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Unannounced Care Inspection
of
Glenmachan House

29 May 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 29 May 2015 from 10.15 to 17.15 hours.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

Overall on the day of the inspection, concerns and areas of improvement were identified and are required to be addressed to ensure that care in the home is safe, effective and compassionate. These areas are set out in the Quality Improvement Plan (QIP) within this report. Refer also to section 1.2 below.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 20 November 2014.

1.2 Actions/Enforcement Resulting from this Inspection

As a result of the inspection, RQIA were concerned regarding the significant lack of progress made by the home, in achieving compliance against the previously stated requirements and recommendations. The findings were reported to senior management in RQIA, following which assurances were sought from the registered manager that priority would be given to fully addressing all matters that are identified within the Quality improvement Plan, within the specified timeframes. The registered persons need to be aware that additional inspection will now be considered and any further lack of progress in achieving compliance is likely to result in enhanced enforcement action being taken.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	8	5

The total number of requirements and recommendations above includes both new and those that have been ‘restated’.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Albert Alan Stephens	**Registered Manager:** Helen Jane Murphy
Person in Charge of the Home at the Time of Inspection: Helen Jane Murphy	**Date Manager Registered:** 01 April 2005
Categories of Care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 39
Number of Patients Accommodated on Day of Inspection: 37	**Weekly Tariff at Time of Inspection:** £620 to £640

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

4. Methods/Process

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

Prior to inspection the following records were analysed:

- 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 (QIP) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with four patients, four care staff, two nursing staff and three patient's visitors/representative.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- ten patient care records
- staff training records
- complaints records
- policies for communication and end of life care
- policies for dying and death and palliative and end of life care.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 20 November 2014. The completed QIP was returned and approved by the care inspector.

Review of Requirements and Recommendations from the last care Inspection on 20 November 2014

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 13 (7) **Stated:** Second time	In the interest of infection prevention and control the following issue needs to be addressed; • the pull cord in Bathroom 2 is discoloured from use, this cord should be replaced. A wipeable covering will facilitate effective cleaning of the new cord.	**Met**
	Action taken as confirmed during the inspection: The pull cord had been replaced. However, there was no wipeable covering on the cord. This was discussed with the registered manager, who confirmed that this was applied immediately following the inspection.	

Requirement 2 **Ref**: Regulation 20 (1) (a) **Stated:** First time	The registered person must ensure that a final statement of competency is recorded on the completed induction training programme of newly appointed staff by the registered manager. **A recommendation has been made on 3 previous occasions in this regard**	**Met**
	Action taken as confirmed during the inspection: A review of two personnel records identified that a statement of competency was recorded on the completed induction training programme.	
Requirement 3 **Ref**: Regulation 20 (2) **Stated:** First time	The registered person must ensure that the registered manager is appropriately supervised **A recommendation has been made on 3 previous occasions in this regard**	**Not Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that she had an appraisal at the end of 2014. However, the records in relation to this were not available. Regular planned, formal supervision had not commenced. This requirement is made for the second time.	

Requirement 4 **Ref**: Regulation 16 (2) (b) **Stated:** First time	The registered person must ensure that the patients' care records are kept under review by ensuring the issues identified are addressed as follows: • supplementary bowel assessments such as Bristol stool chart informs the care plan and evaluation process. • care plans for patients with urinary catheters include fluid output and how signs of infection / blockage are monitored. • monthly evaluation in relation to bladder function should include, for example if the patient remains continent or if there were episodes of incontinence when the aim is to promote continence. • evidence based risk assessments in relation to falls and the use of bedrails should be fully completed and a care plan put in place to address an identified patient's care needs in accordance with the Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety Agency (NPSA) advice.	**Partially Met**
	Action taken as confirmed during the inspection: Care plan evaluations were reviewed and were found to be appropriately maintained and reflective of patients' needs. This element of the requirement has been met. A review of three care records identified that falls risk assessments were completed. Bed rail risk assessments were completed for two patients, who required them. This element of the requirement has been met. A review of four care records identified that the Bristol stool chart was not used to record normal bowel function. This was not evident in the bowel assessments or care plans reviewed. A review of one patient's care plan for the management of a supra-pubic catheter was not sufficiently detailed, regarding how signs of infection / blockage were monitored. This requirement is made for the second time.	

