Unannounced Secondary Care Inspection

Name of Establishment:	**Dunmurry Manor**
Establishment ID No:	**12230**
Date of Inspection:	**15 October 2014**
Inspector's Name:	**Lorraine Wilson**
Inspection ID:	**20717**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Home:	Dunmurry Manor
Address:	Rowan Drive Seymour Hill Dunmurry BT17 9PX
Telephone Number:	028 90610435
E mail Address:	manager.dunmurry@runwoodhomes.co.uk
Registered Organisation/ Registered Provider:	Runwood Homes Ltd Mr Nadarajah (Logan) Logeswaran
Registered Manager:	Mrs Debra Ann Hawthorne (Acting Manager)
Person in Charge of the Home at the Time of Inspection:	Mrs Debra Hawthorne
Categories of Care:	RC-DE, NH-DE
Number of Registered Places:	76
Number of Residents/Patients Accommodated on Day of Inspection:	19 nursing patients 10 residents
Scale of Charges (per week):	Residential Rate: £ 461.00 Nursing Rate: £ 581.00 + £ 15.00 per week third party top – up on all beds.
Date and Type of Previous Inspection:	Pre-registration Inspection 16 July 2014
Date and Time of Inspection:	15 October 2014 11.50 -16.55 hours
Name of Inspector:	Lorraine Wilson

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year are required.

This is a report of an inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being met.

1.1 Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

The Regulation and Quality Improvement Authority aims to use inspection to support providers in improving the quality of services, rather than only seeking compliance with regulations and standards. For this reason, annual inspection involves in-depth examination of a limited number of aspects of service provision, rather than a less detailed inspection of all aspects of the service.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the Provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)
- Other published standards which guide best practice may also be referenced during the Inspection process.

1.2 Methods/Process

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

- discussion with the area manager
- discussion with the acting manager
- discussion with the registered nurse on duty, the team leader, three care staff, one catering assistant and one volunteer
- discussion with patients/residents' individually and to others in groups
- discussion with one visiting relative and one visiting friend
- review of three patients care plans
- review of a sample of staff training records pertaining to staff induction and competency
- observation during a tour of the premises
- review of a sample of policies and procedures
- review of a sample of staff duty rotas
- observation during a tour of the premises
- evaluation and feedback.

1.3 Inspection Focus

Prior to this inspection RQIA received information from the South Eastern Health and Social Care Trust expressing concerns in the following areas:

- management of wounds for identified patients
- lack of effective assessments and care records in respect of wound management
- staffing arrangements and lack of staff knowledge in respect of wound care.

Therefore, the following areas were reviewed during this care inspection.

- the care records for three patients in respect of wound care management
- the staffing arrangements and structure in the home
- the general care environment.

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

2.0 Profile of Service

Dunmurry Manor Nursing home is situated within the Seymour Estate in Dunmurry
The nursing home is owned and operated by Runwood Homes Limited.
The current manager is Mrs Deborah Hawthorne, who is not currently registered with RQIA. However, an application has been submitted to RQIA and is currently pending.

Accommodation for residents is provided on the ground floor of the home, and nursing patients are located on the first floor of the home. Access to the first floor is via a passenger lift and stairs.

Each floor has communal lounges and dining areas provided. A number of communal sanitary facilities are available throughout the home.

The home also provides for catering and laundry services on the ground floor.

In addition hairdresser facilities, a café, secure garden and clinical areas are also available.

The home is registered to provide care for a maximum of 76 persons under the following categories of care:

Nursing care

DE dementia care to a maximum of 40 patients accommodated within the dementia unit on the first floor.

Residential care

DE dementia care to a maximum of 36 residents accommodated within the dementia unit on the ground floor.

3.0 Summary

This summary provides an overview of the services examined during an unannounced care inspection to Dunmurry Manor Nursing Home. This was the first care inspection undertaken since registration was approved by RQIA on 16 July 2014. The inspection was undertaken by Lorraine Wilson on 15 October 2014, from 11.55 to 16.55 hours.

