Unannounced Care Inspection Report
26 April 2018

Fruithill Nursing Home

Type of Service: Nursing Home
Address: 20 Fruithill Park, Andersonstown, Belfast BT11 8GD
Tel No: 028 9061 7717
Inspector: James Laverty

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 35 persons.

3.0 Service details

Organisation/Registered Provider: Ms Orla Frances Sheehan **Responsible Individuals:** Orla Frances Sheehan	**Registered manager:** Veronica Sousa
Person in charge at the time of inspection: Veronica Sousa	**Date manager registered:** 24 January 2017
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. LD – Learning disability. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of registered places:** 35 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.

4.0 Inspection summary

An unannounced inspection took place on 26 April 2018 from 09.10 to 18.30 hours.

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 Care Standards for Nursing Homes 2015.

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

Evidence of good practice was found in relation to monitoring the professional registration of staff and communication with the multiprofessional team.

Areas for improvement under regulation were identified in relation to the manager's working pattern, infection, prevention and control (IPC) practices, adherence to the Control of Substances Hazardous to Health (COSHH) regulations, fire safety, care records, complaints management, staff management and governance processes which focus on quality assurance and service delivery.

Areas for improvement under the standards were identified in relation to staff awareness regarding adult safeguarding, interior signage, communication with patients' relatives/representatives and staff supervision.

Patients said that they were well cared for and expressed confidence in the ability and willingness of staff to meet their care needs. No negative comments concerning nursing care or service delivery were expressed by patients during the inspection.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	10	4

Details of the Quality Improvement Plan (QIP) were discussed with Veronica Sousa, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection dated 12 December 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 12 December 2017. There were no further actions required to be taken following the most recent inspection. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents (SAI's), potential adult safeguarding issues and whistleblowing
- the previous care inspection report
- the returned QIP from the previous care inspection
- pre-inspection audit

During the inspection the inspector met with six patients, nine patients' relatives/representatives and five staff. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. Ten patients' questionnaires and 10 patients' relatives/representatives questionnaires were left for distribution.

A poster was also displayed for staff inviting them to provide feedback to RQIA directly.

A poster informing visitors to the home that an inspection was being conducted was also displayed.

The following records were examined during the inspection:

- staff duty rotas for the period 9 to 22 April 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records for the period 2017/18
- accident and incident records
- one staff recruitment and induction file
- minutes of staff and relatives' meetings
- seven patients' care records
- a selection of governance audits
- complaints records
- maintenance records
- adult safeguarding records
- notifiable incidents to RQIA
- personal emergency evacuation records
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

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

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 12 December 2017

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

6.2 Review of areas for improvement from the last care inspection dated 13 April 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 12 (b), **Stated:** First time	The registered provider must ensure that all wheelchairs which are being used within the home are fit for purpose at all times. This includes those wheelchairs which are designated for use in the event of a potential fire evacuation.	**Met**
	Action taken as confirmed during the inspection: Observation of the wheelchairs within the home confirmed that they were fit for purpose and included those wheelchairs which were designated for use in the event of a potential fire evacuation.	
Area for improvement 2 **Ref:** Regulation 13, (1) (a) (b) **Stated:** First time	The registered provider must ensure that barrier nursing precautions are clearly communicated to all members of staff and relevant third parties who may come into contact with the patient.	**Met**
	Action taken as confirmed during the inspection: Discussion with both the registered manager and nursing/care staff evidenced that an effective system was established and understood by staff in regards to barrier nursing patients. The registered manager advised that no patients required such interventions on the day of the inspection.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 46 **Stated:** First time	The registered provider should ensure that incontinence products are stored appropriately and that patient equipment such as toilet seats and commodes are effectively cleaned in keeping with best practice relating to IPC.	**Partially met**
	Action taken as confirmed during the inspection: Observation of the environment evidenced that toilet seats and commodes had been effectively cleaned. However, incontinence products were	