Requirement 5 **Ref**: Regulation 30 (1) (d & f) **Stated:** First time	The registered person must give notice to the Regulation and Improvement Authority without delay of the occurrence of: • any event in the nursing home which adversely affects the wellbeing or safety of any patient • any accident in the nursing home	**Met**
	Action taken as confirmed during the inspection: A review of notifiable incidents and discussion with the registered manager confirmed that notifiable events were submitted appropriately.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 26.1 **Stated:** Second time	The Annual Quality Report should be further developed to include the analysis of the outcome of the annual patient satisfaction survey, and should provide detail of any subsequent action taken by the nursing home in response to any learning outcomes.	**Not Met**
	Action taken as confirmed during the inspection: The inspector confirmed that patient satisfaction surveys had been completed in January 2015. However, there was no evidence that the information contained within the patient satisfaction surveys had been analysed and of any subsequent action taken in response to any learning outcomes identified. A requirement is made to address this.	

Recommendation 2 **Ref**: Standard 32.8 **Stated:** Second time	It is recommended that the 'Safe use of bed rail policy' is further developed to state the safety checking procedures when bedrails are in use, and also confirm that the person(s) delegated responsibility of checking bed rails had been assessed as competent to do so.	**Not Met**
	Action taken as confirmed during the inspection: The 'Safe use of bed rail policy' reviewed included the safety checking procedures when bedrails are in use. However, there was no competency assessment in place for the person delegated responsibility of checking bed rails. This was discussed with the registered manager, who agreed to source training for this person. The content was discussed with the registered manager, regarding a statement about the responsibility of healthcare workers to identify their own knowledge deficits in relation to the use of bedrails. The registered manager confirmed that this would be reviewed. A requirement is made regarding policy development.	
Recommendation 3 **Ref**: Standard 26.1 **Stated:** Third time	It is recommended the policy on quality assurance for the home includes information/arrangements for the Regulation 29 monthly monitoring reports and the completion of the annual quality report. Information should also be detailed that these reports are available in the home and patients and/or their representatives may read the reports if they so wish.	**Partially Met**
	Action taken as confirmed during the inspection: The policy on quality assurance for the home included information on the Regulation 29 monitoring reports and the annual quality report. However, the policy did not include a statement regarding the availability of these reports to patients and/or their representatives. Given that this recommendation has been stated three times, a requirement is now made to address this. Refer to recommendation two, above.	

Recommendation 4 **Ref**: Standard 19.2 **Stated:** First time	It is recommended that: • evidence based guidelines in relation to bowel/ bladder care are sourced and made available to staff • that policies/procedures in relation to • continence/incontinence management include stoma and catheter care and are further developed/reviewed to include evidence based references and the date of implementation and planned review • induction records evidence competencies assessed in relation to bowel / bladder care • regular audits of the management of incontinence are undertaken and the findings acted upon to enhance already good standards of care	
	Action taken as confirmed during the inspection: Induction records reviewed confirmed that the promotion of continence and management of incontinence was included. There were no guidelines available in relation to bowel/bladder care. The policy in relation to continence/incontinence management did not include stoma or catheter care. The policy on promotion and management of continence did not include reference to patient's' care plans. The policy on preventing constipation did not include faecal incontinence and did not include signs or symptoms of constipation. Regular audits of the management of incontinence had not commenced. This recommendation is stated for the second time.	**Not Met**

Recommendation 5 **Ref**: Standard 19.4 **Stated:** First time	It is recommended that all registered nurses receive an update on male and female catheterisation, care of supra-pubic catheters and management of stoma care until 100% compliance is achieved	**Not Met**
	Action taken as confirmed during the inspection: A review of training records identified that two registered nurses had completed training in male catheterisation and supra-pubic catheterisation. Six out of 29 staff had completed training in catheter care. Three registered nurses had completed training in stoma care. Training records also confirmed that 14 out of 29 care staff had received training in stoma care. No staff members had attended update training following the last care inspection. However, there were no issues identified regarding the ability of the nursing staff to carry out this procedure. Given that registered nurses carry out these procedures on a regular basis, a new recommendation is made, that the registered manager ensures that competency assessments are maintained, regarding catheterisation, care of supra-pubic catheters and management of stoma care.	
Recommendation 6 **Ref**: Standard 25 **Stated:** First time	It is recommended that the registered manager reviews the arrangements in place to ensure robust monitoring of night time practices	**Met**
	Action taken as confirmed during the inspection: A review of the regulation 29 monitoring visits confirmed that they were conducted on the night shift for three months. The registered manager confirmed that night time practices would continue to be monitored, using a template that focused on a number of areas, including call bell response times, staff presentation, cleanliness of the home and health and safety issues. The content of the monitoring template was discussed with the registered manager, who confirmed that the template would be further developed to include the numbers of patients who were not in bed and the time the medication round finished, if observed.	

