confirmed during the inspection: Discussion with patients and observation of the refreshment trolley evidenced that this recommendation had been met.	
Recommendation 3 **Ref**: Standard 4.9 **Stated:** First time	The registered persons should ensure that accurate records are maintained in respect of the level of care provided and/or refused by patients. This refers particularly to the provision of nail care and showers. Strategies to assist in compliance should be included in the patient care plan.	**Met**
	Action taken as confirmed during the inspection: A review of the personal hygiene records confirmed that records were accurately maintained; any incidence of patients refusing care was recorded. Care plans were also in place, to reflect this.	
Recommendation 4 **Ref**: Standard 35.4 **Stated:** First time	The registered persons should ensure that the system for auditing care records is further developed to address the deficits identified during this inspection. This refers particularly to the management of wound care and urinary catheter care; the use of bedrails and recording of pressure relieving mattress settings; the completion of pain assessments and personal hygiene records.	**Not Met**
	Action taken as confirmed during the inspection: Although there was evidence of regular audits being undertaken, the audits were not effective as there was a lack of follow up action taken to ensure that identified shortfalls had been addressed. This recommendation was not met and has been stated for the second time.	

Recommendation 5 **Ref**: Standard 35.7 **Stated:** First time	The registered persons should ensure that the regulation 29 monthly quality monitoring report should be further developed to ensure that there is traceability in regards to the specific records that were examined; and continue to monitor requirements and recommendations stated during this and future inspections.	**Met**
	Action taken as confirmed during the inspection: A review of the monthly quality monitoring reports confirmed that this recommendation had been met. Refer to section 4.6 for further detail.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for week commencing 1 May 2017 evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives and staff evidenced that the staffing levels met the assessed needs of the patients.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks and references were sought, received and reviewed prior to staff commencing work and records were maintained. Areas for improvement were identified in relation to the checking of Chief Nursing Officer (CNO) alerts. Refer to section 4.6 for further detail.

There was evidence that new staff completed an induction programme to ensure they developed their required knowledge to meet the patients' needs. Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, undertook competency and capability assessments and completed annual appraisals.

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 the registered manager.

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).

A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately. Where any shortcomings were identified safeguards were put in place.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Although the registered manager confirmed that they were the adult safeguarding champion, they had not yet attended training in this regard; and the arrangements in place to embed the new regional operational safeguarding policy and procedure were not clear. A recommendation has been made in this regard.

Review of patient care records evidenced that a range of validated risk assessments were generally completed as part of the admission process. Risk assessments were not consistently used to inform the care planning process, although shortfalls were identified during this inspection. Refer to section 4.4 for further detail.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were generally completed following each incident, care management and patients' representatives were notified appropriately. An audit of falls was undertaken on a monthly basis; however improvements were required to ensure better analysis of the information recorded. Refer to section 4.6 for further detail.

A general inspection of the home was undertaken which included a random sample of bedrooms and bathrooms. Although the majority of areas within the home were found to be warm and clean; one identified patient's bedroom was found to be malodourous. Although RQIA acknowledges that there was specific challenges in relation to managing this, there was no evidence that this was being proactively managed; or that care management had been informed in relation to this. A requirement has been made in this regard.

The registered manager advised of a number of environmental improvements and refurbishments completed since the last care inspection and a programme which is ongoing. Some areas of the home were evidently in need of redecoration. These matters were discussed with the registered manager who advised that these areas were included in the refurbishment plan. This will be monitored at future inspection.

Areas for improvement

Areas for improvement were identified in relation to the arrangements for embedding the new regional operational safeguarding policy and procedure; and the management of malodours in one identified patient's bedroom.

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

4.4 Is care effective?

Review of seven patient care records evidenced that a range of validated risk assessments were completed as part of the admission process; however the risk assessments were not reviewed on a regular basis. The regular review of patients' needs or changing needs is complicit to the safe and effective delivery of care. The deficits in the care records had been identified in the care record audits undertaken by the registered manager; and in the monthly quality monitoring reports; however there was no evidence of follow up action taken to ensure that the identified shortfalls had been addressed. A requirement has been made in this regard.

