Carrickfergus Manor
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Unannounced Care Inspection
of
Carrickfergus Manor

8 July 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 08 July 2015 from 10.05 to 17.45.

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, concerns and areas of improvement were identified and are required to be addressed to ensure that care in the home is safe, effective and compassionate. These areas are set out in the Quality Improvement Plan (QIP) within this report. Refer also to Section 1.2 below.

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.

For the purposes of this report, the term 'patients' will be used to described those living in Carrickfergus Manor which provides both nursing and residential care.

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 09 February 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	7	8

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: Runwood Homes Ltd Nadarajah (Logan) Logeswaran	**Registered Manager:** Joanne Neville
Person in Charge of the Home at the Time of Inspection: Catherine McCorry	**Date Manager Registered:** 17 December 2014
Categories of Care: RC-I, RC-DE, NH-I, NH-PH, NH-PH(E) 43 RC-DE on ground floor. One identified RC-I on Nursing Unit.	**Number of Registered Places:** 90
Number of Patients Accommodated on Day of Inspection: 81	**Weekly Tariff at Time of Inspection:** £495 - £727

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)

Information was received by RQIA on 06 June 2015 regarding:

- low staffing levels
- patients not being supervised whilst taking their prescribed medicines
- patients not being assisted to eat their meals.

It is not the remit of RQIA to investigate complaints made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a potential breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

4. Methods/Process

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

Prior to inspection the following records were analysed:

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

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- staff training records
- complaints records
- policies for communication and end of life care
- policies for dying and death and palliative and end of life care

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced Pharmacy inspection dated 28 May 2015. The completed QIP was returned and approved by the pharmacy inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection on 09 February 2015

Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 5.6 **Stated:** First time	The registered manager should review charts requiring staff to evidence care delivery every 30 minutes and make a decision if they are to continue to be required or revised to ensure that they are completed accurately.	**Met**
	Action taken as confirmed during the inspection: The inspectors confirmed that there were no patients who required 30 minute observations at the time of the inspection.	
Recommendation 2 **Ref**: Standard 34 **Stated:** First time	The registered manager should ensure that staff are aware of the home's policy for managing the disposal of waste product on each floor given that there was only one sluice room. Advice should be sought from infection prevention and control services if required.	**Not Examined**
	Action taken as confirmed during the inspection: Not examined. This recommendation is carried forward for inspection at a future date.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

The policies and procedure on communicating effectively and breaking bad news were not available. However, discussion with staff confirmed that they were knowledgeable regarding the skills required to communicate sensitively when breaking bad news.

A review of training records evidenced that staff had not completed training in relation to communicating effectively with patients and their families/representatives. Training in relation to the procedure for breaking bad news as relevant to staff roles and responsibilities had not been provided.

Is Care Effective? (Quality of Management)

A review of five care records reviewed did not evidence patients' individual needs and wishes regarding the end of life care and there was no evidence that the breaking of bad news was discussed with patients and/or their representatives. There was no evidence in the reviewed records, that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs. Refer to inspector comments in sections 5.3 and 5.4.

Is Care Compassionate? (Quality of Care)

Two registered nursing staff demonstrated how they were able to deliver bad news sensitively to patients. They were aware of the barriers to communication and the importance of using verbal and non-verbal communication skills.

Consultation with four patients confirmed that staff treated them with respect and dignity.

Nursing and care staff were observed responding to patients in a dignified manner. It was evident on the residential dementia suite, that staff had developed strong and supportive relationships with patients and their representatives. Staff were observed explaining, reassuring and offering assistance to patients in a calm, unhurried manner. Patients who were unable to verbalise their feelings appeared to be relaxed and comfortable in their surroundings.

There were no compliments records retained in the home.

Areas for Improvement

The policy on communicating effectively should be developed in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.*

Training should be provided to staff, relevant to their roles in communicating effectively.

Number of Requirements:	**0**	**Number of Recommendations**:	**2**

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)

There was a comprehensive manual available on support for relatives following a death. This manual reflected best practice guidance such as the GAIN Palliative Care Guidelines, November 2013; and included guidance on the management of the deceased person's belongings and personal effects; and the care of patients who have no relatives. This manual also included guidance on practical matters, how to cope following a bereavement and contained a list of local support services. This innovative practice is to be commended.

However, policies and procedures on the management of palliative and end of life care were not available in the home. A review of the policy on death and dying identified that it was in need of further development, to reflect current best practice guidance.

Training records evidenced that staff were not trained in the management of death, dying and bereavement; or palliative and end of life care. One registered nurse was not aware of the GAIN Palliative Care Guidelines and both registered nurses acknowledged that they needed to read the policies.