The inspector was welcomed into the home by Mrs Debra Hawthorne, acting manager who was available throughout the inspection.

Verbal feedback of the issues identified during the inspection was given to Mrs Norma McAllister, area manager and to Mrs Debra Hawthorne, acting manager at the conclusion of the inspection. Follow up telephone calls were also made to Mrs Hawthorne and Mrs McAllister on 22 October 2014, requesting an action plan to be submitted to RQIA within an agreed timescale. This information has subsequently been submitted to RQIA as agreed.

Throughout the inspection, the inspector met with patients/ residents, staff and one visiting relative and a friend. Residents and patients looked well cared for and those who were able to provide their views to the inspector indicated they were satisfied with the care and treatment being provided. No matters of concern were raised with the inspector.

In addition, one visiting relative discussed at length the care and treatment provided and was positive regarding the support and guidance provided by the commissioning trust specialist tissue viability nurse, and the staff in the home. There were no expressions of dissatisfaction raised with the inspector.

The inspector observed care practices, reviewed staffing arrangements and examined a selection of records. A general inspection of the nursing home environment was carried out as part of the inspection process.

Some patients had been admitted to the home with wounds, and the management and care records of wound care for three patients was reviewed during this inspection. There was good evidence that the records for wound care had been reviewed and updated and were in accordance with good practice. There was also confirmation of wound healing recorded by some specialist clinicians. However, the three care records examined had not been fully completed in other areas, for example, assessments and risk assessments reviewed had not been commenced or in some were incomplete. A requirement is raised that an audit of all care records is completed to identify areas for improvement. Upon completion a re-audit should also be undertaken to ensure deficits have been effectively addressed.

The inspector observed the serving of lunch in the residential unit. Whilst tables observed were appropriately set, table menus were not displayed on each table. To assist in meeting the needs of patients and residents with dementia, a pictorial menu should be considered. Caring and catering staff were unable to confirm which week of the four weekly menu was being served. The lunch served was not reflective of the four week menu and there was no evidence of a choice being offered or provided to patients/residents. The quality of the meal served was of average quality. Improvements are needed to ensure the dining experience for patients and residents is improved. Confirmation was provided by the area manager that work to address the management of meals was being developed within the home. The need for management to undertake effective monitoring during meal times was also reinforced during this inspection.

This inspection identified that insufficient skilled and experienced staff were available to meet the needs of patients and residents.

In addition to the acting manager there are two full time nurses appointed to meet the need the needs of patients and the home. The nurse on duty in the nursing dementia had recently qualified and was working in their first nursing position. There was no evidence that in accordance with good practice, mentorship arrangements were in place. During the inspection feedback, it was verbally agreed by the area manager that the nursing compliment in the nursing unit would be increased to two registered nurses during the morning period.

The home was dependent on agency staff to provide the required nursing cover particularly during the night duty period. This inspection evidenced that this practice was impacting on the needs of patients. This was evidenced during a review of daily repositioning and fluid records for patients who were bed-bound as these were incomplete specifically during the periods from 20.00 to 08.00 hours.

There were also insufficient numbers of care staff on duty in the residential unit to meet the needs of the ten residents.

The area manager provided an assurance to the inspector that an additional staff member would be on duty in this unit during the morning period with immediate effect.

Confirmation was provided that a recruitment drive was currently ongoing to appoint staff for the home. Post inspection, the inspector was informed that a deputy manager has been recruited and the inspector was advised that they will work supernumerary with staff to address deficits which were identified for a time limited period.

A requirement is made in respect of staffing, staff training, supervision and mentorship for staff.

Many of the care staff spoken with had recently commenced employment and were still in the process of induction and getting to know the patients and residents in their care. Whilst some staff consulted confirmed they had received a detailed programme of induction, this was not the experience of all staff.

The cook and catering staff on duty were also agency staff. This was again impacting on the meal service to patients/residents as menus had not been followed.

