Unannounced Care Inspection Report
18 May 2016

Fruithill Nursing Home

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Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Fruithill Nursing Home took place on 18 May 2016 from 10.00 to 15.15 hours. The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

Staff, patients' and patients' representatives commented that they felt the care provided in the home was safe. Recruitment and selection processes were in place and ensured that all employees were registered with the relevant professional bodies prior to employment; and enhanced criminal checks had also been completed. Staff received an induction period, which ensured that they had the basic knowledge needed to begin work. Staffing levels were subject to regular review and our observations on the day of inspection were that patients' needs were being met in a timely and unhurried manner. Staff training was up to date and those consulted with were knowledgeable regarding their roles and responsibilities in regards to adult safeguarding. Patients' accident/incidents were managed appropriately. However, a deficit was identified, specifically in relation to the provision of regular supervision and appraisal to staff. A recommendation has been made in this regard. Compliance with this recommendation will further drive improvement in this domain.

Is care effective?

Communication was well maintained in the home and all staff consulted confirmed that there was good teamwork in the home, which enabled the patients' needs to be met more effectively. Although there had not been regular staff, patients or relatives meetings, all those consulted with were aware of how to raise concerns, should they need to. However, a review of patients care records identified areas that required improvement. As such, one requirement has been made in regards to the completion of separate risk assessments for patients who require the use of a lap-belt. Two recommendations have been made in relation to the completion of care plans for patients who have 'do not attempt resuscitation' (DNAR) directives in place; and in relation to the completion of patients' risk assessments and care plans, within the recommended period, following admission.

Is care compassionate?

Staff interactions were observed to be compassionate, caring and timely. Patients consulted with confirmed that patients were treated with respect and dignity and were afforded choice in regards to what they ate, the clothing they wore or where they wanted to spend their day. There was a range of activities available for patients to choose from and there was a very welcoming atmosphere in the home, towards visitors. Staff, patients and patients' representatives commented positively regarding the care in the home and some comments have been included in the report. Comments from a lay assessor have also been included in the report. There was evidence that the patients were happy living in the home.

Is the service well led?

There was a clear organisational structure in place and the home was operating within the categories of care, for which the home is registered. Discussion took place with the responsible person in regards to the appointment of a permanent manager. RQIA had been

notified appropriately of all relevant incidents; and there was evidence that any complaints had been managed appropriately. Comments from staff, patients and patients' representatives indicated that they felt that the home was well-led; however, a requirement has been stated to ensure that an annual quality report is completed. Two recommendations have also been stated in regards to further developments that are required in the auditing process of patients' falls; and in the auditing process of patients' care records.

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 DHSS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	*2	*6

The total number of requirements and recommendations above includes one recommendation that was not met and has been made for the second time.

Details of the QIP within this report were discussed with the acting manager and responsible person, as part of the inspection process. The timescales for completion commence from the date of inspection. Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 18 August 2015. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection. There were no areas that required to be followed up in this inspection.

2.0 Service details

Registered organisation/registered person: Orla Frances Sheehan	**Registered manager:** Martina Kearney (Acting)
Person in charge of the home at the time of inspection: Martina Kearney	**Date manager registered:** Application not submitted
Categories of care: NH-LD, NH-I, NH-PH, NH-PH(E), NH-TI There shall be a maximum of two patients accommodated in category NH-LD. The home is approved to provide care on a day basis only to 2 persons.	**Number of registered places:** 35

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

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

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with four patients, four care staff, two nursing staff and four patient's representatives. The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- staff training records
- accident and incident records
- audits
- records relating to adults safeguarding
- complaints records
- recruitment and selection records
- policies and procedures
- NMC and NISCC registration records
- staff induction, supervision and appraisal records
- staff, patients' and patients' representative questionnaires
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 18 August 2015

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 18 August 2015

		Validation of compliance
Requirement 1 **Ref**: Regulation 13.7 **Stated:** Second time	The registered person must ensure that: • the fridge in the dining room is kept clean • commode buckets in the sluices are stored off the floor	**Met**
	Action taken as confirmed during the inspection: We observed the dining room fridge and sluice rooms to be clean and well maintained.	
Requirement 2 **Ref**: Regulation 16 (2) (b) **Stated:** First time	The patient's care plan must be kept under review in relation to wound care. The care plan must reflect the current dressing in use. The wound must be reassessed at each dressing change and this assessment documented in accordance with best practice guidelines.	**Met**
	Action taken as confirmed during the inspection: There were no wounds that required treatment, on the day of inspection. However, discussion with registered nurses confirmed that they were aware of the process to assess wounds at each dressing change.	

