Unannounced Care Inspection Report
17, 18 and 24 October 2016

Dunmurry Manor

Type of Service: Nursing Home
Address: Rowan Drive, Seymour Hill, Dunmurry, BT17 9PX
Tel no: 028 9061 0435
Inspector: Heather Sleator and Alice McTavish

1.0 Summary

An unannounced inspection of Dunmurry Manor (nursing unit) took place on 17 October 2016 from 09.30 to 16.30 and 18 October 2016 from 09.30 to 16.00. A residential care inspector undertook an inspection of the residential unit on 24 October 2016. An estates inspection was undertaken on 24 October 2016 and is reported under separate cover.

The inspection sought to assess progress with any issues raised during and since the last care inspection of 22 to 24 June 2016 and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

The deputy manager Joanne Cairns was in charge of the home at the commencement of the inspection however, Jill Finlay, the newly appointed home manager, commenced employment on 24 October 2016, and was available to support the inspection of the residential care unit.

Is care safe?

Weaknesses were identified in the delivery of safe care, specifically in relation to the staffing arrangements and the deployment of staff, management of medicines, the morning routine, environmental issues, the staff response to the sounding of the nurse call system and patient risk assessments. These deficits have led to a reduction in positive outcomes for patients.

Six requirements have been stated to secure compliance and drive improvement.

Is care effective?

Weaknesses have been identified in the delivery of effective care specifically in relation to the management of care planning; wound care, the management of distressed reactions, pain management, dementia care practice and the patients dining experience. The patients dining experience had been raised previously and there had been no evidence of improvement since the last inspection.

Three requirements and three recommendations have been made in this domain.

Is care compassionate?

There was evidence of staff speaking to and responding to patients in a friendly and sensitive manner. A recommendation has been made however, that the negative comments made by relatives during the inspection are fully investigated by management, and actioned as required. Compliance with this recommendation will further drive improvements in this domain.

One recommendation has been made in this domain.

Is the service well led?

Despite matters relating to the staffing arrangements for the home and the patients dining experience being raised previously, this inspection was unable to evidence positive outcomes for patients. Three requirements have been made. Concerns were in evidence regarding the governance arrangements and the leadership of the home.

Following the inspection, senior management in RQIA agreed that the registered persons would be required to attend a meeting in the Authority, with the intention of issuing three failure to comply notices in regards to staffing arrangements and the deployment of staff , governance and management arrangements and the health and welfare of patients. This meeting was held on 25 October 2016. The registered person; Nadarajah Logan Logeswaran was unable to attend the meeting and nominated the Northern Ireland Operational Director, John Rafferty, to attend on his behalf.

During the meeting Mr Rafferty acknowledged the failings of Dunmurry Manor and discussed actions that had and would be taken to address the identified concerns. It was acknowledged that whilst work was ongoing to address these concerns, RQIA were not fully assured that these had been sufficiently embedded into practice. Given the potentially serious impact on patient care it was confirmed that breaches in The Nursing Homes Regulations (Northern Ireland) 2005 had occurred and therefore three failure to comply notices under Regulation 10 (1) in relation to governance arrangements, Regulation 12 (1) (a) and (b) in relation to the health and welfare of patients and Regulation 20 (1) (a) and (c) (i), in relation to staffing arrangements and the deployment of staff would be issued.

Further inspection will be undertaken to validate that compliance has been achieved and sustained.

The term 'patients' is used to describe those living in Dunmurry Manor which provides both nursing and residential care

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	12*	6**

*Refers to a requirement and recommendation stated for the second time
**Refers to recommendations carried forward for review

Details of the Quality Improvement Plan (QIP) within this report were discussed with John Rafferty, Northern Ireland Operational Director, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action resulted from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 7 September 2016. Enforcement action was not required following this inspection.

The findings of the care inspection evidenced that concerns in respect of medicines management continue in the home. The medicines management team within RQIA have been informed of the findings of the inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection. Refer to sections 4.3 and 4.6 for further information regarding safeguarding issues.