The review of care records, including risk assessments and care plans identified, as previously stated, that they were not maintained and regularly reviewed in response to the changing needs of the patient. The plan of care of one patient did not reflect the assessed needs of the patient despite the need being clearly identified in the relevant risk assessments. For example, the care plan on nutritional needs had not been updated to include weight loss or the specific consistency of pureed diet; the care plan for the patient acquiring chest infections had not been updated when the patient was prescribed antibiotic treatment for an infection; and the patient's bowel assessment was not reflected in the care plan for incontinence. The care plans in place for patients must evidence that they accurately reflect the current and/or changing needs of the patient through review. A requirement has been made in this regard.

A review of bowel records evidenced that staff recorded when the patients' bowels moved and this was recorded in keeping with the Bristol Stool chart. However, given that the staff only recorded in the absence of a bowel movement; we were not assured of the accuracy of the records. This was discussed with the registered manager. A recommendation has been made in this regard.

Despite the shortfalls discussed above, there were some areas of good practice identified. As discussed in section 4.2, 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 daily progress notes, evidenced care delivery in keeping with 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. Patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans; and care plans were in place to help staff communicate effectively with patients, where there were difficulties in understanding their needs.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Discussion with staff evidenced that nursing and care staff, were required to attend a handover meeting at the beginning of each shift. Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained.

Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Discussion with the registered manager and review of records evidenced that patient and/or relatives meetings were held on a regular basis. Minutes were available. All those consulted with expressed their confidence in raising concerns with the home's staff/ management.

Areas for improvement

Areas for improvement were identified in relation to the review of risk assessments and care plans; and in relation to the accurate recording in the bowel records.

Number of requirements	2	Number of recommendations	1

4.5 Is care compassionate?

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff interactions with patients were observed to be compassionate, caring and timely. Patients spoke with stated that were afforded choice, privacy, dignity and respect. 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.

A dedicated staff member was employed to provide activities in the home. Patients consulted with stated that there were always different activities they could participate in. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

As discussed in section 4.2, improvements had been made to the dining experience. We observed the lunch time meal being served in two dining rooms. The atmosphere was quiet and tranquil and patients were encouraged to eat their food. A white board was observed on the wall which listed any specialist diets the patients may require. This was discussed with the registered manager who agreed to have this removed in the interests of patients' privacy.

Although the staff spoken with stated that they were aware of the requirements regarding patient information and confidentiality, they did not recognise that leaving personal care records in the dining room was potentially breaching patients' privacy. This was discussed with the registered manager. A recommendation has been made in this regard.

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. However, the review of the annual quality report identified that it was not very comprehensive. For example, the respondents' satisfaction level was presented in relation to the following areas: catering and food; personal care and support; daily living; premises; and management. We were unable to determine whether suggestions for improvement had been sought as no comments were included. It was also unclear as to whether the findings in the report reflected the opinions of the patients living in the home, or if they were those of their representatives. This was discussed with the registered manager. A recommendation has been made in this regard.

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 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 'wonderful care, compassionate and professional way in which all the staff attended to (the patient's) medical and personal needs'.

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

Patients' representatives

"'Everything is ok".

Patients

"It is good here, I have no complaints".
"They are very good alright".
"All is good".

Staff

"It is alright here".
"It is a great wee home, I love interacting with the patients".
"The home might be old but the care is very good".
"Good care and everyone works as a team".
"I love the patients here, very much".
"I am happy enough".

Visiting Professionals

"I have no concerns here".

We also issued ten questionnaires to staff and relatives respectively; and eight questionnaires were issued to patients. Three staff, three patients and three relatives had returned their questionnaires, within the timeframe for inclusion in this report. Some comments received are detailed below:

Patients: respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in provided was safe, effective and compassionate; and that the home was well-led. No written comments were received.