Requirement 3 **Ref**: Regulation 13 (4) (b) **Stated:** First time	Prescribed thickening agent should be labelled and only be administered to the patient for whom it is prescribed.	**Met**
	Action taken as confirmed during the inspection: We did not observe prescribed thickening agents being used for patients, other than for those, for whom it had been prescribed.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 26 **Stated:** Second time	The registered person must ensure that policies and procedures in relation to continence management are reviewed in line with current best practice as defined by professional bodies and national standard setting organisations.	**Met**
	Action taken as confirmed during the inspection: A review of the policies and procedures in relation to continence management evidenced that they had been reviewed in line with best practice.	
Recommendation 2 **Ref**: Standard 19 **Stated:** First time	It is recommended that a policy on communicating sensitively / delivering bad news be developed and made available to staff with reference to best practice guidelines.	**Met**
	Action taken as confirmed during the inspection: A policy on communicating sensitively/delivering bad news had been developed in line with best practice.	
Recommendation 3 **Ref**: Standard 20 **Stated:** First time	The policy for dying and death should be updated to reflect current best practice guidelines and this shared with staff.	**Not Met**
	Action taken as confirmed during the inspection: An end of life care policy was available. Although the responsible person provided assurance that this had been reviewed following the last inspection, the updated policy was not available for inspection. **This recommendation was not met and has been stated for the second time.**	

Recommendation 4 **Ref**: Standard 20 **Stated:** First time	Staff should update their knowledge of palliative and end of life care by training or other means in accordance with the statement of purpose and the needs of the patients.	**Met**
	Action taken as confirmed during the inspection: There was evidence that a palliative care and end of life care folder had been complied, which included best practice guidance documents. There was evidence that staff had reviewed the information in the folder.	
Recommendation 5 **Ref**: Standard 41 **Stated:** First time	The off duty rota should be kept up to date and clearly reflect the staff who worked over each 24 hour period and the capacity in which they worked.	**Met**
	Action taken as confirmed during the inspection: The duty roster was reviewed and there was evidence that the clinical hours worked by the manager, were identified separately from the office hours worked.	
Recommendation 6 **Ref**: Standard 44 **Stated:** First time	A variation application should be submitted to RQIA in relation to the change of the use of a store room to a laundry room.	**Met**
	Action taken as confirmed during the inspection: An application had been submitted in regards to the changes to the identified storeroom.	
Recommendation 7 **Ref**: Standard 46 **Stated:** First time	Regular audits of the environment and infection control practices should be undertaken and actions taken as appropriate, to ensure compliance with best practice in infection prevention and control.	**Met**
	Action taken as confirmed during the inspection: Environmental/infection prevention and control audits had been conducted on a regular basis.	

4.3 Is care safe?

There were systems in place for the recruitment and selection of staff. Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. Where nurses and carers were employed, their pin numbers were checked with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), to ensure that they were suitable for employment; and these were checked on a regular basis to validate

their registration status. A review of recruitment records evidenced that enhanced criminal records checks were completed with AccessNI and a register was maintained which included the reference number and date received.

There was evidence that new staff completed an induction programme to ensure they developed their required knowledge to meet the patients' needs. Staff consulted confirmed that they received induction; and shadowed experienced staff until they felt confident to care for the patients unsupervised. This ensured that they had the basic knowledge needed to begin work. Although staff commented that they felt supported in their roles, there was no evidence that formal supervisions and appraisals had been completed to monitor staff performance or to ensure that staff received support and guidance. A recommendation has been made in this regard.
The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adults safeguarding. Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. Observation of the delivery of care evidenced that training had been embedded into practice.

The manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota commencing 9 May 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients and patients' representatives evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way. Two staff members commented that the dependency levels of patients were very high and that this placed them under pressure, meeting the patients' needs. This was discussed with the manager and there was evidence that a meeting had been recently held with staff, to address changes to the daily routine to address this.

Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were generally completed following each incident, care management and patients' representatives were notified appropriately. RQIA had also been notified.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction. Personal evacuation plans had been completed for each patient taking into account, their mobility and assistance level. These plans were reviewed monthly to ensure that they were up to date. This was for if the building needed to be evacuated in an emergency.

Areas for improvement

A system should be implemented to ensure that formal supervisions and appraisals are conducted, to monitor staff performance or to ensure that staff receive support and guidance. A recommendation has been made in this regard.

Number of requirements	0	Number of recommendations:	1

4.4 Is care effective?

The home used an electronic system for assessing, planning and recording patients' care needs. The admission process required a range of validated risk assessments to be completed and included where patients may require the use of a hoist or assistance with their mobility and their risk of falling; the use of bedrails and restraint, if appropriate; regular repositioning due to a risk of developing pressure damage and wound assessment, if appropriate; assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties.
Although the review of patients' care records evidenced that risk assessments had generally been completed, a number of deficits were identified. Bedrail risk assessments had been completed as appropriate and care plans had been developed to include their use. Two patients required a lap belt to be secured whilst seated in their chairs. A separate risk assessment had not been completed for the use of the lap belts, nor was this information included in the patients' moving and handling assessments or care plans. There was also no system in place to record when the lap belts had been released and repositioned. Signed consent forms were also not available for the use of bedrails or lap belts. A requirement has been made in this regard.

Two patients who had a 'do not attempt resuscitation' (DNAR) directive in place did not have care plans developed. A recommendation has been made in this regard.

One patient, who had been recently admitted to the home, had care plans developed, despite any risk assessments having been completed. When we raised this with the manager, the assessments were completed immediately on the day of the inspection. A recommendation has been made in this regard.

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

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

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and it provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective and confirmed that if they had any concerns, they could raise these with their line manager and/or the registered manager.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Discussion with the manager confirmed that formal staff', patients and relatives' meetings had not been held on a regular basis. Although there was evidence that one informal meeting had been recently held, to address the organisation of the working day, staff consulted and the manager agreed that meetings had not been held in some time. Discussion with the responsible person and a review of the monthly monitoring report in

accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005, evidenced that this was being addressed.

Relatives were also asked to comment regarding the safety of their relative in the home. Those spoken with expressed their confidence in raising concerns with the home's staff/management.

Areas for improvement

Separate risk assessments must be completed for the use of lap belts, and this information must be included in the patients' care plan, as appropriate. Records must also be available, in respect of signed consent forms and records of regular release and repositioning of restraint must be maintained. A requirement has been made in this regard.

Patients who have a 'do not attempt resuscitation' (DNAR) directive in place should have care plans developed, to include this information. A recommendation has been made in this regard.

A process should be implemented to monitor the development of patients risk assessments and care plans, to ensure that they are completed within five days of admission to the home. A recommendation has been made in this regard.

Number of requirements	**1**	**Number of recommendations**:	**2**

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with patients individually and with others in smaller groups, confirmed that they were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and their feedback had been listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day.

Menus were displayed clearly and were correct on the day of inspection. We observed the lunch time meal, which was served in the dining-room. The atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set with tablecloths; and specialist cutlery and plate guards were available to help patients who were able to maintain some level of independence as they ate their meal. Menus were available in pictorial format to help patients make a choice.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home and there was a range of activities provided each day, which patients could choose to attend. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. Patients consulted with stated that they knew how to use their call bells and stated that staff usually responded to their needs in a timely manner.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. One written comment provided, commended the staff for the compassion shown and stated that this was 'the most outstanding feature of the care provided at Fruithill'.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. All comments on the returned questionnaires were positive. Some comments received are detailed below:

Staff

'I am comfortable here. It is challenging in a good way and I get good job satisfaction'
'The level of care here is quite good'
'I have recommended this home several times. I am very much Fruithill-orientated'
'The care is good'

Patients

'I am well looked after and am happy with all the staff who look after me'.
'The staff are friendly and helpful'.
'I am very happy with the home and the staff'.
'I am very happy to be here'.
'I am happy that I am allowed to stay in my room'.

Patients' representatives

'It is very welcoming and I feel that my presence is very much valued here'.
'It is brilliant. The staff even give ice cream to (the patient's) grandchildren, when we visit'.
'We are very pleased. The staff are lovely and are very much on the ball'.
'Absolutely fabulous. I couldn't praise them enough. The level of service is unbelievable'.
'The care is very personal and (the staff) make me feel like part of the family'.