2.0 Service details

Registered organisation/registered person: Runwood Homes Ltd Nadarajah Logan Logeswaran	**Registered manager:** Joanne Cairns, Deputy Manager Jill Finlay newly appointed Home Manager from 24 October 2016
Person in charge of the home at the time of inspection: Joanne Cairns Jill Finlay in charge from 24 October 2016	**Date manager registered:** Jill Finlay application pending
Categories of care: RC-DE, NH-DE	**Number of registered places:** 76

3.0 Methods/processes

Prior to inspection we analysed the following information:

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

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector met with approximately 15 patients both individually and in groups, two registered nurses, two care staff and five resident's visitors/representative. During the inspection of 24 October we spoke with a number of residents and met with two care staff, 3 ancillary staff, the dementia services manager and the manager and deputy manager.

Questionnaires for patients (8), relatives (10) and staff (10) to complete and return were left for the deputy manager to distribute. Please refer to section 4.5 for further comment.

The following were examined during the inspection:

- validation evidence linked to the previous QIP
- staff roster
- staff induction records
- staff recruitment records
- adult safeguarding records
- complaints records
- incident and accident records
- records of quality audits and
- records of staff, patient and relatives meetings
- patient care records
- supplementary nursing care records

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 7 September 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector.

The findings of this care inspection evidenced that concerns in respect of medicines management continue in the home. The medicines management team within RQIA have been informed of the findings of the inspection of 17 and 18 October 2016.

4.2 Review of requirements and recommendations from the last care inspection dated 22 June 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 20 (1) (a) **Stated:** First time **To be completed by:** 31 July 2016	The registered provider must ensure that the dependency levels of patients is kept under regular review to ensure that the numbers and skill mix of staff deployed is appropriate to meet the needs of the patients.	**Not Met**
	Action taken as confirmed during the inspection: The review of the staff rota and observation of the delivery of care evidenced that the staffing arrangements and the deployment of staff had not improved from the previous inspection. Evidence was not present on the duty rota of consistency regarding the numbers of staff on duty and the skill mix of staff, was not in accordance with the DHSSPS Care Standards for Nursing Homes 2015. The impact of the staffing arrangements on the delivery of care was observed throughout the inspection with call bells not being responded to in a timely manner, morning medications being dispensed at 12.00 and patients remaining in the dining room for extended periods of time. Refer to section 4.3 for further detail. **This requirement is stated for a second time and is subsumed into enforcement action.**	

Requirement 2 **Ref:** Regulation 9 Schedule 2 (5) **Stated:** First time **To be completed by:** 31 July 2016	The registered provider must detail and have documentary evidence of the registration of staff with the appropriate professional regulatory body. A robust system for the monitoring of the registration of staff must be in place and be regularly reviewed. **Action taken as confirmed during the inspection**: A review of the system in place to monitor the registration status of staff with their professional bodies was reviewed. The review evidenced that a more structured process was operational and the information viewed was current and up to date.	**Met**
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 39 **Stated:** First time	The registered provider should ensure that the induction training record of any staff member evidences the signature of both the inductee and inductor and that the manager has signed the record to validate the completion of the induction training. **Action taken as confirmed during the inspection**: Three staff personnel records were reviewed. Evidence was present within one of the three files of a completed induction training programme. The deputy manager stated that as the remaining two staff members had recently started and were still in completing induction their records were not retained in their file. The deputy manager stated staff retains their induction training record until induction is complete. A more robust process for monitoring the induction training of staff should be introduced and evidenced. **This recommendation is stated for a second time.**	**Partially Met**

Recommendation 2 **Ref:** Standard 5.3 **Stated:** First time	The registered provider should ensure that the rationale for the locking of the front door is included in the Statement of Purpose. A review of the entrance area into the residential unit should be completed, using best practice dementia guidelines, to ensure the area is designed and managed to promote the wellbeing of persons with dementia.	**Not Reviewed**
	Action taken as confirmed during the inspection: This recommendation was not reviewed during this inspection due to concerns identified during inspection, and will be assessed at the next inspection.	
Recommendation 3 **Ref:** Standard 43.11 **Stated:** First time	The registered provider should ensure the environmental issues, for example; the provision of shelving in storage areas and the upkeep of the garden, are addressed.	**Not Reviewed**
	Action taken as confirmed during the inspection: This recommendation was not reviewed during this inspection due to concerns identified during inspection, and will be assessed at the next inspection.	
Recommendation 4 **Ref:** Standard 12.21 and 12.22 **Stated:** First time	The registered provider should ensure that the patients' dining experience, as discussed, and including a review of the serving of meals, is addressed.	**Not Met**
	Action taken as confirmed during the inspection: We observed the serving of the midday meal. The patients dining experience had not improved and areas for improvement which had previously been discussed and recommended had not been implemented. Refer to section 4.4 for further detail. **This recommendation has become a requirement of this report and is subsumed into enforcement action.**	

