Unannounced Care Inspection Report
8 April 2019

The Graan Abbey

Type of Service: Nursing Home
Address: Derrygonnelly Road, Enniskillen BT74 5PB
Tel No: 02866327000
Inspector: Michael Lavelle

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 61 patients.

3.0 Service details

Organisation/Registered Provider: Carewell Homes Ltd **Responsible Individual:** Carol Kelly	**Registered Manager and date registered:** Heather Lyttle – registration pending
Person in charge at the time of inspection: Pamela Fee, registered nurse from 11.30 hours to 12.00 hours and Heather Lyttle, manager from 12.00 hours onwards.	**Number of registered places:** 61 A maximum of 31 patients in category NH-I and NH-PH, a maximum of 20 patients in category NH-DE and a maximum of 10 patients in category NH-MP/MP(E). There shall be a maximum 1 named resident receiving residential care in category RC-DE.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. MP – Mental disorder excluding learning disability or dementia. MP (E) - Mental disorder excluding learning disability or dementia – over 65 years. PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** 45

4.0 Inspection summary

An unannounced inspection took place on 8 April 2019 from 11.30 hours to 20.30 hours.

The inspection assessed progress with any areas for improvement identified during and the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staffing, induction, adult safeguarding, communication between patients, staff and other key stakeholders, the culture and ethos of the home and governance arrangements.

Areas requiring improvement were identified in relation to supervision of patients, storage of thickening agents, staff supervision and appraisal and ensuring PEEP's are reflective of the actual number of patients in the home.

Patients described living in the home in positive terms. Residents unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others/ with staff.

Comments received from patients, people who visit them and staff during the inspection, are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	*3	*4

*The total number of areas for improvement includes one under regulation and two under the care standards which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Heather Lyttle, Manager; Wendy Shannon, Quality and Governance Lead; and Carol Kelly, Registered Person, 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.

4.2 Action/enforcement taken following the most recent inspection dated 15 January 2019

The most recent inspection of the home was an unannounced enforcement compliance medicines management inspection undertaken on 15 January 2019. This inspection focused solely on the actions contained within the failure to comply notices issued on 6 December 2018. This inspection found that the home had made the necessary improvements to comply with the regulations. Further enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home.
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home.
- observe practice and daily life.
- review documents to confirm that appropriate records are kept.

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire.
A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff from weeks commencing 1 April 2019 and 8 April 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- one staff recruitment and induction files
- three patient care records
- a selection of patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits/records
- complaints record
- compliments received
- annual quality report
- staff supervision and appraisal planner
- minutes of staff meetings
- statement of purpose and patient guide
- a sample of reports of visits by the registered provider
- RQIA registration certificate.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as either met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 15 January 2019

The most recent inspection of the home was an unannounced enforcement compliance medicines management inspection. No areas for improvement were identified.

The completed QIP was returned and approved by the pharmacist inspector.

6.2 Review of areas for improvement from the last care inspection dated 26-27 June 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 27 (4) (c) **Stated:** First time	The registered person shall ensure adequate means of escape in the event of a fire. This area of improvement is made in reference to ensuring fire exits are corridors are kept clear and not obstructed.	**Met**
	Action taken as confirmed during the inspection: Review of the environment evidenced fire exits and corridors were clear of obstruction.	
Area for improvement 2 **Ref**: Regulation 13 (7) **Stated:** First time	The registered person shall ensure suitable arrangements are in place to minimise the risk/spread of infection between patients and staff. This area for improvement is made in reference to the issues highlighted in Section 6.4.	**Met**
	Action taken as confirmed during the inspection: Review of the environment, observation of practice and examination of records evidenced the deficits highlighted at the previous care inspection had been addressed.	
Area for improvement 3 **Ref**: Regulation 14 (2) (a) (c) **Stated:** First time	The registered person shall ensure as far as is reasonably practicable that all parts of the home to which the patients have access are free from hazards to their safety, and unnecessary risks to the health and safety of patients are identified and so far as possible eliminated. This area for improvement is made with specific reference to the treatment room and domestic cleaning stores.	**Met**