Lay assessor comments

Throughout the duration of the inspector there was a lay assessor present. The lay assessor spoke with patients and reviewed the home's environment. Feedback was provided by the lay assessor on their findings. Comments made during feedback were related to the staff's knowledge of patients' food preference; toileting arrangements for bed-bound patients during the night; and the provision of activities to patients who either could not or chose not, to partake in group activities. Two observations were also made in relation to the environment. These comments were communicated to the manager and to the responsible person, during feedback.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.6 Is the service well led?

One relative provided written comment regarding the numerous changes in management within the last five years. The manager had been in employment since December 2015 and had been managing the home in an 'acting' capacity and had not yet submitted an application to RQIA to be the registered manager. Following the inspection, the registration status of the current manager was discussed with the responsible person, who provided assurances, that plans were in place to recruit a permanent manager.

Discussion with the manager and observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. The manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis and staff confirmed that they had access to the policies and procedures. There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

Discussion with the manager and review of the home's complaints record evidenced 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. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the registered manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Staff, patients and patients' representatives, all commented that they felt that the home was well-led. One written comment received stated that there was a 'very open and transparent management environment' in place. Patients and their representatives stated that they felt that their views were always welcomed and questionnaires were available at the front entrance, which enable them to put their views forward. Questionnaires had been issued to patients and their representatives in July 2015, in regards to the quality of the food served in the home. However, there was no evidence that this information had been analysed and areas for improvement acted upon. There was also no evidence that an annual quality report had been completed for 2015, in accordance with Regulation 17, of The Nursing Homes Regulations (Northern Ireland) 2005. A requirement has been made in this regard.

Discussion with the manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, the manager outlined how the following audits were completed in accordance with best practice guidance:

- falls
- financial audit
- medicines management
- supplements audit
- infection prevention and control
- care records audit
- audit of deceased residents
- training
- NISCC registrations
- environment and equipment checks
- menu likes/dislikes
- complaints
- Audit of food quality and presentation
- diversional therapy audit

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. Audits of falls were not conducted on a regular basis. One audit was reviewed, which identified the falls which had occurred between 1 January 2016 and the day of the inspection. This audit had been generated from entries made in the electronic recording system and did not evidence all the incidents that had been recorded in the accident/incident report book. There was also no evidence of analysis in terms of identifying patterns or trends, and there was no evidence of action taken in response to identified deficits. As such, we were not assured of the effectiveness of the audit completed. A recommendation has been made in this regard.

One requirement and two recommendations have also been stated in regards to the effectiveness of the care provided. Refer to section 4.3 for further detail. A recommendation has also been made in this regard, to address the process of auditing patient care records.

Discussion with the manager and review of records evidenced that Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005, monitoring visits were completed in accordance with the regulations and/or care standards and copies of the reports were available for patients, their representatives, staff and trust representatives. The monthly monitoring report provided a comprehensive overview of areas that were meeting standards and areas where improvements were required.

Areas for improvement

An annual quality audit report must be completed, to ensure that the quality of nursing and other service provision is reviewed. This report must also provide for consultation with patients and their representatives. A requirement has been made in this regard.

The process for auditing patients' accidents/incidents should be further developed, to ensure that trends and patterns are identified, to ensure that appropriate action is taken to further reduce the risk of falls. An action plan should be developed, to ensure that action is taken in response to identified deficits. A recommendation has been made in this regard.

The process for auditing patients' care records should be further developed to include a review of the supplementary documentation, in addition to the patients' electronic care records. Records of key checks (audits) completed should be maintained and made available for inspection. A recommendation has been made in this regard.

Number of requirements	**1**	**Number of recommendations**:	**2**

5.0 Quality improvement plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the manager and responsible person as part of the inspection process. The timescales commence from the date of inspection.