Recommendation 5 **Ref:** Standard 6.14 **Stated:** First time	The registered provider should ensure that patients' personal care and grooming needs are regularly assessed and met and patients are dressed appropriately.	**Met**
	Action taken as confirmed during the inspection: The personal care needs of patients were observed to have been met. Patients appeared well dressed and their clothing was appropriate to age, gender and the time of the year.	

4.3 Is care safe?

The deputy manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 25 September 2016 to 8 October 2016 did not evidence that the staffing arrangements in place, ensured that safe and effective care was being delivered due to insufficient staffing levels, skill mix, competency, and the experience of staff on duty. On the 17 October 2016 there were two registered nurses and seven care assistants on duty, four of whom were agency staff and not permanent staff of the home. During the week preceding the inspection, it was evidenced that the staffing complement varied significantly between four to six care staff on duty. The minimum skill mix of 35% registered nurses and 65% care assistants had not been maintained in accordance with DHSSPS Care Standards for Nursing Homes 2015. As a requirement of the previous inspection report of 22 to 24 June 2016 the registered provider was to ensure that the numbers of and skill mix of staff deployed met the needs of the patients. The inconsistency of the staffing arrangements meant that staff were unable to provide care in an efficient manner and this had the potential to place patients at risk of harm.

Discussion with staff and observation of the delivery of care evidenced that patients' needs were not being met. We observed that staff did not respond in a timely manner to patients' call bells. The call bell in an identified patient's room was observed to be continually sounding for a period of 30 minutes without staff responding. We observed that the dining experience for patients was not managed in keeping with dementia best practice guidelines. There was a lack of supervision of patients in the dining rooms; patients were observed to be left sitting in the dining room until 11.30 hours after breakfast and until 14.40 hours, after serving of the midday meal. The mid-morning snack service only commenced at 12.00 hours. A requirement regarding the staffing arrangements and the deployment of staff is stated for the second time.

We observed that on both days of the inspection in the nursing unit, patients were receiving their morning medications between 11.45 and 12.00 hours.

In discussion with the registered nurse who was administering the medications, it was stated that the reason for this delay in administration was due to the overall dependency of patients. The registered nurse stated that it could take a significant period of time to ensure each patient took their medication, and that there were a number of other factors including responding to and making telephone calls, and responding to queries from care staff regarding patient care. The registered nurse also stated that the locking mechanism of both the medicine trolleys was faulty.

A review of these patients' medication records evidenced that medications were administered at 10.00 when they were not administered up until 12.00. A requirement is made that medications are accurately recorded at the correct time of administration. This matter was referred to and discussed with the medicines management team of RQIA. It is also required that the registered person must review the deployment of staff in regard to the morning routine in the home, to ensure the needs of patients are met in a timely way.

In discussion with a relative a number of concerns were raised regarding the care and wellbeing of their family member. The relative stated that the concerns had been forwarded to the Adult Safeguarding team of the health and social care trust by a trust representative. It was further concerning that the issues raised regarding the patient's care had been previously identified in other safeguarding investigations and identified areas of learning, had not been embedded into practice by the staff team. A requirement is stated that a system to ensure the learning from any safeguarding investigation is transferred to staff, embedded into practice and monitored by the manager. Further discussion regarding care practice and the governance arrangements in respect of safeguarding investigations are detailed in sections 4.4 and 4.6.

Review of two patient care records evidenced that a range of validated risk assessments were to be completed as part of the admission process; these were subsequently reviewed and evidence was not present of a consistent and accurate approach to the completion of risk assessments. There was minimal evidence that risk assessments informed the care planning process.