	Action taken as confirmed during the inspection: Review of the environment confirmed the treatment room door and domestic cleaning stores were locked.	
Area for improvement 4 **Ref**: Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that nursing staff promote and make proper provision for the nursing, health and welfare of patients and where appropriate treatment and supervision of patients. This area for improvement is made in reference to the following: • post fall management • care planning • nutrition management.	**Partially met**
	Action taken as confirmed during the inspection: Review of three care records evidenced deficits in relation to post fall management and care planning in relation to activities. This is discussed further in 6.5 of this report. **This area for improvement is partially met and is stated for a second time**.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 11 **Stated:** First time	The registered person shall ensure the programme of activities reflects the preferences and choices of the patients and is evaluated regularly. This shall be displayed in a suitable format and a record kept of all activities that take place, with the names of the person leading them and the patients who participate.	**Not met**
	Action taken as confirmed during the inspection: Discussion with patients, relatives and staff, observation of practice and examination of records evidenced this area for improvement has not been met. This is discussed further in 6.6 of this report. **This area for improvement is not met and is stated for a second time**.	

Area for improvement 2 **Ref**: Standard 12 **Stated:** First time	The registered person shall ensure that menus are displayed for patients/visitors information in a suitable format and on a daily basis.	**Not met**
	Action taken as confirmed during the inspection: Review of the environment confirmed this area for improvement has not been met. This is discussed further in 6.6 of this report. **This area for improvement is not met and is stated for a second time**.	
Area for improvement 3 **Ref**: Standard 41 **Stated:** First time	The registered person shall ensure that the staffing rota clearly identifies the first and last name of all staff working in the home, their designation and the capacity in which they worked.	**Met**
	Action taken as confirmed during the inspection: Review of the staffing rota confirmed this area for improvement has been met.	
Area for improvement 4 **Ref**: Standard 35 **Stated:** First time	The registered person shall ensure monthly audits should be completed in accordance with best practice guidance. Any shortfalls identified should generate an action plan to ensure learning is disseminated and the necessary improvements can be embedded into practice, specifically, the care records audit and hand hygiene audit.	**Met**
	Action taken as confirmed during the inspection: Review of a selection of governance audits evidenced this area for improvement has been met.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

We arrived at the home at 11.30 hours and were greeted by the nurse in charge who was friendly and welcoming. They 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 weeks commencing 1 April 2019 and 8 April 2019 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping staff were on duty daily to meet the needs of the patients and to support the nursing and care staff.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patient's needs. Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. However, during review of the environment we observed a staff member leave the lounge in the dementia unit unsupervised. During this time patients had access to the unlocked kitchen which had open access to thickening agents. This was discussed with the staff member on their return who acknowledged the potential risk to patients. This was discussed with the manager and to ensure appropriate supervision of patients in the home an area for improvement under regulation was made. We observed further evidence of inappropriate storage of thickening agents within the home. We discussed the need for all prescribed medication to be stored in a secure place with the manager. The manager agreed to review the management and storage of thickening agents within the home. An area for improvement under regulation was made. The aligned pharmacy inspector for RQIA was also informed for action as appropriate.

Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in The Graan Abbey. Some comments received included:

"I can't complain. The staff are very good."

Review of one staff recruitment file confirmed staff were recruited in accordance with relevant statutory employment legislation and mandatory requirements. Appropriate pre-employment checks are completed and recruitment processes included the vetting of applicants to ensure they were suitable to work in the patients in the home. Review of records and discussion with the manager evidenced that a gap in the employee's employment record had been explored at interview but not recorded. This was discussed with the manager who agreed to ensure all gaps in employment are explored and recorded.

Staff spoken with said they completed a period of induction alongside a mentor and they would actively support new staff during their induction to the home. Review of records confirmed that a comprehensive induction was given to two recently recruited employees. Review of records evidenced the manager had a robust system in place to monitor staffs registration with their relevant professional bodies.

Discussion with staff and the manager confirmed that systems were in place for staff training, supervision and appraisal. Although these were actively managed we did discuss the low uptake

of training with the Quality and Governance Lead and the manager. The manager must ensure that mandatory training for all staff is completed in a timely manner to achieve a 100 per cent compliance. This will be reviewed at a future care inspection. Review of staff supervision and appraisal planners evidenced that annual appraisals and twice yearly supervisions were not being completed for all staff. To ensure supervision and appraisal requirements are met an area for improvement under the care standards was made.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice. The manager also confirmed that work had commenced on the annual adult safeguarding position report.

We reviewed accidents/incidents records since January 2019 in comparison with the notifications submitted by the home to RQIA. Records were maintained appropriately and notifications were submitted in accordance with regulation. A number of head injuries that had occurred since January 2019 had not been notified. This was discussed with the manager who submitted these retrospectively.