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

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

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and 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 person/manager 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 person/manager 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 14 (5) **Stated:** First time **To be completed by:** 15 July 2016	The registered persons must ensure that separate risk assessments are completed for the use of lap belts, and this information must be included in the patients' care plan, as appropriate. Records must also be available, in respect of signed consent forms and records of regular release and repositioning of restraint must be maintained. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: Restraint consent forms are available for recording: type of restraint, reason for use, length of time used, for signature by resident/relative, doctor and staff nurse. A separate risk assessment tool is being developed to incorporate this information into computerised care plans.
Requirement 2 **Ref:** Regulation 17 (1) **Stated:** First time **To be completed by:** 15 July 2016	The registered persons must ensure that an annual quality audit report is completed, to ensure that the quality of nursing and other service provision is reviewed. This report must also provide for consultation with patients and their representatives. **Ref: Section 4.6**
	Response by registered person detailing the actions taken: The Quality Audit report is in progress.
Recommendations	
Recommendation 1 **Ref**: Standard 20 **Stated:** Second time **To be completed by:** 15 July 2016	The policy for dying and death should be updated to reflect current best practice guidelines and this shared with staff. **<u>This policy should be submitted to RQIA with the return of the QIP</u>** **Ref: Section 4.2**
	Response by registered person detailing the actions taken: The policy for death and dying was updated in November 2015. The policy has been updated again to include "care of a dying patient in a shared room". A copy of the policy is available for all staff in the nurses station. Leaflets and information to support staff and family members in care of the dying and death are available for circulation. A copy of the policy has been forwarded with this QIP, as requested.

Recommendation 2 **Ref**: Standard 40.2 **Stated:** First time **To be completed by:** 15 July 2016	The registered persons should ensure that a system is implemented to ensure that formal supervisions and appraisals are conducted, to monitor staff performance or to ensure that staff receive support and guidance. **Ref: Section 4.3**
	Response by registered person detailing the actions taken: Two new staff nurses are currently under one-to- one formal supervision by the Acting Manager. Staff appraisals for all staff are deferred to appointment of a Nurse Manager.
Recommendation 3 **Ref**: Standard 33.2 **Stated:** First time **To be completed by:** 15 July 2016	The registered persons should ensure that patients who have a 'do not attempt resuscitation' (DNAR) directive in place, have care plans developed, to include this information. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: All patients who have a DNAR directive in place, have care plans developed, accordingly.
Recommendation 4 **Ref**: Standard 4.1 **Stated:** First time **To be completed by:** 15 July 2016	The registered persons should ensure that a process is implemented to monitor the development of patients risk assessments and care plans, to ensure that they are completed within five days of admission to the home. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: Each patient receives a comprehensive assessment of care needs and an agreed plan of care within 5 days of admission. in the last 60 days, we have had 4 new admissions; , care plans for each patient, following risk assessment, have been completed within 5 days. The Home's Admission policy, now states that risk assessment and care plans are to be completed within 5 days of admission.

Recommendation 5 **Ref**: Standard 22.10 **Stated:** First time **To be completed by:** 15 July 2016	The registered persons should ensure that the process for auditing patients' accidents/incidents is further developed and conducted on a monthly basis, to ensure that trends and patterns are identified and appropriate action is taken, to further reduce the risk of falls. An action plan should be developed, to ensure that action is taken in response to identified deficits. **Ref: Section 4.6**
	Response by registered person detailing the actions taken: Each time a patient has a fall, the Acting Manager receives an email notification of it. Each incident is reviewed, at the time, to consider causative factors and reduce any risk(s) of a recurrence. falls data can be presented graphically to show: no. of falls in a given time, rate of falls per patient, time of day of falls etc, residents most at risk of falls. This helps inform better prevention strategies to minimise risk of falls.
Recommendation 6 **Ref**: Standard 35.4 **Stated:** First time **To be completed by:** 15 July 2016	The registered persons should ensure that a process for auditing patients' care records is further developed to include a review of the supplementary documentation, in addition to the patients' electronic care records. Records of key checks (audits) completed should be maintained and made available for inspection. **Ref: Section 4.6**
	Response by registered person detailing the actions taken: The computerised care system allows for auditing patient records to include supplementary documentation. Attachment of paper documentation as pdf files will be reviewed patient by patient until all supplementary documentation can be accessed via the electronic care record. The registered person and acting manager/sister-in charge receive a weekly report of key checks (audits) generated by the computerised care system. These are printed and cascaded to staff nurses and appropriate staff to address any deficits. Hard copies are signed that the weekly audit has been checked, and filed.

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address

The Regulation and Quality Improvement Authority

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