The management of pain was discussed with registered nurses who stated that they assessed the level of pain by patients' by their facial expression. There was a lack of evidence that registered nurses were using a pain assessment tool to effectively and consistently assess pain management or that staff reviewed and monitored the effectiveness of analgesia prescribed to patients.

Staff training records were not reviewed during the inspection. However, the observation of care, discussion with relatives and the review of records did not evidence that staff were appropriately trained and competent to meet the needs of the patients. Staff competency deficits were evidenced in the following areas: the management of distressed reactions; dementia awareness and the dining experience; prevention and management of pressure ulcers and pressure relieving equipment; the management of pain, and the use of pain assessment tools. A requirement has been made.

It was not possible to complete a review of records pertaining to accidents, incidents and notifications forwarded to RQIA as the information could either not be located by the deputy manager or the system in operation for the recording of, and monitoring of accidents and incidents did not enable an accurate review to take place. The Northern Ireland Operational Director, Runwood Care Homes, John Rafferty, was informed of the inadequate governance arrangements in place regarding accidents and incidents and a requirement has been made.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, the dining room and storage areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. However, a relative expressed concern regarding the flooring in their relative's ensuite facility stating that despite bringing this to the attention of management on a number of occasions, no action had been taken. The Northern Ireland Operational Director, Runwood Care Homes, John Rafferty agreed to progress this issue.

An anonymous complaint was received into RQIA regarding environmental aspects of the home. Concerns were raised in respect of fluctuating hot water temperatures, poor water pressure in bathrooms and showers, monitoring of legionella and that there was no maintenance personnel working in the home. The information received was discussed with the senior inspector, for nursing homes team and the senior inspector, estates team and it was agreed that an estates inspection of the home to review the issues raised would be undertaken. The inspection took place on 24 October 2016 and a separate report in respect of the findings of the estates inspection will be issued.

Areas for improvement

The registered person must ensure that the staffing arrangements for the home reflect that the numbers, skill mix, competency, and the experience of staff on duty are sufficient to meet the needs of the patients. The registered persons must review the morning routine to ensure that there is evidence of management oversight and leadership, regarding the deployment of staff and delegation of duties, to ensure that safe and effective care is being delivered.

The registered persons must ensure that the correct times medications are administrated are stated on the medication records.

The registered person must ensure that any learning identified from adult safeguarding investigations undertaken in relation to the home, are cascaded to the staff team.

The registered person must ensure that the assessment of patients' needs is fully completed and evidence of regular review is present. The assessment of need must include a pain management assessment.

The registered person must ensure that staff are trained and competent in the following areas; the management of distressed reactions; dementia awareness and the dining experience; prevention and management of pressure ulcers and pressure relieving equipment; the management of pain, and the use of pain assessment tools.

The registered person must ensure that systems are established to accurately record and monitor any accident or incident which may occur in the home.

Number of requirements	6	**Number of recommendations**	0

4.4 Is care effective?

As discussed in section 4.3 the review of two patient care records did not evidence that a range of validated risk assessments were accurately and consistently completed as part of the admission process and were subsequently reviewed as required. There was evidence that some risk assessments informed the care planning process. However as previously stated in section 4.3, there should be pain assessments in place for all patients requiring regular or occasional analgesia and evidence of pain assessment being undertaken on a regular basis, to ensure the patient's pain was effectively controlled.

Care records were identified as requiring improvements and they were not sufficiently detailed to reflect the needs of patients.

The following issues were identified in the named care records provided to the deputy manager and the Northern Ireland Operational Director. One care record had been updated to respond to and support a patient's condition. However, information within the care record evidenced that the advice provided by the clinical nurse facilitator from the local healthcare trust was not being adhered to; regarding repositioning records and pressure relieving advice and equipment. A care plan was present however; it was unclear how often the wound was to be dressed, leading to varying and at times lengthy periods between wound care. There was no photograph of the wound present.

One care record did not evidence that the management of distressed reactions displayed by a patient was appropriately managed. A care plan to assist staff in supporting the patient had been written however, there was no evidence that the care plan had been reviewed and evaluated from the time of writing. The review of the patient's daily progress records did not evidence that care interventions, as stated in the care plan were being implemented. We observed that staff were not responding to the patient's distressed reaction in a timely manner.

Improvements are required to ensure that care records are updated in keeping with legislative requirements, best practice and professional guidelines.