Discussion with two nursing staff confirmed that:

- there were arrangements in place for staff to make referrals to specialist palliative care services
- staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken

There was no protocol for timely access to any specialist equipment or drugs, however discussion with two registered nurses confirmed their knowledge of the procedure to follow.

There was no specialist equipment, in use in the home on the day of inspection. The deputy manager confirmed that training in the use of syringe drivers would be accessed through the local Healthcare Trust Nurse, if required.

There was no palliative care link nurse identified, however the deputy manager confirmed that there were plans in place to train a nurse for this role.

Is Care Effective? (Quality of Management)

A review of five care records evidenced that patients' needs for palliative and end of life care were not assessed and reviewed on an ongoing basis. Care plans also were not consistently updated. The review included the management of hydration and nutrition, pain management and symptom management. Refer to inspector comments in Section 5.4.

There was no evidence within the care records that patient's wishes and their social, cultural and religious preferences were considered. Care records did not evidence discussion between the patient, their representatives and staff in respect of death and dying arrangements.

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 visiting Palliative Care Nurse confirmed that referrals were made appropriately.

Discussion with the deputy manager and staff 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 deaths had been notified appropriately.

Is Care Compassionate? (Quality of Care)

As previously discussed, a review of the care records did not evidence that patient's wishes and their social, cultural and religious preferences were considered. However, discussion with two registered nurses confirmed that religious and cultural preferences are considered and taken into account, when delivering care. Both registered nurses consulted 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. Staff consulted stated that catering/snack arrangements would be provided for family members.

From discussion with the deputy manager and staff there was evidence that arrangements in the home were sufficient to support relatives during this time. Compliments records were not available to validate this.

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.

All 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 staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included 1:1 counselling, if required.

Information regarding support services was available and accessible for staff, patients and their relatives.

Areas for Improvement

All policies and procedures should be reviewed to ensure that they are subject to a three yearly review. The policies on palliative and end of life care should be developed in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines (2013.* The policy on death and dying should also 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.

Training should be provided to staff, relevant to their roles in death, dying and bereavement; and palliative and end of life care.

Care plans for palliative and end of life care must be completed to meet the assessed needs of the patients and must be discussed with the patients and/or their representatives.

Number of Requirements:	1	Number of Recommendations:	2

5.5 Additional Areas Examined

Care Records

A review of five care records identified that assessments and care plans were not consistently completed. One care record evidenced an assessment of need that was commenced on 05 March 2014; it was partially completed. Risk assessments, such as the falls risk assessment, Abbey pain scales, nutritional risk assessments and Braden scales were not consistently completed. One patient's falls risk assessment had not been completed in four months. One identified patient did not have any assessments or care plans completed eight days after admission. This is unacceptable. This was discussed with the deputy manager during feedback. Following the inspection, it was confirmed to RQIA that all assessments and care plans had been completed. Two requirements are made to ensure that patient assessments and care plans are completed and reviewed on an ongoing basis.

The process of auditing care records was discussed with the deputy manager. Five care file audit forms were reviewed. Where deficits were identified there was no follow up with the named nurse, to ensure that shortcomings were addressed. Previously completed audit forms were unavailable for inspection. The manager's self-audit, dated 29 June 2015, stated that all assessment tools had been re-evaluated and that all areas of plan were complete. Another audit identified that some care plan evaluations needed to be updated, however there was no traceability regarding the names of the care records that had been audited.

A requirement is made regarding the auditing of care records, to ensure regulatory and professional standards are met.

Medicines Management

Prior to the inspection information was received by RQIA regarding patients on the residential suite not being supervised whilst taking their medicines. A review of the complaints in the previous three months identified one similar complaint.

Two senior carers consulted with stated that the patients are supervised swallowing their medications. However, the medication round was observed on the residential unit and two senior carers were observed preparing medicines in the treatment room and administering the medications to individual patients. This is high risk practice that could contribute to potential medication errors. One senior carer continued with this practice, despite being advised by the inspector. This was discussed with the deputy manager during feedback, who advised that this practice has been ongoing. The deputy manager was informed that the arrangements for the administration of medicines must be reviewed, to ensure that staff, prepare medicines for administration, in the presence of the patients for whom the medicine is prescribed. A requirement is made to address this.

The medication round on the general nursing suite was not observed, however discussion with the deputy manager and two registered nurses identified that the medication round frequently took two and a half hours to complete. The staff consulted identified the number of patients and constant interruptions as contributing factors to the length of time the medication round took. Staff gave examples of having to leave the medication trolley to make and take phone calls and stated that they often had to interrupt the medication round to speak with GPs. The length of time devoted to administering medicines on the nursing suite must be reviewed and is incorporated into the above requirement.