Relatives: respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in provided was safe, effective and compassionate; and that the home was well-led. No written comments were received.

Staff: respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in provided was safe, effective and compassionate; and that the home was well-led. No written comments were received.

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

Areas for improvement were identified in relation to the storage of personal care records; and the comprehensiveness of the annual quality audit.

Number of requirements	0	Number of recommendations	2

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. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern. Staff were able to identify the person in charge of the home and all staff consulted with confirmed that there were good working relationships within the home.

It was evident that action had been taken to improve the effectiveness of the care, since the last care inspection; with the exception of one recommendation, all other requirements and recommendations had been met. All staff consulted with described the registered manager in positive terms, stating that they were 'very approachable' and 'listens and takes things seriously'.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were logged appropriately; however, there was no evidence that one complainant had been responded to within the recommended 28 days in keeping with the DHSSPS Care Standards for Nursing Homes 2015. There was also no evidence that the patient's care manager had been informed that a complaint had been received. This was discussed with the registered manager. A recommendation has been made in this regard.

A review of notifications of incidents to RQIA during the previous inspection year/or since the last care inspection confirmed that these were managed appropriately.

As discussed in section 4.2 and 4.4, there were systems were in place to monitor and report on the quality of nursing and other services provided. However, we were not assured of the effectiveness of the audits, given that identified shortfalls had not been followed up. For example, the care record audits for two patients identified that assessments and care plans required updating; these had not been completed one week later.

Many of the audits undertaken were incorporated into a wider home management audit tool. Advice was given in relation to this. For example, the audits of accidents and incidents were included in the home management audit tool; however there was a lack of analysis in terms of the patients involved, the timing of incidents; and there was no evidence that any patterns or trends had been identified. This was discussed with the registered manager. A recommendation has been made in this regard.

Similarly, whilst there was evidence that the registered manager had oversight of the patients' weights and that that patients had been referred appropriately to the dietician, there was no formal auditing process in place to ensure that any weight loss was being identified in a timely manner. This was discussed with the registered manager who agreed to develop a proforma for future audits.

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. However, improvements were required in relation to the management of Chief Nursing Officer (CNO) staff alerts relating to staff who had sanctions imposed upon their employment by their professional bodies. 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 with the regulations and/or care standards. Although an action plan was generated to address any areas for improvement, the review of the care records, as stated in section 4.4, evidenced that follow up action had not been taken in a timely manner. This was discussed with the registered manager who agreed to address the matter with staff. Two requirements have been made in the domain of effective care in relation to this.

Areas for improvement

Areas for improvement were identified in relation to the management of complaints; the development of the falls audit; and the systems in place for maintaining and checking Chief Nursing Officer (CNO) alerts.

Consideration should also be given to the number of requirements and recommendations made in the delivery of safe, effective and compassionate care.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Jeya Pratheeksha, 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 18 (2) (j) **Stated:** First time **To be completed by:** immediate from the day of inspection	The registered persons must ensure that the malodours in the identified patient's bedroom are eliminated. Any difficulties in obtaining consent in relation to this must be evidentially communicated to care management. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: A new audit has been put in place to ensure that commode is removed from room each morning. Met with resident and imformed of the need for this action. Also met with social worker and next of kin to discuss issues raised. Night staff have been removing commode each morning. Resident had be reluctant to let domestic staff clean her room, but i have stressed the importance of this both to resident and domestic staff. Malodours are not present in room now.
Requirement 2 **Ref:** Regulation 15 (2) (a) and (b) **Stated:** First time **To be completed by:** 8 July 2017	The registered persons must ensure that the assessment of patient need is kept under review and revised to reflect patients' changing needs. **Ref: section 4.4**
	Response by registered provider detailing the actions taken: Met with staff to discuss the issues raised with regard to the assessment of patient need is kept under review. This has been fully addressed through a new monthly audit system, that will insure that all reviews are up to date and reflect the resdients changing needs.
Requirement 3 **Ref:** Regulation 16 (1) and (2) **Stated:** First time **To be completed by:** 8 July 2017	The registered persons must ensure that patients' care plans accurately reflect the current and/or changing needs of the patient and evidence is present of regular evaluation of care. **Ref: section 4.4**
	Response by registered provider detailing the actions taken: Met with staff to discuss the issues raised with regard to the assessment of patient need is kept under review. This has been fully addressed through a new monthly audit system, that will insure that all reviews are up to date and reflect the resdients changing needs. The residents file has been rewritten to reflect current and changing needs.