There was no evidence that the care planning process included input from patients and/or their representatives, where appropriate and a recommendation has been made. There was evidence of communication with representatives within the care records.

We observed the serving of the midday meal in the nursing unit. It was concerning to observe there had been no improvement in the arrangements of the dining experience for patients as recommended at the previous inspection of 22 to 24 June 2016. We observed that patients were seated in both dining rooms at 13.00. One heated trolley serviced both dining rooms, and service commenced in the first dining room and only when completed was the heated trolley moved to commence the meal service in the second dining room. This arrangement resulted in patients in the second dining room waiting for approximately 35 minutes before their meal was served and still being seated in the dining room at 14.40 hours.

A registered nurse was not present in the dining rooms to direct, supervise and monitor the nutritional needs of patients. There was no record of patients' meal choice available and the day's menu was not displayed for patients' information. Staff did ask patients their preferred choice of meal however this should have been supported by a visual choice, as far as possible. Patients' meals were served on cold plates. In one dining room dining plates were observed to be 'stacked' on the draining board of the sink unit prior to service and the sink was observed to have a number of used and unwashed crockery and equipment. This was not hygienic.

Mealtime arrangements in the residential unit were assessed during the inspection of 24 October 2016. The serving of the midday meal was observed and this was a positive experience for patients. Dining tables were appropriately set and patients were offered a choice of meal and their preferred drink. As with the nursing unit the day's menu was not displayed in a suitable format and patients were served hot meals on cold plates.

It had previously been recommended that an audit of the patients dining experience should be completed. We were informed this had been undertaken by the organisation's dementia services manager. The audits however, were not available on request at the inspection. Two requirements and one recommendation have been made regarding mealtime arrangements.

Areas for improvement

The registered person must ensure that the written nursing plan of any patient is in accordance with the assessed need of patients and kept under review.

The registered person must ensure that the dining experience for patients is reviewed and enhanced in accordance with best practice in dementia care guidelines.

The registered person must ensure that a record of foods provided to patients is maintained in sufficient detail to determine the adequacy of nutrition for patients.

The registered person must ensure that any recommendation made by other professionals is strictly adhered to.

The registered person must ensure that patients or their representatives are consulted in relation to the planning of care.

The registered person must ensure that the day's menu is clearly displayed and in a format suitable to the needs of the patients

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

4.5 Is care compassionate?

Staff interactions with patients were observed to be caring. Staff were observed speaking to patients in a friendly and sensitive manner and an improvement in the appearance of patients was observed. A relative raised concerns in respect of the level of personal care afforded to their relative and stated that at times, family had to provide additional personal support and care to their relative. The staffing arrangements and deployment of staff as observed during the inspection had a negative impact on the delivery of compassionate care experienced by patients. This included, as previously stated, patient's left sitting in the dining room for an inappropriately prolonged period after breakfast and lunch had concluded. The mid-morning tea and coffee service did not commence until 12.00 hours and the administration of morning medicines was only completing at 12.00 hours.

On this occasion the activities in the home were not fully assessed. The arrangements for the provision of activities had improved and a full and part time activities coordinator had been appointed. The activities coordinator was very enthusiastic regarding their role and had recently introduced various activities not previously available in the home, for example 'come dine with me.' Activities will be reviewed during future inspections.

During the inspection, we met with six patients on an individual basis, two care staff, two registered nurses and five patients' representatives. Some comments received are detailed below:

'The care is very good here.' (from staff member)

'All day I press (call bell) and no-one comes.' (from a patient)

Relatives expressed concerns regarding: the high turnover of managers, the high turnover of staff and high usage of agency staff, poor communication to families, standards of care had fallen, some environmental issues and the administration of medications. The Northern Ireland Operational Director, John Rafferty was informed of the nature of the concerns brought to our attention.

In addition to speaking with patients, relatives and staff, RQIA provided questionnaires. At the time of writing this report one relative completed and retuned a questionnaire. No staff questionnaires were returned. Comments received from a relative were very negative in respect of the management of incontinence, the availability of medication, the management of personal hygiene and the registered provider's response to complaints.

The manager and the Operational Director should record the issues raised as an expression of dissatisfaction and develop an action plan to address the issues raised.