It was positive to note that a number of staff attended pressure care training which was being delivered by the commissioning trust specialist tissue viability nurse on the day of inspection.

There was evidence that staff and resident/ patient interaction and communication demonstrated that patients/residents were treated courteously, with dignity and respect. During the afternoon period patients/residents were observed taking part in a baking session as part of the activity provision for the day.

The environment was clean, and well maintained. The fire alarm went off during the inspection, and upon hearing the alarm the maintenance man went to the laundry and on return advised it was a false alarm. Other staff on duty did not respond.

Conclusion

In the three care records reviewed, there were examples of assessments being incomplete, and recommendations have been made in respect of these issues.

The inspector can confirm that on the day of inspection the delivery of care to patients in respect of wound care was mostly in accordance with evidence based practice. Areas for improvement were identified; these were in respect of recording pressure relieving equipment for patients when sitting out of bed, accurate maintenance of repositioning records and of fluid records.

In the inspectors professional opinion there are insufficient numbers of staff to meet the needs of nursing patients and the use of agency staff particularly during the night duty periods was impacting. The need for appropriate staff induction including agency staff, mentorship arrangements, training for staff in wound care and competency and capability assessments for nursing staff in charge of the home in the absence of the acting manager is identified. A verbal assurance was provided by the area manager, that an additional registered nurse would be on duty in the nursing unit, and the staffing arrangements in the residential unit would be increased during the morning period (08.00- 14.00).

The patients/residents were observed to be treated with dignity and respect by staff.

The management of the meal service requires improvement to ensure that;

- choice is offered to patients/residents
- meals provided are in keeping with the recorded rotational and daily menus
- meals are appropriate to meet the needs of patients/residents with dementia.

The environment was clean and well maintained. During inspection, the fire alarm sounded, however, whilst this was identified as a false alarm, issues in respect of the staff response were identified. The area manager had also identified issues with the staffing response and was addressing these issues on the day of inspection.

As a result of the issues raised during this inspection, the area manager voluntarily agreed to cease admissions of nursing patients effective from 17 October 2014, until the areas identified have been effectively addressed. In addition, the area manager submitted an action plan post inspection to RQIA detailing the action to be taken.

Five requirements and seven recommendations were made during this inspection.

The inspector would like to thank the residents, patients, relatives, area manager, acting manager and staff for their assistance and co-operation throughout the inspection process, and for the hospitality provided.

4.0 Follow-Up on Previous Issues

Due to the focus of this inspection requirements and or recommendations which had been made during the pre-registration visit were not inspected.

4.1 Follow up on any issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if there is considered to be a breach of regulation as stated in the Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

Prior to this inspection RQIA received information from the South Eastern Health and Social Care Trust expressing concerns in respect of staffing arrangements and wound care management in the home. Following this inspection, feedback was provided to the South Eastern Health and Social Care Trust in respect of the issues raised in respect of wound care and staffing arrangements in the home.

5.0 Areas Examined

5.1 Wound management

Three care records were reviewed, and the care records indicated that one of the residents and some patients had been admitted to the home with wounds. On the day of inspection, one resident and four patients had wounds.

The wound care records for three of the identified patients were reviewed.

Care records reviewed included:

- Assessment of daily need
- Braden & Waterlow risk assessments
- Body Mapping record
- Abbey pain scale
- Malnutrition Universal Screening Tool (MUST) assessment
- care plans
- open wound assessment
- daily evaluation notes
- repositioning charts
- communication records for relatives and visiting professionals.

The wound care records reviewed demonstrated that wound care treatment was being delivered as prescribed in accordance with the specialist wound care nurse (TVN) dressing plan. Communication records completed by professionals indicated that wounds were healing.

Pressure ulcers were graded using an evidenced based classification system and following the visit by the specialist TVN, retrospective notifications of pressure ulcers grade 2 and above had been notified to RQIA in accordance with evidenced based practice.

The pressure relieving equipment required when the patient was sitting out of bed had not been recorded, and this information should be recorded in the patient's care plan. The maintenance arrangements should also be recorded. A requirement will be made.