<table>
<tr><td rowspan="2">Recommendation 7

Ref: Standard 28.4 & 13

Stated: First time</td><td>It is recommended that the registered manager addresses the issues identified by staff in relation to:

• staff training on Human Rights and management or use of restraint
• the arrangements in place for individual interactions with patients</td><td rowspan="2">Partially Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of training records and discussion with the registered manager confirmed that training had not been provided for staff on human rights and the management or use of restraint.

The registered manager stated that the arrangements for staff interactions with patients was addressed at a staff meeting, following the last inspection. This was not recorded in the minutes of the staff meeting. However, there were no issues raised with the inspector, in relation to staff not having time to talk with patients.

This recommendation is stated for the second time.</td></tr>
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5.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was not available on communicating effectively. However, DHSSPSNI (2003) *Breaking Bad News* guidelines were available and discussion with two registered nurses confirmed that they were knowledgeable regarding this guidance document.

A review of training records confirmed that seven carers had training in communication, as part of training in fundamentals of care. Communication was also included in the induction training programme for care assistants. All registered nurses were trained in palliative and end of life care. This training included the procedure for breaking bad news as relevant to staff roles and responsibilities.

Is Care Effective? (Quality of Management)

Seven care records reflected patient individual needs and wishes regarding the end of life care. Recording within records included reference to the patient's specific communication needs.

A review of seven care records evidenced that the breaking of bad news was discussed with patients and/or their representatives, options and treatment plans were also discussed, where appropriate.

There was evidence within the records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

Two nursing staff consulted demonstrated their ability to communicate sensitively with patients and/or representatives when breaking bad news, by providing examples from their experiences caring for patients nearing end of life care.

Is Care Compassionate? (Quality of Care)

Discussion with three staff and the manager indicated a good level of knowledge regarding the necessary skills for communicating sensitively. Staff were able to provide examples of current practice; and provided an overview of how they delivered bad news sensitively. Staff referred to privacy, support from family members, environmental factors, use of tone and consideration needed for those with sensory impairments.

The complaints records were reviewed and there were no complaints with regards to the theme inspected. There were a number of compliments recorded that indicated high satisfaction with the level of care provided to a patient who was dying and their representatives.

Areas for Improvement

The policy and procedure for delivering bad news to patients and their families should be developed in line with best practice, such as DHSSPSNI (2003) *Breaking Bad News*.

Number of Requirements:	**0**	**Number of Recommendations:** *a recommendation is incorporated under standard 32 below	**0***

5.3 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

Policies and procedures on the management of palliative and end of life care and death and dying were available in the home. However, the policies did not specifically reference current best practice guidance such as the GAIN Palliative Care Guidelines, November 2013. The policy on death and dying included the management of a deceased's person's personal effects, spiritual needs, the provision of last offices and the responsibilities for the nurse who has responsibility for being in charge of the home. The management of shared rooms was not included in the policies.

Training records evidenced that staff were trained in the management of death, dying and bereavement. Registered nursing staff were aware of and able to demonstrate knowledge of the GAIN Palliative Care Guidelines, November 2013.

A review of the training records evidenced that all registered nursing staff had completed recent training in respect of palliative/end of life care. The registered manager confirmed that six staff were also scheduled to attend training.

Discussion with two registered nursing staff confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the manager, two staff and a review of four care records evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

There was no formal protocol in place for timely access to any specialist equipment or medication. However, discussion with two registered nurses confirmed their knowledge of the procedure to follow, if these were required.

There was no specialist equipment, in use in the home on the day of inspection. Considering that the home is registered to provide care for patients who are terminally ill, the training needs of staff were discussed with the registered manager. A palliative care folder was available and included staff' competency assessments, regarding the use of the McKinley syringe driver.

The registered manager was confirmed as the palliative care link nurse for the home.

Is Care Effective? (Quality of Management)

A review of four care records evidenced that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain management and symptom management. There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

A key worker/named nurse was identified for each patient approaching end of life care. There was evidence that referrals had been made to the specialist palliative care team and where instructions had been provided, these were evidently adhered to.