Staffing

Prior to the inspection, information was received by RQIA regarding staffing levels. This was discussed with the deputy manager and as a consequence, staffing arrangements were reviewed during this inspection.

Dependency levels were assessed regularly using the Rhys Hearns Dependency tool. Although the total numbers of staff required to meet patient need were in place, the skill mix of registered nurses to care staff was not adequate on the nursing suite. This was discussed with the deputy manager, who acknowledged the difficulties experienced in recruiting registered nurses. The deputy manager confirmed that there was a high use of agency staff to cover 172 hours of registered nurse vacancies and that nursing agencies were not consistently able to provide a third nurse for the morning shift. Considering the concerns identified above, regarding the length of time devoted to administering medicines on the nursing suite and the deficits that were also identified in care records, a recommendation is made to ensure that staffing levels are reviewed on the nursing suite.

The provision of activities on the dementia residential suite was discussed and the deputy manager confirmed that an additional five hours of activities had been recently approved. The current activities coordinator works one hour earlier in the mornings, to assist with the serving of breakfast. It was concerning that on the day of inspection, the patients in the home did not have any formal activities. The activities coordinator was deployed to assist the hair dresser for the duration of her shift. Other care staff consulted stated that they did not have the time to carry out activities. One care assistant did not know that providing activities to patients was part of her role. Considering that there is currently 81 patients accommodated in the home, it is concerning that there is only 30 hours currently allocated for activity provision. A recommendation 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	10
Patients	2	1
Patients representatives	7	7

Some comments on the returned questionnaires were positive. However, other comments which raised concerns regarding the quality of care provided in the home are detailed below:

Patients

'Nurses are very good to you. The food is good. I would recommend it.'
'Staff are attentive.'
'The girls are good fun.'
'It's great here.'
'I like it here. The girls are lovely.'
'I would like a quicker response to the call bell.'

Patients' representatives

'My (relative) is being well cared for by staff that are professional and attentive. He always appears to be well looked after and always happy.'
'Can't find anything wrong with care. Nurses very good at helping with pain.'
'Thank God for Carrickfergus Manor and the pressure it takes off our family.'
'There is not enough staff, particularly at shift switchover and at mealtimes.'
'Unsatisfied with the quality of care due to staffing levels.'
'They are at times very slow to respond to the alarm button call. Sometimes it takes one and a half hours.'
'They leave the dinner in front of (my relative) and we come in to find it untouched and cold.'
'The food and catering is very poor. Most of the food arrives at the table cold. A dramatic improvement is required in this area.'

Prior to the inspection, information was received by RQIA regarding patients not being assisted to eat their meals. Comments made by relatives regarding the lack of supervision at mealtimes and meals not being eaten and being left to go cold were discussed with the deputy manager. Following the inspection, the regional director confirmed that a full day observational audit of the serving of meals and support of staff had been completed and had not identified any concerns. Assurances were provided that a follow up audit would be conducted, to address the concerns identified during this inspection. A requirement is made to ensure that this is addressed.

A review of the manager's self-audits confirmed that call bell response times were monitored, however, there was no traceability in the records, regarding the location that was checked or the length of time taken to respond to the call bell. There was also no evidence that response times were audited during times when patients required maximum assistance or at change of shift. A recommendation is made to address this.

Staffing

Nursing Suite

'It is common place for the drug round to take two and a half hours, with so many interruptions.'
'Staff help each other, creating team work and thus providing good care to residents.'
'We had an extra nurse in the morning, but it did not last.'
'When the diary is full, we have no time. We have one wound dressing that takes one hour to complete.'
'We only have occasional staff meetings.'
'It's not too bad here. I like it.'
'I have no concerns about patients' care.'

As previously indicated, a recommendation is made to ensure that the staffing arrangements in the nursing suite are reviewed, to ensure that the skill mix to registered nurses is adequate. The deputy manager confirmed that staff meetings were conducted every three months, however there were no minutes available after a meeting held in April 2014. A recommendation is made to address this.

Dementia Residential Suite

Two staff members commented:
'Dementia training is very informative. Each time I attend I learn something new.'
'I would place my mother here. It is hard work but that is the same everywhere.'
'No concerns. We do our best.'

Three staff members commented:
'The soup comes up and it is not blended. Neither staff or patients would eat it.'
'We are being crucified here, being so over worked.'
'If the Care Team Leader is busy with the diary, they cannot come to help with the care.'
'We don't have time to do activities with the patients. Even having time to answer the phone is hard.'
'I did not know we (the carers) had to do activities.'