Risk assessment tools were in place to determine pressure ulcer risk; however, some records reviewed had two different tools in use. To avoid confusion for staff one tool should be used. A recommendation is made. Pain assessments were in place, however in the care plans reviewed and in daily evaluation records, there was no evidence that nursing staff were monitoring the effectiveness of analgesia to determine if it was effective.

In the records examined, the following deficits were noted.

Two patients repositioning charts were reviewed and revealed that the charts did not evidence that the repositioning regimes prescribed in the care plan were being adhered to. For example, repositioning evidence was not recorded for the periods from 20.00 hours to 08.00 hours. This was discussed with the nurse on duty who confirmed that agency staff on duty did not always complete the records. The inspector also reviewed daily fluid intake charts for two patients during a three day period. There was again inconsistency in recording, with no entries recorded from 20.00 hours to 08.00.

In accordance with the Nursing Homes Regulations (Northern Ireland) 2005, regulation 19(1)(a), schedule 3, 2(k) the registered person shall maintain contemporaneous notes of all nursing provided to each patient. A requirement is raised. Repositioning charts and daily fluid charts must be accurately maintained to evidence care delivered. It is recommended that records include all drinks offered and recorded as either consumed or refused.

The inspector concluded there have been improvements made in respect of wound care records and treatments, which should continue to be improved and sustained.

However, the inspector also noted in the care records reviewed that not all assessments had been completed, for example, there were no bowel types being recorded referencing the Bristol stool chart and no monitoring of bowel patterns were being recorded.

Records for one patient indicated they had lost weight but there was no recorded evidence of any action taken to address the weight loss.

The inspector could not evidence that an effective system was in place to identify, assess and manage deficits in care records.

A requirement is made that an audit of all care records should be undertaken by senior management to identify areas for improvement and a re-audit undertaken to ensure the identified deficits are effectively addressed.

5.2 Staffing

The acting manager currently in post commenced employment in September 2014. An application for registration with RQIA has been submitted and is currently being processed.

This inspection identified that there were insufficient skilled and experienced staff available to meet the needs of patients and residents. The home was also dependent on agency staff to provide the required nursing cover particularly during the night duty period from 20-00 hours to 08.00 hours. This was impacting on the needs of patients, and there was no management oversight to address this deficit.

The inspector observed there was one staff member (Team Leader) in the residential unit for 10 residents and given the layout and the observations made, there were insufficient numbers of care staff on duty in the residential unit to meet the needs of the residents. The area manager provided an assurance to the inspector that an additional staff member would be on duty in this unit during the morning period with immediate effect.

One student who commenced an unpaid placement on the day of inspection was wearing a uniform similar to that worn by care staff. This could cause confusion for residents and relatives and the student would be perceived as a staff member. Therefore this should be addressed.

The nurse on duty in the nursing dementia had recently qualified and this was their first nursing position. The inspector was unable to evidence that mentorship arrangements were in place in accordance with good practice. In addition there had been occasions when the nurse was left in charge of the home in the absence of the manager, and in accordance with regulations, no competency and capability assessment had been completed.

It was verbally agreed by the area manager that in future two nurses would be on duty in the nursing unit during the morning period. Duty rosters worked for the periods from 17 October to 3 November 2014 should be submitted to RQIA with confirmation that these are the hours which have actually been worked. A recommendation is made.

Many of the care staff spoken with had recently commenced employment and were still in the process of induction and getting to know the patients and residents in their care. Whilst some staff consulted confirmed they had received a detailed programme of induction, this was not the experience of all staff.

The cook and catering staff on duty was also agency staff. Again this was impacting on the meal service to patients as menus had not been followed.

Confirmation was provided by the acting manager that a recruitment drive was currently ongoing to appoint staff for the home.