Discussion with the manager and two registered nursing staff and a review of care records evidenced that environmental factors had been considered. Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. Through discussion there was evidence that staff had managed shared rooms appropriately.

A review of notifications of death to RQIA during the previous inspection year confirmed that all deaths had been notified appropriately.

Is Care Compassionate? (Quality of Care)

Discussion with two registered nursing staff and a review of seven care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences regarding end of life care.

Two registered nursing staff consulted demonstrated an awareness of patient's expressed wishes and needs as identified in their care plan.

Arrangements were in place in the home to facilitate, as far as possible, in accordance with the persons wishes, for family/friends to spend as much time as they wish with the person. Overnight facilities were only available if there was a vacant room and all staff consulted confirmed that catering/snack arrangements were provided to family and friends during this time.

From discussion with the manager, two registered nursing staff and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives during this time. There was evidence within compliments records that relatives had commended the management and staff for their efforts towards the family and patient. Two visiting relatives, of a patient who had recently died in the home, commented positively on the care that was provided when their relative was receiving end of life care. Refer to relatives' comments in section 5.4.

Discussion with the manager and a review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

All staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death.

From discussion with the manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included 1:1 counselling and formal bereavement support, if appropriate.

Information regarding support services was available and accessible for staff, patients and their relatives. This information included an information leaflet from the Health and Social Care Bereavement Network on caring at end of life and guidance after the death of a relative or friend in a nursing home. Information leaflets were also available regarding patient choice and planning ahead with relevant support services included.

Areas for Improvement

A policy on palliative and end of life care should be developed in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines.*

A policy on death and dying should be developed in line with current best practice, such as DHSSPSNI (2010) *Living Matters: Dying Matters* and should include the procedure for managing shared rooms and the protocol for accessing specialist equipment and medication.

Number of Requirements:	**0**	**Number of Recommendations:**	**1**

5.4 Additional Areas Examined

Complaints

A review of the complaints in the previous inspection year confirmed that records were appropriately maintained.

Staffing

Staffing arrangements were reviewed. The total numbers of staff required to meet patient need were in place.

Questionnaires

As part of the inspection process we issued questionnaires to staff, patients and their representatives.

Questionnaire's issued to	Number issued	Number returned
Staff	10	7
Patients	5	2
Patients representatives	5	2

All comments on the returned questionnaires were in general positive. Some comments received are detailed below:

Staff

'The nursing home has an 'open home' policy, allowing relatives to spend as much time as they want, with patients'
'I feel everyone who works here, enjoys their job. We have worked with each other for years and are good friends, which I think helps the day to day duties'
'This is a good place to work. I have no concerns regarding patient safety'

One staff member commented in the returned questionnaire that they had only received fire training. Following the inspection, this was discussed with the registered manager who confirmed that all staff had received the mandatory training. The registered manager did not confirm that all bank staff had completed the mandatory training. A requirement is made to address this.

Patients

'Very pleased with care in the home'
'If staff phone in sick it makes everything slower to be done'
'I am very happy here. Everyone is so good to me'
'They are good to me here'
'I have no concerns. I am happy with all the staff here'
'When my (relative) was dying, the staff here were the best'
'If I was dying, I would be happy to have the staff here looking after me'

Patients' representatives

'We are very happy with the care my relative receives. She is always treated with kindness'
'I am happy (my relative's) needs are met. Staff go the extra mile'
'All the staff are lovely, helpful, friendly and good at their job'
'We have found the standard high in all departments'

Personnel Records

The inspector identified one personnel record which identified information regarding a safeguarding of vulnerable adults incident that occurred in the staff member's previous place of employment. Concerns were raised immediately with the registered manager who contacted the South Eastern Trust Safeguarding Team for clarification on the matter. The inspector was assured by the information received. However, RQIA are concerned that patients have been put at unnecessary risk as a result of a lack of robustness in the process for the recruitment and selection of staff. A requirement and a recommendation is made to address this.

Governance arrangements

Background/Context

Following an inspection dated 24 July 2013, a recommendation was made that any requirements and/or recommendations made by RQIA should be included in the regulation 29 monitoring report. This recommendation was made for the second time on 13 February 2014.

With reference to the above, at the time of this inspection, it was disappointing to find that a number of previously stated recommendations and requirements had not been fully addressed.