Recommendations	
Recommendation 1 **Ref**: Standard 35.4 **Stated:** Second time **To be completed by:** immediate from the day of inspection	The registered persons should ensure that the system for auditing care records is further developed to address the deficits identified during this inspection. This refers particularly to the management of wound care and urinary catheter care; the use of bedrails and recording of pressure relieving mattress settings; the completion of pain assessments and personal hygiene records. **Ref Section 4.2 and 4.6**
	Response by registered provider detailing the actions taken: Met with staff to discuss the issues raised with regard to the assessment of patient need is kept under review. This has been fully addressed through a new monthly audit system, that will ensure that all reviews are up to date and reflect the resdients changing needs
Recommendation 2 **Ref**: Standard 13 **Stated:** First time **To be completed by:** 8 July 2017	The registered persons should ensure that arrangements are put in place to embed the new regional operational safeguarding policy and procedures. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Met with staff to discuss the new regional operational safeguarding policy. Staff are now aware of this policy and is available for them to implement.
Recommendation 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 8 July 2017	The registered persons should review the process for recording bowel motions, in the absence of bowel functioning, to ensure that bowel records are accurately maintained. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Met with staff and raised the importance of this issue. Staff have been told to record all bowel and absence of bowel fuctioning on the bristol stool chart.
Recommendation 4 **Ref**: Standard 37.1 **Stated:** First time **To be completed by:** immediate from the day of inspection	The registered persons should ensure that consideration is given to how confidential patient information is retained to support and uphold patients' rights to privacy and dignity at tall times. **Ref: Section 4.5**
	Response by registered provider detailing the actions taken: The information that was on the notice board was removed. Staff have been told not to record this type of information on notice boards for public to see.

Recommendation 5 **Ref**: Standard 35.16 **Stated:** First time **To be completed by:** 8 July 2017	The registered persons should further develop the system in place for monitoring, auditing and reviewing the quality of nursing care, to ensure that the annual quality report provides an accurate reflection of the standard of care and services provided; and the opinions of key stakeholders. **Ref: Section 4.5**
	Response by registered provider detailing the actions taken: The annual report is in the process of being rewritten and all this aspects will be reflected in this report.
Recommendation 6 **Ref**: Standard 16.10 **Stated:** First time **To be completed by:** 8 July 2017	The registered persons should ensure that complaints are investigated and responded to within 28 days and when this is not possible, complainants are kept informed of any delays. Copies of such investigations and responses must be available for inspection. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: I will ensure that there is accurate recording and follow up of all compaints. Complaints will be answered within 28 days. Copies of all complaints and investigations are kept on file.
Recommendation 7 **Ref**: Standard 22.10 **Stated:** First time **To be completed by:** 8 July 2017	The registered persons should ensure that falls 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: New falls audit has been introduced this will ensure that any patterns or trends will be identified. So that correct action is taken.
Recommendation 8 **Ref**: Standard 35.18 **Stated:** First time **To be completed by:** immediate from the day of inspection	The registered persons should ensure that the system for dealing with Chief Nursing Officer (CNO) alerts is further developed and maintained, to ensure that recruitment checks are more robust. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: We have devised a new system for the recording of alerts from CNO so all information is clear on one sheet. Recruitment checklist will be implements to enusre that all relivent checks are complete.

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