The registered person must ensure that sufficient numbers of suitably qualified, skilled and experienced persons are employed to work in the nursing home at all times, and the use of agency staff is significantly reduced. The registered person must also ensure that staff working in the home completes a structured programme of induction, and are assessed and deemed competent by management upon successful completion of the programme. All registered nursing staff must have wound care training and care staff should receive training in providing pressure relief. Each staff member in charge of the nursing home in the absence of the manager must have completed a competency and capability assessment which is reviewed by the manager at least annually. A requirement will be made in respect of these issues.

On the day of inspection, a number of staff attended pressure care training in the home which was being delivered by the commissioning trust specialist tissue viability nurse.

5.3 Care Practices

During the mid-morning, the inspector under took a tour of the home, and observed residents in the residential unit being assisted to the dining room by the team leader on duty.

In the nursing unit, the majority of patients were sitting in the lounges or in their bedroom as was their choice. The inspector observed that staff in the home were very busy but were quietly attending to the patients'/residents' needs. Staff and patient/resident interaction and communication demonstrated that patients/residents were treated courteously, with dignity and respect. Good relationships were evident.

The inspector spoke with the majority patients/residents who commented positively in regard to the care they were receiving, and those patients/residents who were unable to verbally express their views were observed to be well groomed, appropriately dressed in clean matching attire and seemed relaxed and comfortable in their surroundings.

One relative spoke at length with the inspector and the relative had been kept informed of their relatives wound care treatment and spoke positively about the care provided by the Trust tissue viability specialist nurse and the staff in the home.

5.4 Meals and Mealtimes

The inspector observed the serving of the lunch meal in the residential unit. The majority of residents were served their meal in the dining room, though a small number of residents were served their meal in their bedroom.

Generally the tables were appropriately set, with table covering, place settings, cutlery, glass wear and condiments in place. Improvements are needed to ensure that daily menus which meet the needs of patients and residents with dementia are provided. In addition the meal of sausages, gravy, potatoes and beans was not reflective of the weekly menu planners on display, and no choice of meal was offered to patients or residents, despite a choice being recorded. Catering and caring staff consulted were unable to advise on the meal choice being provided. Agency staff were also providing catering services in the home, and the catering assistant on duty was unaware of the choice being offered.

5.5 General Environment

The inspector undertook a tour of the home and examined a number of residents', patients' bedrooms, lounges, bathrooms and toilets at random. A number of bedrooms were personalised with photographs, pictures and personal items. The home was appropriately heated and fresh smelling throughout.

5.5.1 Fire Safety

The fire alarm went off during the inspection, and apart from the maintenance man there was no response by care staff. However, the maintenance man responded promptly and declared there was a false alarm in the laundry. The inspector was concerned at the lack of response, this was discussed with the area manager who confirmed that she was updating the procedure on the day of inspection. This information was also escalated to the RQIA estates inspector.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with, Mrs Deborah Hawthorne, acting manager, and Mrs Norma McAllister, area manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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.

Enquiries relating to this report should be addressed to:

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

_____ _____

Lorraine Wilson **Date**
Inspector/Quality Reviewer

The Regulation and Quality Improvement Authority

Quality Improvement Plan

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The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Mrs D Hawthorne, acting manager, and Mrs N McAllister, area manager, either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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.

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 (NI) 2005

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	12. 1)(a) (b)(c), (2)(a)(b)	**Requirements to ensure quality of nursing and other service provision** The registered person shall provide treatment, and any other services to patients in accordance with the statement of purpose, and shall ensure that the treatment and other services provided to each patient – (a)meet his individual needs; (b)reflect current best practice; and (c)are (where necessary) provided by means of appropriate aids or equipment. (2) The registered person shall ensure that all aids and equipment used in or for the purpose of the nursing home is – (a)suitable for the purposes for which it is to be used; and (b)properly maintained and in good working order. • The pressure relieving equipment required when the patient was sitting out of bed had not been recorded,	One	Care records are compiled using information gained from nursing assessments, MDT and medical assessments and the completion of a pre-assessment visit to the patient prior to admission. Family input is also incorporated. Relevant referrals to other members of the MDT are made when specialist equipment or aids are required. The pressure relieving equipment required is now recorded in the care plan.	From date of inspection