Observation of practices, discussion with staff and review of records evidenced that infection prevention and control measures were generally well adhered to. Staff were knowledgeable in relation to best practice guidance with regards to hand hygiene and use of personal protective equipment (PPE) and were observed to wash their hands/use alcohol gels and use PPE at appropriate times. One staff member was observed not taking an opportunity to wash their hands following patient contact. This was discussed with the staff member at the time and fed back to the manager during inspection feedback. PPE was readily available throughout the home. The cleaning schedule records were reviewed and were well completed. Patient equipment was observed to be stored in one identified communal bathroom with disposable aprons stored on a clinical waste bin. In addition, a PPE dispensing unit was fitted in the bathroom which is an area of high risk of cross contamination. This was discussed with the manager who agreed to address the deficits identified and include these in their environmental audit. This will be reviewed at a future care inspection.

Discussion with domestic staff evidenced a good knowledge in relation to dilution of chemicals for cleaning. However, two bottles containing disinfectant were observed to be stored in a domestic cleaning cupboard. This was discussed with a member of domestic staff who confirmed that the disinfectant should be disposed of within 24 hours of dilution in keeping with manufacturer's guidance. This was discussed with the manager who agreed to action this as appropriate.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices. There was also evidence of consultation with relevant persons. Care plans were in place for the management of restrictive practices including bedrails. Review of records confirmed a restrictive practice matrix was being reviewed on a bi-monthly basis.

Discussion with the manager and review of records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. Following this review an action plan was devised to address any identified deficits. This information was also reviewed as part of the monthly monitoring visits.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be

warm, well decorated and fresh smelling. A small number of commodes in ensuites were observed to be used as shower chairs. This was discussed with the manager who confirmed there is an ongoing programme of replacing these with shower chairs.

Fire exits and corridors were observed to be clear of clutter and obstruction, although one door was observed to be wedged open with a metal wedge. This was brought to the attention of the manager and was required to be addressed without delay to ensure the safety and wellbeing of patients in the home. The aligned estates inspector for RQIA was also informed for action as appropriate.

Review of records evidenced that fire drills were ongoing and the manager confirmed that additional drills were planned for the rest of the year. The manager should establish a system to ensure all staff participate in a fire evacuation drill at least once a year, training is provided by a competent person at the start of employment and is repeated at least twice a year. This will be reviewed at a future care inspection.

Review of the personal emergency evacuation plans (PEEP's) for patients in the home evidenced that whilst the information was current for all patients, the folder was not reflective of the actual number of patients in the home at the time of the inspection. This was brought to the attention of the manager who agreed to review and update the records immediately. This has been identified as an area for improvement under the care standards.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, induction, adult safeguarding and risk management and the home's environment.

Areas for improvement

Two areas for improvement under the care standards were identified in relation to supervision of patients and storage of thickening agents.

Two areas for improvement under the care standards were identified in relation to staff supervision and appraisal and ensuring PEEP's are reflective of the actual number of patients in the home.

	Regulations	Standards
Total numb of areas for improvement	2	2

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of three patient care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process. Care plans were in place to direct the care required and reflected the assessed needs of the patient. We reviewed the management of nutrition, falls and wound care. Generally care records contained details of the specific care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care.

Deficits were identified in relation to the management of falls. Review of four falls for two identified patients evidenced inconsistencies in monitoring clinical/neurological observations and appropriate medical attention was not sought on two occasions. Review of the post falls policy evidenced it was not in keeping with best practice guidance with regards to patients on anticoagulant therapy. Post fall management was identified as an area for improvement during the previous care inspection on 26 and 27 June 2018. It is of concern that improvements have not been made and this matter is stated for a second time.

One care record reviewed evidenced care plans and associated risk assessments had not been updated for periods of two and three months. In addition there were significant deficits in care planning for activities with activities assessments missing from some care records. The provision of activities is discussed further in 6.6. Care planning was identified as an area for improvement during the previous care inspection on 26 and 27 June 2018; this is stated for a second time.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care manager, General Practitioners (GPs), optician, chiropodist and diabetic nurse specialist. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals.

We observed the serving of the mid-afternoon snacks and midday meal. Patients were assisted to the dining room and staff were observed assisting patients with their meal appropriately. Patients appeared to enjoy the mealtime experience and were offered a choice of meal and drinks. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes. One staff member was observed modifying fluids for a patient using thickening agent prescribed for another patient. This was discussed with the manager who was reminded that all staff should have appropriate training in the appropriate use, administration and recording of thickening agents. This will be reviewed at a future care inspection. Review of the menu and discussion with the cook evidenced that planned meals had been adhered to. A minor change in the menu on the day of inspection was observed although this was not recorded. This was discussed with the manager who agreed to ensure there was a system in place to record changes to the planned menu.