Areas for improvement

The manager and Operational Director should manage concerns detailed in this section, as raised by relatives, as an expression of dissatisfaction and develop an action plan to address the issues. A requirement has been made regarding the management of complaints in this report and the requirement forms part of the Failure to Comply with regulations notice.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

The monthly quality monitoring reports in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 were requested. The reports of July to September 2016 were requested and the July and September reports were made available. The report of August 2016 was not available for review. We were unable therefore to assess the robustness of the process and whether any actions identified as a result of the monthly quality monitoring visit had been completed. The monthly quality monitoring reports are required to be retained in the home and made available, on request, for inspection or for review by patients, patient representatives or other professionals from health and social care trusts. A requirement has been made.

A review of the home's complaints record did not evidence that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Records were not maintained of all complaints and evidence was lacking in respect of communication with the complainant, the result of any investigation and action taken and if the complainant was satisfied with the outcome. Discussion with relatives and comments received from a relative via a returned questionnaire did not evidence that relatives had confidence that their complaint was acknowledged, investigated and the outcome of an investigation, if any, was communicated. A requirement has been made.

A review of records regarding the management of adult safeguarding concerns and referrals, did not evidence that a system had been implemented to record and identify the nature of the safeguarding referral, the result of any investigation and action taken as a result and the learning outcomes for the home and staff team. This was concerning as there had been a number of recent safeguarding investigations in respect of the home, led by the health and social care trust, and evidence should have been present of the cascading of the learning from investigations to the staff team and that good practice was embedded into practice. A requirement has been made, refer to section 4.3.

Discussion with the deputy manager and review of records evidenced that robust systems to monitor and report on the quality of nursing and other services provided were not in place. For example, audits were completed in relation to care records however the audits viewed were incomplete and of no intrinsic value to the monitoring of the standard of care planning and care documentation, similarly with the auditing of incidents and accidents. Completed audits should evidence that they had been analysed or that the appropriate actions had been taken to address any shortfalls identified. There was no evidence that the necessary improvements had been embedded into practice. A requirement has been made.

The concerns were raised with John Rafferty, Northern Ireland Operational Director regarding the overall management of the home and the leadership arrangements. Concerns were raised regarding the management arrangements of the home and that temporary or acting managers did not have sufficient time and management oversight of the daily management of patient's care and as a result staff deployment arrangements were not in keeping with the delivery of safe, effective and compassionate care.

There was a lack of evidence of robust governance/management and leadership arrangements to ensure the safe and effective delivery of care to patients. As previously stated there were concerns raised about the quality of audits, staffing arrangements and the delegation of duties to ensure that safe and effective care was being delivered. There was also a lack of evidence that the care planning process was accurate and reliable and that the recommendations of other health care professionals were adhered to at all times.

The Northern Ireland Operational Director confirmed the appointment of the new home manager Jill Finlay who commenced employment on 24 October 2016. Mr Rafferty gave an assurance that this manager will drive the required improvements as identified during the inspection.

Areas for improvement

The registered person must ensure that the monthly quality monitoring reports completed in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. are available in the home and that the reports clearly identify any areas for improvement and that the subsequent remedial action taken.

The registered person must ensure that any complaint received by the home is recorded, investigated and the complainant informed of the outcome of the investigation. Any complaint received must be investigated in accordance with Regulation 24, the Nursing Homes Regulations (Northern Ireland) 2005.