		and this information should be recorded in the patient's care plan. The maintenance arrangements should also be recorded. **Ref 5.1**		Maintenance records for pressure relieving equipment are in place.	
2.	19 (1)(a)(b) (2) (3)(a)(b)(4)	**Records** The registered person shall – (a)maintain in respect of each patient a record which includes the information, documents and other records specified in Schedule 3 relating to the patient; (b)ensure that the record referred to in sub-paragraph (a) is kept securely in the nursing home. The registered person shall maintain in the nursing home the records specified in Schedule 4. The registered person shall ensure that the records referred to in paragraphs (1) and (2) – (a)are kept up to date; and (b)are at all times available for inspection in the home by any person authorised by the Regulation and Improvement Authority to enter and inspect the nursing home. The records referred to in paragraphs (1) and (2) shall be retained for not less than 6 years from the date of the last entry.	One	The Statement of Purpose and the Service User Guide have been updated to reflect current changes within the home. There is a record of assessment of needs for each resident. All relevant information in order to manage the well being of the resident. Contact details of the MDT who contribute to the well being of the resident are also recorded. All risk assessments are completed. There are at least two detailed entries in the daily activity notes. Care plan evaluations have been completed. The records are kept in a secure cupboard. Records of residents who are no longer in the home have had their records archived.	From date of inspection

		• The registered person should maintain contemporaneous notes of al nursing provided to each patient. Repositioning charts and daily fluid records must be accurately maintained to evidence the care delivered. **Ref 5.1**		Accountabillity for record keeping was discussed with care staff at a meeting on 7th November 2014. A copy of the NISCC Standards were given to staff present. Random audits have been commenced.	
3.	20 (1)(a)(b)(c)(i)(ii)(iii)(iv), (2), (3).	**Staffing** The registered person shall, having regard to the size of the nursing home, the statement of purpose and the number and needs of patients – (a)ensure that at all times suitably qualified, competent and experienced persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients; (b)ensure that the employment of any persons on a temporary basis at the nursing home will not prevent patients from receiving such continuity of nursing as is reasonable to meet their needs; (c)ensure that the persons employed by the registered person to work at the nursing home receive – (i)appraisal, mandatory training and other training appropriate to the work they are to perform; and (ii)are supported to maintain their registration	One	Our recruitment drive has resulted in five experienced nurses commencing employment for both days and nights. The use of temporary staff has been reduced significantly. to maintain continuity of care. A block booking sytem was put in place for the use of agency staff. An appraisal schedule is now in place. An e-learning programme has been introduced to provide mandatory training and this is being supplemented with face to face practical sessions. Staff have attended wound care and medication training. Places have also been secured for Swallow Awareness	From date of inspection

		with the appropriate regulatory or occupational body; and (iii)are enabled from time to time to obtain training and/or further qualifications appropriate to the work they perform; (iv)are provided with a job description outlining their responsibilities. (2) The registered person shall ensure that persons working at the nursing home are appropriately supervised. (3) The registered person shall ensure that at all times a nurse is working at the nursing home and that the registered manager carries out a competency and a capability assessment with any nurse who is given the responsibility of being in charge of the home for any period of time in his absence. • There should be sufficient numbers of suitably qualified, skilled and experienced persons employed to meet the needs of patients and residents with dementia. • The use of agency staff is significantly reduced. • All staff employed in the home must complete an induction programme and be assessed as competent by management upon successful completion of the programme.		Training and Palliative Care update on the use of McKinley Syringe Driver An inhouse Dementia Awareness Programme is to be provided in January 2015. A job description has been provided to all staff. Nurse in Charge competencies have been carried out on all staff left in charge of the home in the absence of the Manager. Recruitment is ongoing. We have recruited seven new nurses three of whom are RMN. The use of agency nurses has decreased significantly. All nursing and Care Staff have now completed an induction and a competency assessment and have been assessed as competent.	