	stored inappropriately and not in keeping with best practice guidance. This is discussed further in section 6.4. This area for improvement has been partially met and has been subsumed into a new area for improvement under regulation.	
Area for improvement 2 **Ref:** Standard 43 **Stated:** First time	The registered provider should ensure that all patient bedrooms are kept in a good state of repair and that internal piping is appropriately covered.	**Met**
	Action taken as confirmed during the inspection: Observation of the environment confirmed that all patient bedrooms were kept in a good state of repair and that internal piping was appropriately covered.	
Area for improvement 3 **Ref:** Standard 21 **Stated:** First time	The registered provider should ensure that supplementary care records are completed contemporaneously and are consolidated at the end of any 24 hour period in keeping with best practice.	**Met**
	Action taken as confirmed during the inspection: Review of supplementary care records evidenced that they were completed contemporaneously and were consolidated at the end of any 24 hour period in keeping with best practice.	
Area for improvement 4 **Ref**: Standard 12 **Stated:** First time	The registered provider should ensure that the dining room is free from clutter and has adequate space to facilitate the needs of both patients and staff.	**Met**
	Action taken as confirmed during the inspection: Observation of the dining room confirmed that it was free from clutter and had adequate space to facilitate the needs of both patients and staff.	

Area for improvement 5 **Ref**: Standard 22 **Stated:** Second time	The registered provider 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.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and review of governance records confirmed that this area for improvement was satisfactorily met.	
Area for improvement 6 **Ref**: Standard 35 **Stated:** Second time	The registered provider 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.	**Partially met**
	Action taken as confirmed during the inspection: Review of governance records and discussion with the registered manager did evidence that a process for auditing patients' care records had been further developed to include a review of supplementary documentation. However, shortfalls were noted in relation to the effective auditing of patients' care records. This is discussed further in section 6.7. This area for improvement has been partially met and has been subsumed into a new area for improvement under regulation.	
Area for improvement 7 **Ref**: Standard 35 **Stated:** First time	The registered provider should develop and implement a robust maintenance audit to ensure the home delivers services effectively in accordance with legislative requirements, minimum standards and current best practice.	**Met**

	Action taken as confirmed during the inspection: Review of governance records and discussion with the registered manager/staff evidenced that a robust maintenance audit/process was in place and being used effectively.	
Area for improvement 8 **Ref:** Standard 39 **Stated:** First time	The registered provider should ensure that records relating to the competencies and capabilities of the nurse in charge are appropriately maintained.	**Met**
	Action taken as confirmed during the inspection: Review of governance records confirmed that records relating to the competencies and capabilities of the nurse in charge were appropriately maintained.	
Area for improvement 9 **Ref:** Standard 35 **Stated:** First time	The registered provider should ensure that a robust audit process is in place to ensure that all staff read and are familiar with updated/new policies thereby helping to ensure a consistent delivery of care.	**Met**
	Action taken as confirmed during the inspection: Review of governance records and discussion with the registered manager/staff confirmed that a robust audit process was in place to ensure that all staff read and were familiar with updated/new policies.	

6.3 Inspection findings

6.4 Is care safe?

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

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to a monthly review to ensure that the assessed needs of patients were met. Discussion with the registered manager also confirmed that contingency measures were in place to manage short notice sick leave when necessary. The registered manager advised that from 9 to 22 April 2018 there were five occasions when planned staffing levels were not fully adhered to due to staff sickness. Discussion with patients and staff confirmed that they had no concerns regarding staffing levels.

Discussion with the registered manager and a review of the staffing rota for the same period also evidenced that the majority of the manager's hours were worked and rostered in the capacity of a registered nurse rather than solely as the registered manager. Deficits which were found within governance records also highlighted the importance of the registered manager being allocated sufficient hours in a management capacity. It was stressed to the registered manager that sufficient management hours are integral to ensuring that areas for improvement identified during this inspection are addressed in order to effectively maintain existing quality assurance monitoring/governance processes. These governance deficits are discussed further below and in section 6.7. An area for improvement under regulation was made.