The registered person must implement a robust system to review the quality of nursing and other services provided by the home.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with John Rafferty, Northern Ireland Operational Director, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 20 (1) (a) **Stated:** Second time **To be completed by:** 30 November 2016	The registered provider must ensure that the dependency levels of patients is kept under regular review to ensure that the numbers and skill mix of staff deployed is appropriate to meet the needs of the patients. **This requirement forms part of the Failure to Comply with regulations notice.** **Ref section 4.3**
	Response by registered provider detailing the actions taken: The Rhys Hearn tool has been updated and will be constantly reviewed as and when occupancy is altered. A new staffing structure has been implemented to mirror dependency levels and accommodate residents needs.
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate	The registered persons must ensure that the correct times medications are administrated are stated on the medication records. **This requirement forms part of the Failure to Comply with regulations notice.** **Ref: section 4.3**
	Response by registered provider detailing the actions taken: Medication records have been audited and cross checked in line with prescription and Kardex documents. This process will be continuous if and when amendements to the residents medications are made.
Requirement 3 **Ref:** Regulation 14 (4) **Stated:** First time **To be completed by:** 30 November 2016	The registered person must ensure that any adult protection (safeguarding) investigation undertaken in relation to the home, is fully documented and any action to be taken and learning outcomes are cascaded to the staff team. **This requirement forms part of the Failure to Comply with regulations notice.** **Ref: section 4.3**
	Response by registered provider detailing the actions taken: The Health Trusts Adult Safeguarding Teams (AST) have been contacted to ascertain outstanding or live investigations. This process will be continuous until investigations are screend out or actioned. A new auditing system is currently operational to monitor and track investigations.

Requirement 4 **Ref:** Regulation 15 (2) **Stated:** First time **To be completed by:** 30 November 2016	The registered person shall ensure that the assessment of patients' needs is fully completed and evidence of regular review is present. **<u>Assessments of need must include a pain management assessment</u>.** **This requirement forms part of the Failure to Comply with regulations notice.** **Ref: Sections 4.3, 4.4**
	Response by registered provider detailing the actions taken: Patients care plans are currently under review. A new electronic documentation system is to be implemented in the near future which will assist health professionals methodically streamline documentation and audit care records.
Requirement 5 **Ref:** Regulation 20 (1) (c) (i) **Stated:** First time **To be completed by:** 4 January 2017	The registered person must ensure that staff are trained and competent in the following areas; • the management of distressed reactions; • dementia awareness; • the dining experience; • prevention and management of pressure ulcers and pressure relieving equipment; and • the management of pain, and the use of pain assessment tools **This requirement forms part of the Failure to Comply with regulations notice**. **Ref: Sections 4.3, 4.4**
	Response by registered provider detailing the actions taken: Training is currently being organised and implemented by internal and external education and development specialists.
Requirement 6 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** 30 November 2016	The registered person must ensure that systems are established to accurately record and monitor any accident or incident which may occur in the home. **This requirement forms part of the Failure to Comply with regulations notice.** **Ref: sections 4.3 and 4.6**
	Response by registered provider detailing the actions taken: Accident and incidents are cross checked daily and an audit tool developed to assist root cause analysis.

Requirement 7 **Ref:** Regulation 15 (2) and 16 (2) **Stated:** First time **To be completed by:** 12 December 2016	The registered persons must ensure that patient care records are maintained with accuracy and contain a detailed and comprehensive assessment of need, appropriate risk assessments, detailed person centred care plans and appropriate regular reviews. Registered nurses must complete records in keeping with NMC guidance. **This requirement forms part of the Failure to Comply with regulations notice.** **Ref: section 4.4**
	Response by registered provider detailing the actions taken: Patients care plans are currently under review. A new electronic documentation system is to be implemented in the near future which will assist health professionals methodically streamline documentation and auditing of care records. This Requirement will be a focus in planned appraisal and supervisions for staff.
Requirement 8 **Ref:** Regulation 12 (1) (b) **Stated:** First time **To be completed by:** 30 November 2016	The registered person must ensure that the dining experience for patients is reviewed and enhanced in accordance with best practice in dementia care guidelines. **This requirement forms part of the Failure to Comply with regulations notice**. **Ref: section 4.4**
	Response by registered provider detailing the actions taken: An amended catering system has been developed and currently in pilot phase to ensure an optimun dining experience for all residents.
Requirement 9 **Ref:** Regulation 19 (2) Schedule 4, 13 **Stated:** First time **To be completed by:** 30 November 2016	The registered person must ensure that a record of food provided to patients is maintained in sufficient detail to determine whether the diet is satisfactory, in relation to nutrition and otherwise, and of any special diets prepared for individual patients. **Ref: section 4.4**
	Response by registered provider detailing the actions taken: Diet records have been updated and further developed to communicate the residents special needs and requirements to all staff involved in asssiting and supervising residents at meal times.