Copies of the previous three month's regulation 29 reports and minutes from the monthly management meetings were forwarded to RQIA. There was no evidence in the reports reviewed of progress made by the home in addressing the previously stated requirements and recommendations made in the Quality Improvement Plan.

In view of the concerns above regarding previously stated requirements and recommendations not being addressed and the period of time from when recommendations were first made, the monthly monitoring report was identified as not being sufficiently robust, to ensure compliance against the statutory requirements and recommendations made. A requirement is made to address this.

As a result of the inspection, RQIA were concerned regarding the lack of progress made by the home, to achieving compliance against the previously stated requirements and recommendations. The findings were reported to senior management in RQIA, following which assurances were sought from the registered manager that priority would be given to fully addressing all matters that are identified within the Quality improvement Plan, within the specified timeframes. The inspection findings were communicated in correspondence to the registered person.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

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

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/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. 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 weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref**: Regulation 20 (2) **Stated:** Second time **To be Completed by: 26 July 2015**	The registered person must ensure that the registered manager is appropriately supervised **A recommendation has been made on three previous occasions in this regard.** **Response by Registered Person(s) Detailing the Actions Taken:** The Registered Person is supervising the Register Manager.
Requirement 2 **Ref:** Regulation 16 (2) (b) **Stated:** Second time **To be Completed by: 26 July 2015**	The registered person must ensure that the patients' care records are kept under review by ensuring the issues identified are addressed as follows: • supplementary bowel assessments such as Bristol stool chart informs the care plan and evaluation process. • care plans for patients with urinary catheters include fluid output and how signs of infection / blockage are monitored. **Response by Registered Person(s) Detailing the Actions Taken:** The Registered Person is checking patient records with the Registered Manager to ensure issues are addressed.
Requirement 3 **Ref:** Regulation 17 **Stated:** First time **To be Completed by: 26 July 2015**	The Annual Quality Report must be further developed to include the analysis of the outcome of the annual patient satisfaction survey, and should provide detail of any subsequent action taken by the nursing home in response to any learning outcomes. The responsible person should submit a copy of the further developed annual report to RQIA with the return of the QIP. **A recommendation has been made on two previous occasions in this regard.** **Response by Registered Person(s) Detailing the Actions Taken:** The Annual Quality Report has been completed to include the outcome of Annual Patient Survey and actions taken by management to address an issues / concerns identified.

Requirement 4 **Ref:** Regulation 17 **Stated:** First time **To be Completed by:** **26 July 2015**	The 'Safe use of bed rail policy' must be further developed to state the safety checking procedures when bedrails are in use, and also confirm that the person(s) delegated responsibility of checking bed rails had been assessed as competent to do so. A copy of the update bedrail policy must be submitted to the RQIA with the return of the QIP. **A recommendation has been made two times in this regard.**
	Response by Registered Person(s) Detailing the Actions Taken: The safe use of bedrails policy has been updated to reflect safety checking procedures and persons delegated responsibility of checking bed rails have been assessed as competent to do so.
Requirement 5 **Ref:** Regulation 17 **Stated:** First time **To be Completed by:** **26 July 2015**	The policy on quality assurance for the home must detail that the Regulation 29 monthly monitoring reports and the annual quality report are available in the home and patients and/or their representatives may read the reports if they so wish. A copy of the updated policy on quality assurance for the home must be submitted to RQIA with the return of the QIP. **A recommendation has been made three times in this regard.**
	Response by Registered Person(s) Detailing the Actions Taken: This policy has been updated to detail that the monthly monitoring reports and the Annual Quality Report is available in the home and patients and/or their representatives may read reports if they so wish.
Requirement 6 **Ref**: Regulation 20 (1)(c)(i) **Stated:** Second time **To be Completed by:** **26 July 2015**	The registered person must ensure that all staff employed in the nursing home receives mandatory training appropriate to their role. This relates specifically to training for bank staff. A copy of the training matrix for the home which illustrates compliance with all areas of mandatory training should be submitted to RQIA with the return of the QIP. **A recommendation has been made on three previous occasions in this regard.**
	Response by Registered Person(s) Detailing the Actions Taken: Mandatory training for all staff is ongoing and is 70% up to date to include Bank Staff. We aim to achieve 100% by 26th July 2015.
Requirement 7 **Ref:** Regulation 21 (1)(c)	The registered persons must ensure that all staff members who work at the nursing home have two written references relating to the person, including a reference from the person's present or most recent employer.