Discussion with the registered manager and review of governance records confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through an annual appraisal process. However, discussion with the registered manager/staff and review of supervision records evidenced that a significant number of staff had not received bi-annual supervision in keeping with best practice standards. This was highlighted to the registered manager and an area for improvement under the standards was made.

Discussion with the registered manager indicated that training was planned to ensure that mandatory training requirements were met. Additional face to face training was also provided, as required, to ensure staff were enabled to meet the assessed needs of patients. Staff spoken with demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Staff awareness in regards to adult safeguarding is discussed further below.

Discussion with the registered manager confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. It was noted that these monthly governance records did not clearly evidence the date on which they were audited by the registered manager. It was therefore agreed that the registered manager would sign and date these upon review each month.

Discussion with the registered manager evidenced that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. The registered manager also confirmed that an 'adult safeguarding champion' (ASC) was identified for the home. While the registered manager confirmed that mandatory adult safeguarding training for staff was ongoing, some staff who were spoken with demonstrated limited knowledge of their specific roles and responsibilities in relation to adult safeguarding, specifically their obligation to report concerns. This was highlighted to the registered manager and an area for improvement under the standards was made.

Review of notification records evidenced that all notifiable incidents were reported to the Regulation and Quality Improvement Authority (RQIA) in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the registered manager and review of records evidenced that there were effective arrangements for monitoring and reviewing the registration status of nursing staff with the Nursing and Midwifery Council (NMC) and care staff with the Northern Ireland Social Care Council (NISCC). Records confirmed that the registered manager had reviewed the registration status of staff on a monthly basis.

An inspection of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. Patients' bedrooms, lounges and dining rooms were found to be warm and comfortable. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. Review of the environment evidenced that one sluice lacked appropriate signage. Following the inspection, the responsible individual confirmed that this had been satisfactorily addressed. It was further noted that one communal room had signage indicating that it was a designated smoking area for patients. However, the room was found to be cluttered with several wheelchairs and specialist seating awaiting collection by a local Health and Social Care Trust (HSCT). The registered manager stated that the room was not being used as a designated smoking area. The need to have appropriate signage which promotes the orientation of patients was stressed along with ensuring that communal areas remain suitable for the assessed needs of patients at all times. An area for improvement under the standards was made.

It was also observed that signage for patients/visitors was not being consistently used whenever oxygen therapy was in use either within patients' bedrooms or communal areas. The need to ensure such signage is consistently used in order to promote the safety of patients/visitors was emphasised.

Fire exits and corridors were observed to be clear of clutter and obstruction. One storage area, which was to be kept locked by staff in keeping with current fire safety recommendations, was found to be unlocked and unattended on two occasions. This was discussed with the registered manager and it was agreed that fire training must be consistently embedded into staff practice. An area for improvement under regulation was made.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices, for example bed rails and alarm mats. There was also evidence of consultation with patients' relatives/representatives. Comprehensive and person centred care plans were in place for the management of restrictive practices, where necessary. Deficits with regards to the auditing of restrictive practices is discussed further in section 6.7.

Shortfalls with regards to the delivery of care in compliance with infection, prevention and control best practice standards were noted, namely: the inappropriate storage of incontinence products within one cabinet and the communal use of net pants for patients. These deficits consequently impacted the ability of staff to deliver care in compliance with IPC best practice standards and guidance. An area for improvement under the regulations was therefore made.

During a review of the environment it was noted that there was one area in which patients could potentially have had access to harmful chemicals. This was discussed with the registered manager and it was stressed that the internal environment of the home must be managed to ensure that Control of Substances Harmful to Health (COSHH) regulations are adhered to at all times. The identified substance was secured by the registered manager before the conclusion of the inspection and an area for improvement under regulation was made.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to monitoring the professional registration of staff and the notification of incidents.