Requirement 10 **Ref:** Regulation 29 **Stated:** First time **To be completed by:** 30 November 2016	The registered person must ensure that the Regulation 29 monthly quality monitoring reports are available in the home and that the reports clearly identify any areas for improvement and the subsequent remedial action taken. **This requirement forms part of the Failure to Comply with regulations notice.** **Ref: section 4.6**
	Response by registered provider detailing the actions taken: Regulation 29 Reports are available for perusal and upon completion, agreed actions are signed and dated.
Requirement 11 **Ref:** Regulation 24 **Stated:** First time **To be completed by:** 30 November 2016	The registered person must ensure that any complaint received by the home is recorded, investigated and the complainant informed of the outcome of the investigation. Any complaint received must be investigated in accordance with Regulation 24, the Nursing Homes Regulations (Northern Ireland) 2005. **This requirement forms part of the Failure to Comply with regulations notice.** **Ref: sections 4.5 and 4.6**
	Response by registered provider detailing the actions taken: A new complaint protocol and audit tool to track outcomes of investigations has been developed and deployed across the nursing and residential units.This system is within the Groups Policy and Procedure guidelines for making and dealing with complaints either formal or informal.
Requirement 12 **Ref:** Regulation 17 (1) **Stated:** First time **To be completed by:** 30 November 2016	The registered person must implement a robust system to review the quality of nursing and other services provided by the home. Audits should be present of the review of: • nursing care records • accidents and incidents • complaints management • adult safeguarding referrals and investigations **This requirement forms part of the Failure to Comply with regulations notice.** **Ref: section 4.6**
	Response by registered provider detailing the actions taken: Audits of this Requirement are available for perusal. Audits are to highlight areas for improvement, set an action plan and evidence when the outcome has been achieved.

Recommendations	
Recommendation 1 **Ref**: Standard 39 **Stated:** Second time **To be completed by:** 30 November 2016	The registered provider should ensure that the induction training record of any staff member evidences the signature of both the inductee and inductor and that the manager has signed the record to validate the completion of the induction training. **Ref: section 4.1**
	Response by registered provider detailing the actions taken: New staff are to be asigned a mentor to assist and support induction in the infancy of their employment.
Recommendation 2 **Ref**: Standard 4.4 **Stated:** First time **To be completed by:** Immediate	The registered person should ensure that any recommendation made by other professionals is strictly adhered to. **Ref: section 4.4**
	Response by registered provider detailing the actions taken: Feedback, advice and support from all visiting professionals is to be adhered to and evidence of agreed actions are to be promptly relayed and communicated to all stakeholders.
Recommendation 3 **Ref**: Standard 4.5 **Stated:** First time **To be completed by:** 30 November 2016	The registered person should ensure that patients or their representatives are consulted in relation to the planning of care. **Ref: section 4.4**
	Response by registered provider detailing the actions taken: Future care plans are to be signed off when agreed by the resident (when possible), relative, care manager and a senior member of the nursing team.
Recommendation 4 **Ref**: Standard 12 **Stated:** First time **To be completed by:** Immediate	The registered person should ensure that the day's menu is clearly displayed and in a format suitable to the needs of the patients **Ref: section 4.4**
	Response by registered provider detailing the actions taken: A new user friendly menu board has been purchased and displayed. Daily menus are clearly displayed on the tables within the dining rooms.

Recommendation 5 **Ref**: Standard 43.11 **Stated:** First time **To be completed by:** Immediate	The registered provider should ensure the environmental issues, for example; the provision of shelving in storage areas and the upkeep of the garden, are addressed. **Ref: Carried forward from the previous inspection report**
	Response by registered provider detailing the actions taken: A new maintenance manager has commenced post and currently addressing all environmental issues that require attention.
Recommendation 6 **Ref**: Standard 5.3 **Stated:** First time **To be completed by:** Immediate	The registered provider should ensure that the rationale for the locking of the front door is included in the Statement of Purpose. A review of the entrance area into the residential unit should be completed, using best practice dementia guidelines, to ensure the area is designed and managed to promote the wellbeing of persons with dementia. **Ref: Carried forward from the previous inspection report**
	Response by registered provider detailing the actions taken: Statement of Purpose has been amended to meet Recommendation. The reception area to the residential unit is currently under review.

Please ensure this document is completed in full and returned to web portal

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