The above comments were discussed with the deputy manager during feedback. As previously stated, two requirements and one recommendation are made regarding the meal time experience, medicines management and the provision of activities within the home.

Regulation 29 Monitoring visit report

The last Regulation 29 monitoring report available in the home was dated March 2015. The deputy manager was unsure if it had been completed due an infectious disease outbreak in the home. Following the inspection, the regional director confirmed that monitoring visits had been conducted and that copies were now available in the home. A requirement is made to address this.

Registration Certificate

The categories of care for which the home is registered was reviewed during the inspection. There was one patient identified who had been admitted for palliative care. Carrickfergus Manor is not currently registered to provide care for patients who are terminally ill. Following the inspection, the regional director confirmed that an application to vary the registration for one identified patient, would be submitted to RQIA.

Environment

A tour of the home found that the home was generally maintained clean, tidy and there were no malodours present. A number of issues that posed risk to infection control were identified in one identified bathroom. Signage was not laminated and there were open packs of incontinence pads in the bathroom. The toilet seat was dirty and the lid was in need of replacement. A recommendation is made to address this.

One armchair in an identified patient's bedroom room was torn and in need of replacement. Following the inspection the regional director confirmed that the identified chair would be repaired and that all other furnishings in the home were fit for purpose.

On the lower level floor, there was an activities store room and a cleaner's store that was cluttered with items stored on the floor. The deputy manager provided assurances that this matter would be addressed.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the 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.

6.1 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.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015 and the Residential Care Homes Minimum Standards, August 2011. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 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) **Stated:** First time **To be Completed by:** 05 September 2015	Patient assessments must be completed and kept under review. This refers to the completion of: • Falls risk assessments • Braden assessment tool • Nutritional risk assessments • Pain assessments
	Response by Registered Person(s) Detailing the Actions Taken: Monthly evaluations or care plans and risk avaluations are carried out by Primary Nurses. Manager completes and actions monthly audits.
Requirement 2 **Ref:** Regulation 16 **Stated:** First time **To be Completed by:** 05 September 2015	Care plans must be prepared by a registered nurse as to how a patient's needs, in respect of their health and welfare, are to be met and that the care plan must be kept under review. This refers specifically to: • Falls prevention care plans • Prevention of pressure ulcers • Eating and drinking • Managing pain
	Response by Registered Person(s) Detailing the Actions Taken: Monthly evaluations or care plans and risk avaluations are carried out by Primary Nurses. Manager completes and actions monthly audits.All assessments are monitored closely.
Requirement 3 **Ref:** Regulation 16 **Stated:** First time **To be Completed by:** 05 September 2015	Care plans for palliative and end of life care must be also be completed to meet the assessed needs of the patients and must be discussed with the patients and/or their representatives.
	Response by Registered Person(s) Detailing the Actions Taken: New palliative care and end of life policy in place End of life care plans are put in place with agreement of residents representive
Requirement 4 **Ref:** Regulation 17 (1) **Stated:** First time **To be Completed by:** 05 September 2015	A system of robust auditing must be implemented, to ensure that care records meet regulatory and professional standards. Traceability of the identified records and follow up on identified areas must be evident.
	Response by Registered Person(s) Detailing the Actions Taken: All care plan audits are in a separate file. care plan audits are carried out monthly and actioned. This is now recorded and availabe to see action taken,

Requirement 5 **Ref:** Regulation 13 (4) **Stated:** First time **To be Completed by:** 05 September 2015	The arrangements for the administration of medicines must be reviewed to ensure that: • medication is prepared in the presence of the patient for whom it is prescribed • medication is administered within the timeframe.
	Response by Registered Person(s) Detailing the Actions Taken: All staff now prepare medication in the presence of the residents subject to certain risk factors for example type of medication and route of medication. Processes have been put in place to prevent prolonged medication rounds. Staff wear tabards with do not disturb. Nurses are not interupted with phone call unless an emergency.
Requirement 6 **Ref:** Regulation 12 (4) (a) (b) **Stated:** First time **To be Completed by:** 05 September 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. **An audit of the mealtime experience must be submitted to RQIA with the returned QIP.**
	Response by Registered Person(s) Detailing the Actions Taken: Meal time audits has been completed. Audits are the main focus for the new Dementia Service Manager. The Dementia Service Manager is reviewing all the meal time experiences throughout the group. All staff are made available to assist at meal times. Meals come up to units in the Bain Maries at the regulated temperature. Staff serve meals to residents who require assistance straight from the Bain Marie so that meals are not left to go cold. Staff are available in the dining rooms during meal times and observe residnets who are eating in their rooms. All staff ensure respect and dignity is maintained when assisting residnets at meal times.
Requirement 7 **Ref:** Regulation 29 (5) (a) **Stated:** First time **To be Completed by:** 05 September 2015	A copy of the regulation 29 monitoring reports must be retained in the home and available for inspection.
	Response by Registered Person(s) Detailing the Actions Taken: All regulation 29 monitoring reports are retained in the home.