Areas for improvement

Areas for improvement under regulation were identified in relation to the registered manager's working pattern, fire safety; infection, prevention and control practices; COSHH compliance.

Areas for improvement under the standards were highlighted with regards to adult safeguarding, the interior environment and staff management.

	Regulations	Standards
Total number of areas for improvement	4	3

6.5 Is care effective?

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

Discussion with staff and the registered manager evidenced that nursing/care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' conditions and that they were encouraged to contribute to the handover meeting.

Staff who were spoken with stated that that if they had any concerns, they could raise these with their line manager and/or the registered manager. Staff spoke positively about working within the home.

All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, their colleagues and with other healthcare professionals.

Supplementary care records, such as food and fluid intake, evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff also demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

There was also evidence of multi-disciplinary working and collaboration with professionals such as GPs, Tissue Viability Nurses (TVN) dieticians and speech and language therapists (SALT). Regular communication with representatives within the daily care records was also found. While care records evidenced that a range of validated risk assessments were used and informed the care planning process, deficits were found in regards to the monthly review of care plans. Care records for one patient highlighted that 16 out of 17 care plans were significantly overdue their monthly reassessment by nursing staff. Review of a relevant care plan for a second patient who had an assessed risk of falling was also overdue. These shortfalls were discussed with the registered manager and an area for improvement under regulation was made.

Weaknesses were identified in relation to provision of urinary catheter care. Review of care records for one patient requiring catheter care evidenced that although a corresponding care plan was in place, it lacked comprehensive information in regards to the delivery of such care. Nursing staff did confirm that the patient's catheter was functioning properly on the day of inspection and that no complications had been noted in relation to the catheter. Care plans for this patient also lacked sufficient information relating to the patients' daily fluid intake requirements. In addition, daily nursing entries with regards to the patient's fluid intake were also sporadic. While discussion

with staff confirmed that the patient's hydration needs were being met at present, these weaknesses impacted the ability of nursing staff to meaningfully assess the patient's hydration needs on an ongoing basis. An area for improvement under regulation was made.

Weaknesses were also noted in relation to wound care records. Review of care records for one patient requiring ongoing wound care highlighted that although nursing staff had sought multiprofessional advice from the TVN, there were no specific care plans for several identified wounds. In addition, although discussion with staff together with supplementary wound care records did evidence that the patient's wound dressings were being reviewed by nursing staff in a timely manner, some records were either incomplete or missing. These deficits were highlighted to the registered manager and an area for improvement under regulation was made.

Further shortfalls were also noted with regards to the provision of pressure area care for patients. Care records for two patients who required the use of pressure relieving equipment evidenced that the use of such equipment (including any required settings to promote patient comfort) was absent. In addition, no specific care plans were in place with regards to preventing pressure damage to the patients' skin. Staff did confirm that neither patient had any pressure sores on the day of inspection. These shortfalls were highlighted to the registered manager and an area for improvement under regulation was made.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication with the multiprofessional team.

Areas for improvement

Four areas for improvement under regulation were identified in regards to care records and care delivery.

	Regulations	Standards
Total number of areas for improvement	4	0

6.6 Is care compassionate?

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

Staff interactions with patients were observed to be compassionate and caring. All patients were positive in their comments regarding the staffs' ability to deliver care and respond to their needs and/or requests for assistance. Discussion with the registered manager and staff confirmed that they were aware of the need to deliver care in a holistic and person-centred manner.

Feedback received from several patients during the inspection included the following comments:

"It's good."
"I like the girls."
"It's great."

Feedback received from patients' relatives/representatives during the inspection included the following comments:

"The staff are wonderful."
"Absolutely superb …the best home in Northern Ireland."
"Fruithill has been an oasis … empathy is the heart of the place."