		• All nursing staff in charge of the home must have a competency and capability assessment completed by the manager. • All nursing staff should receive wound care training and all care staff should have pressure care training. **Ref 5.2**		All nurses in charge of the home have completed a competency assessment. Wound Care training has been provided and is ongoing for all grades of staff.	
4	17 (1)	**Review of quality of nursing and other service provision** The registered person shall introduce and ensure systems are maintained for reviewing at appropriate intervals the quality of nursing and other service provision in or for the purposes of the nursing home and that any such review is undertaken not less than annually. • The registered person should ensure that an audit of all care records is undertaken to identify all areas for improvement. A re-audit should also be undertaken to ensure identified deficits have been addressed. **Ref 5.2**	One	An initial care plan audit was carried out by the registered person in both the nursing and the residential units. This audit was repeated and if omissions were identified they have been addressed.	17 October 2014

5	12,(4)(a)(b)(c)(d)	**Requirements to ensure quality of nursing and other service provision** The registered person shall ensure that food and fluids – (a)are provided in adequate quantities and at appropriate intervals; (b)are properly prepared, wholesome and nutritious and meets their nutritional requirements; (c)are suitable for the needs of patients; (d)provide choice for the patients; **Ref 5.4**	One	A new Kitchen Manager has been appointed and an ongoing review of the meals provided is taking place. Support was provided from another home with regard to preparation of modified diets. A choice of meals is available for all patients. The time for serving the main meal was reviewed.	From date of inspection

Recommendations

These recommendations are based on The Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	5.2	The registered person should ensure that to avoid confusion for staff, there is one pressure risk assessment tool in use. **Ref 5.1**	One	The Braden Scale pressure risk assessment tool is in use.	From date of inspection
2.	12.12	The registered person should ensure that fluid records include all drinks offered and recorded as either consumed or refused. **Ref 5.1**	One	Revised food and fluid charts have been introduced. Random daily audits have commenced to assess compliance.	From date of inspection
3	30.7	The registered persons should ensure that worked staff duty rosters commencing 20 October to 23 November 2014 are submitted to RQIA for review. **Ref 5.2**	One	Duty Rosters are attached.	When returning the Quality Improvement Plan.
4	12.4	The registered persons should ensure that menu choices displayed are adhered to, and a daily menu which meets the needs of patients/residents with dementia related conditions is displayed. **Ref 5.4**	One	A four week menu is in place and adhered to. Picture menus are now displayed on the tables.	By 30 November 2014.
5	36.4	The registered persons should ensure that all staff have fire training and are aware how to respond to the fire alarm.	One	Fire Training is ongoing to ensure all current and newly recruited staff are aware of how to respond to the fire	From date of inspection

		Ref 5.5.1		alarm.	
6	25.24	There are arrangements in place to enable international nurses to have a period of supervised practice experience to give safe and effective nursing care, until deemed competent in accordance with NMC procedures. **Ref 5.2**	One	The international nurses have been provided with a perceptorship programme as part of their supervised practice The nurses have been supported and coached by more experienced staff.	From date of inspection
7	25.2	The registered persons should inform RQIA when admission to the nursing unit recommences. **Ref Conclusion**	One	The Manager informed the Inspector of the date admissions to the nursing unit were to commence. Spoke with LW	From date of recommencement

The registered provider / manager is required to detail the action taken, or to be taken, in response to the issue(s) raised in the Quality Improvement Plan. The Quality Improvement Plan is then to be signed below by the registered provider and registered manager and returned to:

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

SIGNED: N. Logeswaran

NAME: Logan. N. Logeswaran.
Registered Provider

DATE 15-12-2014.

SIGNED: D. Hawthorne

NAME: DEBRA HAWTHORNE
Registered Manager

DATE 15/12/14

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable			
Further information requested from provider			

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

NAME OF REGISTERED MANAGER COMPLETING QIP	
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	X	Heather Sleator	22/12/2014
Further information requested from provider			