Recommendations	
Recommendation 1 **Ref:** Standard 34 **Stated:** First time **To be Completed by:** 05 September 2015	The registered manager should ensure that staff are aware of the home's policy for managing the disposal of waste product on each floor given that there was only one sluice room. Advice should be sought from infection prevention and control services if required. **Carried forward from previous inspection.**
	Response by Registered Person(s) Detailing the Actions Taken: Public health had been contacted following last inspection. Memo has been sent out to staff reminding them of infevtion control and remov al of yellow and laundry bags from the units.
Recommendation 2 **Ref:** Standard 36.2 & 36.4 **Stated:** First time **To be Completed by:** 05 September 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 the out of hours procedure 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* and should include the procedure for dealing with patients' belongings after a death. The policies and guidance documents listed above, should be made readily available to staff.
	Response by Registered Person(s) Detailing the Actions Taken: Policies were in place pre inspection. On the day of inspection the person in charge did not supply relevant policies. All policies are in place. All new polices will be made available on e-learning (BookShelf) in the future. Staff will have access at all times.
Recommendation 3 **Ref:** Standard 39.4 **Stated:** First time **To be Completed by:** 05 September 2015	Training should be provided to staff, relevant to their roles in: • communicating effectively • death, dying and bereavement • palliative and end of life care
	Response by Registered Person(s) Detailing the Actions Taken: As part of the new strategy, training is being sourced and organised for all Runwood Homes in N Ireland. There will also be new training made available to all levels of staff on e-learning.

Recommendation 4 **Ref:** Standard 41.4 **Stated:** First time **To be Completed by:** 05 September 2015	The staffing levels on the nursing unit should be reviewed to ensure that at all times there are sufficient numbers of staff and skill mix deployed to meet the needs of the patients in the home.
	Response by Registered Person(s) Detailing the Actions Taken: Staffing levels are continously monitored as well as staff practice to meet the needs of the residents.
Recommendation 5 **Ref:** Standard 11 **Stated:** First time **To be Completed by:** 05 September 2015	The arrangements for the provision of activities in the residential unit should be reviewed, in line with increasing occupancy and the dependency levels of the patients, to ensure patients' individual needs are fully met and their quality of life in the home enhanced
	Response by Registered Person(s) Detailing the Actions Taken: Activites are being reviewed by the dementia service Manager. There is regional training for all activity leads. Special focus on need of our residents with dementia. The activity therapist from now on will be focusing on activies only.
Recommendation 6 **Ref:** Standard 35.16 **Stated:** First time **To be Completed by:** 05 September 2015	The registered manager should audit the call bell response times on a regular basis. This audit should include response times at or nearing change of shifts.
	Response by Registered Person(s) Detailing the Actions Taken: Nurse call audit now in place and carried out on a regular basis.
Recommendation 7 **Ref:** Standard 41.8 **Stated:** First time **To be Completed by:** 05 September 2015	Staff meetings should take place on a regular basis and records kept of the minutes of discussions and any actions agreed.
	Response by Registered Person(s) Detailing the Actions Taken: Staff meeting occur every 3 months. These are planned out at the start of the year for the entire year. Displayed for staffs attention in the staff room. Minutes and actions planned are documented. Regular meetings with heads of departments are carried out.

Recommendation 8 **Ref:** Standard 46.2 **Stated:** First time **To be Completed by:** 05 September 2015	There should be an identified nurse with day-to-day responsibility for monitoring compliance with infection prevention and control procedures, to address the issues identified. This refers to: • unlaminated signage in bathroom areas • communal use of incontinence pads • toilet seat lid that was broken
	Response by Registered Person(s) Detailing the Actions Taken: All staff have the responibility for monitoring infection control and reporting any faults. A new nurse has been identified to undertake the role of infection control nurse. Local trust has been contacted re infection control link nurse. This will give support, training and reseach for our staff.

Registered Manager Completing QIP	J Neville	**Date Completed**	24/08/15
Registered Person Approving QIP	Logan N Logeswaran	**Date Approved**	25/08/15
RQIA Inspector Assessing Response	Dermot Walsh	**Date Approved**	29/9/15

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