In addition to speaking with patients, patients' relatives and staff, RQIA provided 10 questionnaires for patients and 10 questionnaires for patients' relatives to complete. A poster was also displayed for staff inviting them to provide online feedback to RQIA.

At the time of writing this report, one relative questionnaire has been returned within the specified timescales. The respondent expressed satisfaction with the delivery of care. In addition, one staff questionnaire was also received within specified timescales. The respondent indicated that they were very satisfied that patients were safe within the home and satisfied that patients were cared for compassionately. The staff member was undecided as to whether care delivered to patients was effective although expressed no concerns in regards to how the service was managed.

Questionnaire comments received after specified timescales will be shared with the registered manager as necessary.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

There were systems in place to obtain the views of patients and their representatives on the running of the home.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

Observation of the lunch time meal evidenced that patients were given a choice in regards to the meals being served. The dining area appeared to be clean, tidy and appropriately spacious for patients and staff. Staff demonstrated a good knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plans and associated SALT dietary requirements. All patients appeared content and relaxed in their environment. It was commendable to hear staff gently encouraging patients with their meals and offering alternative choices if necessary. Patients were offered a selection of drinks to accompany their meal although care staff were observed decanting milk into patients' glasses using a milk carton. This was brought to the attention of the registered manager and it was agreed that a more suitable receptacle should be used.

While several patients' relatives who were spoken with did praise the "homely" atmosphere of Fruithill, some shortfalls were noted with regards to communication with patients' relatives/representatives. Observation of one noticeboard used for relatives highlighted that it contained information that was significantly out of date and also inaccurate. The care records for one patient also evidenced that nursing staff had not updated a patient's relative in relation to the patient's altered emotional state on one occasion. This was discussed with the registered manager and the need to ensure that patient's relatives/representatives are engaged with in a

timely and effective manner was stressed. An area for improvement under the standards was made.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff communication with patients.

Areas for improvement

An area for improvement under the standards in relation to communication with patients' relatives/representatives was made.

	Regulations	Standards
Total number of areas for improvement	0	1

6.7 Is the service well led?

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

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. While discussion with staff and patients evidenced that the registered manager effectively engaged with patients, their representatives and the multiprofessional team, review of the registered manager's working patterns was identified as an area for improvement. This is discussed further in section 6.4.

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

The registered manager confirmed that there was a system in place to ensure that policies and procedures for the home were systematically reviewed on a three yearly basis. The registered manager/staff also confirmed that staff were expected to record whenever they had read any new policies relevant to their work duties.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the registered manager evidenced that the home was operating within its registered categories of care. Discussion with the registered manager, responsible individual, several patients/staff and patients' relatives confirmed that effective methods had been employed to keep these stakeholder groups sufficiently updated with regards to the imminent acquisition of the home by a new proprietor.

Patients spoken with confirmed that they were aware of the home's complaints procedure and that they were confident the home's management would address any concerns raised by them appropriately. While the registered manager confirmed that any expression of dissatisfaction should be recorded appropriately as a complaint, complaints records evidenced that one complaint which had been received in August 2017 had not been recorded as a complaint.

Although the registered manager provided assurance that the complaint had been satisfactorily resolved, there was no written record of this. There was also no monthly analysis of complaints by the registered manager at the end of August 2017. An area for improvement under regulation was made.

Discussion with the registered manager and a review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

A review of records evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. Copies of the reports were available for patients, their representatives, staff and Trust representatives. It was noted that these monthly visits did not include any auditing of patients' care records. This was discussed with the responsible individual and it was agreed that all future monthly monitoring visits would include this area of focus. This will be reviewed during a future care inspection.

Staff recruitment information was available for inspection and records for one staff member evidenced that all relevant checks including enhanced AccessNI checks were sought, received and reviewed prior to them commencing work in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The registered manager confirmed that the equality data collected was managed in line with best practice.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and that minutes were maintained. Staff confirmed that such meetings were held and that the minutes were made available.