Review of supplementary care charts such as food and fluid intake records, personal care records, sleep chart and repositioning charts evidenced that records were generally well maintained.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they would raise these with the manager or the nurse in charge. When we spoke with staff they had a good knowledge of patients' abilities and level of decision making; staff know how and when to provide comfort to patients because they know their needs well.

All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other health care professionals. Discussion with one visiting professional evidenced good communication and rapport with staff in the home. Some comments received included:

"The staff are good and proactive in having patients' vision checked. The staff are also informed re. eye issues. Everything is done really well. Glasses are fixed and repaired and they take any advice on board."

Discussion with the manager and review of records confirmed that staff meetings were held regularly and records maintained. We encouraged the manager to ensure staff comments/action points are collated and reviewed at each staff meeting and reflected in the minutes of the staff meetings.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication between patients, staff and other key stakeholders.

Areas for improvement

No new areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff were also aware of the requirements regarding patient information and patient confidentiality.

Significant deficits were identified with regards to the provision of activities in The Graan Abbey. Relatives spoken with stated there was a lack of provision and stimulus for patients. Some comments received included:

"There could be more stimulation for patients, particularly in the dementia unit."
"It would be nice if there were bigger windows. My relative doesn't get outside at all. I can't fault the girls but there is a lack of activities."
"The care is good but I never see much going on other than patients sleeping."

Review of the dementia unit confirmed that there was no activities board on display. The activity co-ordinator was not on duty during the inspection and staff confirmed there was no provision for activities in their absence. One patient spoken with stated they did not take part in activities provided within the home describing them as "hopeless." Discussion with staff confirmed that there were a number of external visitors to the home who provided music and spoke with the patients, with one volunteer confirming they would take part in activities "downstairs" in the home. One registered nurse stated they would not regularly review the activity record when completing daily records. Review of records evidenced significant gaps in recording of activity provision.

There was no evidence that the area for improvement in relation to activities stated at the previous care inspection on 26 and 27 June 2018 had been actioned. This was discussed with the senior management team who gave assurances that a review of activity provision throughout the home would be prioritised. This area for improvement is stated for a second time.

The environment had been adapted to promote positive outcomes for the patients. Many of the bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences. A small number of bedrooms were found to lack personalisation. This was discussed with the manager who agreed to review this as required. Review of menus in the home evidenced they were not in a suitable format to meet the needs of all the patients. No menu was on display in the dementia unit with the menu in the dining area only partially legible. This was discussed with the manager and identified as an area for improvement during the previous care inspection on 26 and 27 June 2018. This area for improvement is stated for a second time.

During observation of the midday meal we observed that all patients in the dementia unit were served drinks in plastic tumblers. Although meals were served on ceramic plates there was also plastic bowels observed in the kitchen area. This was discussed with the manager who acknowledged there were particular challenges with some patients during meal time that made it difficult to use glasses although they agreed to review the dining experience within the home. This will be reviewed at a future care inspection.

Consultation with 13 patients individually, and with others in smaller groups, confirmed they were happy and content living in The Graan Abbey. Some of the patients' comments included:

"It's very homely here. I like it."
"They are fierce good here. You couldn't be in a better place."
"I can't complain. The staff are very good."
"The food and people are good. It's a home from home."
"I have no fault with them. I am well fed and well kept."

Five patient questionnaires were provided; three were returned in the expected timeframe. All three responses indicated the patients were very satisfied with care across all four domains. Comments received included:

"Looked after alright. Attentive every day."

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.

Five relative questionnaires were provided and staff were asked to complete an online survey; we had no responses within the timescale specified. Eight relatives/visitors were spoken with during the inspection. Some of the comments received included the following:

"We receive more communication about our relative from older staff as opposed to younger staff with less experience. Although all staff are polite, friendly and professional."
"I have no concerns. The care is good."
"I have no complaints."

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home and dignity and privacy.

Areas for improvement

No new areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been a change in management arrangements, RQIA were notified accordingly. A review of the duty rota evidenced that the manager's hours, and the capacity in which these were worked, were clearly recorded. The manager was reminded that all duty rotas are to be signed by them or a designated representative and the duty rota should reflect the actual hours worked by all staff. Discussion with staff, patients and visiting professionals evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the registered manager.