A review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to wound management; record keeping; the use of restrictive practices and infection control. Review of the IPC audits evidenced that they were completed on a monthly basis by the registered manager and comprehensively highlighted any deficits which required attention.

Review of the restrictive practice audit evidenced that it effectively highlighted particular deficits within patients' care records. However, these audit records did not include the corrective actions required or the deadline by which should actions should be achieved. Deficits which were identified in February 2018, with regards to restrictive practice care records for eight patients, remained unaddressed on the day of the inspection. Review of a recent wound care audit also highlighted that the audit was inaccurate and therefore ineffective. Care record audits were also reviewed and discussed with the registered manager. It was noted that while a tool had been developed for auditing care records, its use on a monthly basis was ineffective with only one individual audit having been completed during 2018. In addition, that audit was also found to be incomplete and not actioned. These deficits were highlighted to the registered manager and an area for improvement under regulation was made.

Discussion with the registered manager and a review of records evidenced that an up to date fire risk assessment was in place.

The registered manager confirmed that there was an available legionella risk assessment which had been conducted within the last two years. The registered manager was reminded of the usefulness of periodically reviewing this no less than two yearly in keeping with best practice guidance.

The registered manager further confirmed that all hoists and slings within the home had been examined in adherence with the Lifting Operations and Lifting Equipment Regulations (LOLER) within the last six months.

Discussion with the registered manager evidenced that there was a process in place to ensure that urgent communications, safety alerts and notices were reviewed, and where relevant, made available to appropriate staff in a timely manner. Medical device and equipment alerts which are published by the Northern Ireland Adverse Incident Centre (NIAIC) were reviewed by the registered manager and shared with all grades of staff as appropriate.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the selection and recruitment of staff.

Areas for improvement

Two areas for improvement under regulation were identified in regards to complaints management and governance audits.

	Regulations	Standards
Total number of areas for improvement	2	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Veronica Sousa, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

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

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

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

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

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 20 (1) (a) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that that the registered manager works sufficient hours in a management capacity to ensure that the governance systems within the home are sufficiently and consistently robust. Ref: Section 6.4 **Response by registered person detailing the actions taken :** Nurse Manager hours have been amended to ensure that there is sufficient hours available in a management capacity to undertake associated duties. Additionally we are in the process of recruiting an additional nursing sister.
Area for improvement 2 **Ref:** Regulation 27 (4) (b) (c) (d) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that adequate precautions against the risk of fire are taken and that best practice guidance in relation to fire safety is embedded into practice. Ref: Section 6.4 **Response by registered person detailing the actions taken:** Continence product store identified is now kept locked when not in use as advised.
Area for improvement 3 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk and spread of infection. Ref: Section 6.4 **Response by registered person detailing the actions taken:** The cupboard identified has been removed. Net pants identified were disposed and new supply of net pants was sourced and allocated individually per residents.
Area for improvement 4 **Ref:** Regulation 14 (2) (a)(c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that chemicals are stored in keeping with COSHH regulations. Ref: Section 6.4 **Response by registered person detailing the actions taken:** A new lockable cupboard is in situ for storage of washing powder.

Area for improvement 5 **Ref:** Regulation 16 (2) (b)(c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all patients' care plans are reviewed and updated in a timely and comprehensive manner. Ref: Section 6.5
	Response by registered person detailing the actions taken: Monthly Care Plan Audits have been updated and will be undertaken on scheduled monthly basis.
Area for improvement 6 **Ref:** Regulation 13 (1) (a)(b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the following in relation to the provision of catheter care for patients: • that care plan(s) are in place which prescribe the required catheter care and refer, if appropriate, to any relevant multiprofessional recommendations which should also be available within the patient's care record, • that nursing staff shall record and meaningfully evaluate the patient's fluid intake/output on a daily basis in compliance with legislative and best practice standards. Ref: Section 6.5
	Response by registered person detailing the actions taken: Multiprofessional recommendations are included in the patient's care records including details of catheter care. Nursing staff are evaluating and recording patient fluid intake / output for those patients with catheters in situ.
Area for improvement 7 **Ref:** Regulation 13 (1) (a)(b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the following in relation to the provision of wound care for all patients: • that care plan(s) are in place which accurately describe the assessed needs of patients with regards to wound care, • that nursing staff shall record all wound care interventions in an accurate, thorough and consistent manner in compliance with legislative and best practice standards. Ref: Section 6.5
	Response by registered person detailing the actions taken: Care plans are in place in relation to the assessed needs of patients with wound care. Nursing staff are required to record all wound care interventions in a detailed fashion in compliance with legislative and best practice standards.

Area for improvement 8 **Ref:** Regulation 13 (1) (a)(b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the following in relation to the provision of pressure area care for all patients: • that care plan(s) are in place which accurately describe the assessed needs of patients with regards to pressure area care, • that the use of any pressure relieving equipment is clearly outlined within such care plans and, where appropriate, the required settings of such equipment is provided and kept under review. Ref: Section 6.5
	Response by registered person detailing the actions taken: Care plans are now in place which accurately describe the assessed needs of patients with regards to pressure care. Details of pressure relieving devices is recorded within care plans including the required setting for such devices which are kept under review.
Area for improvement 9 **Ref:** Regulation 24 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all expressions of dissatisfaction are recorded as complaints and managed in accordance with legislative and best practice standards. Ref: Section 6.7
	Response by registered person detailing the actions taken: All expressions of dissatisfaction are recorded in the home's complaints book. Complaints are now included as part of monthly audits undertaken by the Nurse Manager.
Area for improvement 10 **Ref:** Regulation 13 (1) (a)(b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that a robust system of audits is implemented and maintained to promote and make proper provision for the nursing, health and welfare of patients. Such governance audits shall be completed in accordance with legislative requirements, minimum standards and current best practice, specifically, restrictive practice audits, care record audits and wound care audits. Ref: Section 6.7
	Response by registered person detailing the actions taken: New Restraint audit toll includes corrective action required and date to be actioned by. Wound care audit completed monthly has been reviewed and care plan audits have been further implemented and completed with 10 individual audits completed and 6 of them actioned so far for 2018.

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 40 **Stated:** First time **To be completed by:** With immediate effect	The registered persons shall ensure that staff have recorded individual, formal supervision according to the home's procedures, no less than every six months for staff who are performing satisfactorily. Ref: Section 6.4
	Response by registered person detailing the actions taken: A new schedule for staff supervision is now been drafted to ensure that staff receive a minimum of six monthly staff supervision sessions.
Area for improvement 2 **Ref**: Standard 44 **Stated:** First time **To be completed by:** 10 May 2018	The registered person shall ensure that the communal room identified during this inspection is safe, well maintained and remains suitable for the assessed needs of patients at all times. This also includes the provision of appropriate signage for that room. Ref: Section 6.4
	Response by registered person detailing the actions taken: Communal room identified during inspection has now been cleared including smoking signage. New signage has been errected to identify the room as a quiet room.
Area for improvement 3 **Ref**: Standard 39 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that appropriate governance arrangements are in place to ensure that all staff attend adult safeguarding training and have sufficient awareness of the home's adult safeguarding policy to help ensure that it is embedded into practice. Ref: Section 6.4
	Response by registered person detailing the actions taken: Online safeguarding training frequency has been increased to yearly and in view of the level of knowledge of staff identified at inspection a refresher safeguarding training session has been arranged for 27.06.18

Area for improvement 4 **Ref**: Standard 7 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the relatives' notice board contains only accurate information which promotes and supports effective participation and engagement with patient's relatives/representatives. Ref: Section 6.6
	Response by registered person detailing the actions taken: Old memos have been removed from the relatives notice board.

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

The Regulation and Quality Improvement Authority

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