There was evidence of good management oversight of the day to day working in the home. A number of audits were completed to assure the quality of care and services; areas audited included wounds, care plans, infection prevention and control/environment and accidents and incidents. Audits generated action plans that highlighted areas for improvement and there was evidence that the deficits identified were actioned as required.

Discussion with the manager and review of records evidenced that with the exception of the small number of head injuries, systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. Review of records evidenced that quality monitoring visits were completed on a monthly basis on behalf of the responsible individual in accordance with the relevant regulations and standards.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed appropriately in line with best practice guidance. Patients spoken with said they would be confident if they raised a complaint that it would be dealt with accordingly.

Discussion with the registered manager and review of records evidenced a relatives and patients survey was completed in 2018. Review of the responses evidenced positive feedback from all relatives. There was no evidence of a patients/relatives meetings taking place in the home although the manager confirmed the home operated an open door policy. An annual quality report was also completed in 2018. The Quality and Governance lead stated there were plans to do additional surveys in the next few months with the manager confirming plans for a "patient of the day." These quality initiatives will be reviewed at a future care inspection.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

No new areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Heather Lyttle, Manager; Wendy Shannon, Quality and Governance Lead; and Carol Kelly, Registered Person, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref:** Regulation 13 (1) (a) (b) **Stated:** Second time **To be completed by:** Immediate action required	The registered person shall ensure that nursing staff promote and make proper provision for the nursing, health and welfare of patients and where appropriate treatment and supervision of patients. This area for improvement is made in reference to the following: • post fall management • care planning. Ref: 6.5
	Response by registered person detailing the actions taken: The falls policy has been reviewed and updated with further guidance and actions to take when a resident is prescribed an anti-coagulant and further guidance on the completion of clinical observations A review of keyworkers has taken place to ensure that careplans and risk assessmernts are reviewed within an appropiate time scale. The audit schedule for careplans has been increased to 4 monthly as opposed to 6 monthly
Area for improvement 2 **Ref**: Regulation 13 (1) (b) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that the nursing home is conducted so as to make proper provision for the nursing and supervision of patients. Ref: 6.4
	Response by registered person detailing the actions taken: Reflection with the staff member followed the inspection to ensure supervision of the residents
Area for improvement 3 **Ref:** Regulation 13 (4) (a) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure thickening agents are stored in a secure place. Ref: 6.4
	Response by registered person detailing the actions taken: The inappropiate storage was actioned on the day of inspection and reviewed to provide a locked cupboard for storage

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 11 **Stated:** Second time **To be completed by:** 31 May 2019	The registered person shall ensure the programme of activities reflects the preferences and choices of the patients and is evaluated regularly. This shall be displayed in a suitable format and a record kept of all activities that take place, with the names of the person leading them and the patients who participate. Ref: 6.6
	Response by registered person detailing the actions taken: Supervision was completed with the activity therapist with reference to documentation and activity planners. Further recruitment has taken place to enhance the level of activities provided. Community volunteers also support the home with story telling, music and poetry reading as on the day of the inspection.
Area for improvement 2 **Ref**: Standard 12 **Stated:** Second time **To be completed by:** 31 May 2019	The registered person shall ensure that menus are displayed for patients/visitors information in a suitable format and on a daily basis. Ref: 6.6
	Response by registered person detailing the actions taken: A review of menu boards has taken place and new picture boards have been purchased and put in place
Area for improvement 3 **Ref**: Standard 40.2 **Stated:** First time **To be completed by:** 8 July 2019	The registered person shall ensure all staff have a recorded annual appraisal and supervision no less than every six months. A supervision and appraisal schedule shall be in place, showing completion dates and the name of the appraiser/supervisor. Ref: 6.4
	Response by registered person detailing the actions taken: The supervision and appraisal schedule has been reviewed and supervion has been completed, appraisals have been commenced
Area for improvement 4 **Ref:** Standard 48.7 **Stated:** First time **To be completed by:** 8 May 2019	The registered person shall ensure the personal emergency evacuation plans (PEEP's) are maintained in an up to date manner. Ref: 6.4
	Response by registered person detailing the actions taken: This was actioned on the day of the inspection for the identified resident.

Please ensure this document is completed in full and returned via Web Portal

The Regulation and Quality Improvement Authority

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