Stated: First time **To be Completed by:** **26 July 2015**	
	Response by Registered Person(s) Detailing the Actions Taken: All staff have two written references to include a reference from the persons present or most recent employer.

Requirement 8 **Ref**: Regulation 29 (3) (c) **Stated:** Second time **To be Completed by:** **26 July 2015**	The responsible person must ensure that any requirements and/or recommendations made by RQIA are included in the regulation 29 monitoring report and evidences progress made by the home, ensuring compliance against the identified matters. The regulation 29 monthly monitoring reports should be submitted to the inspector within 5 working days of the beginning of each new month. This must commence immediately and continue until further notice.
	Response by Registered Person(s) Detailing the Actions Taken: The Regulation 29 monthly report includes progress made towards complaince with requirements and or recommendations made by RQIA.

Recommendations	
Recommendation 1 **Ref**: Standard 19.2 **Stated:** Second time **To be Completed by:** **26 July 2015**	It is recommended that: • evidence based guidelines in relation to bowel/ bladder care are sourced and made available to staff • that policies / procedures in relation to continence / incontinence management include stoma and catheter care and are further developed /reviewed to include evidence based references and the date of implementation and planned review • regular audits of the management of incontinence are undertaken and the findings acted upon to enhance already good standards of care.
	Response by Registered Person(s) Detailing the Actions Taken: Evidance based guidleines (NICE) are available for staff information. Policies and Procedures have been updated to include continence / incontinence management of stoma and catheter care. Regular audits of the management of incontinence are now undertaken and acted upon to enchance the already good standards of care.
Recommendation 2 **Ref**: Standard 39.9 **Stated:** First time **To be Completed by:** **26 July 2015**	It is recommended that the registered manager should ensure that competency assessments are maintained regarding urinary catheterisation, to ensure that the knowledge, skills and competence of registered nurses is up to date.
	Response by Registered Person(s) Detailing the Actions Taken: All Nurses have had competency assessments to ensure they have the knowledge, skills and competences regarding urinary catheterisation.
Recommendation 3 **Ref**: Standard 28.4 & 13 **Stated:** Second time **To be Completed by:** **26 July 2015**	It is recommended that the registered manager addresses the issues identified by staff in relation to: • staff training on Human Rights and management or use of restraint • the arrangements in place for individual interactions with patients
	Response by Registered Person(s) Detailing the Actions Taken: Staff training on human rights and use of restraint is now being implemented and we aim to have this completed by the end of July. There are documentated arrangements for individual interactions with patients and staff.

Recommendation 4 **Ref**: Standard 36.2 **Stated:** First time **To be Completed by: 26 July 2015**	All policies and procedures should be reviewed to ensure that they are subject to a three yearly review: • A policy on communicating effectively should be developed in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.* • A policy on palliative and end of life care should be developed in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines (2013)* • A policy on death and dying should be developed in line with current best practice, such as DHSSPSNI (2010) *Living Matters: Dying Matters* and should include the procedure for dealing with patients' belongings after a death; managing shared rooms; and accessing specialist equipment/medication. • The policy on pain management should be further developed to include procedural guidance on the use of the McKinley syringe driver. The policies and guidance documents listed above, should be made readily available to staff. A copy of the policy documents listed above should be submitted to RQIA with the returned of the QIP.
	Response by Registered Person(s) Detailing the Actions Taken: A policy on communicating effectively has been developed in line with current best practice. A policy of palliative and end of life care has been deloped in line with regional GAIN guidelines. A policy on death and dying has been developed in line with current best practice Living Matters Dying Matters. The policy on pain management has been further developed to include procedural guidance on use of Mc Kinley Syringe driver. These policies and guidance documents are now readily available to staff.
Recommendation 5 **Ref**: Standard 38 **Stated:** First time **To be Completed by: 26 July 2015**	The policy on recruitment of staff should be reviewed to include the need for two written references to be provided, one of which must be from the applicant's most recent employer.
	Response by Registered Person(s) Detailing the Actions Taken: This policy has been reviewed and updated.

Registered Manager Completing QIP	JEAN MURPHY	**Date Completed**	16 07 2015
Registered Person Approving QIP	DR ALAN STEPHENS	**Date Approved**	16 07 2015
RQIA Inspector Assessing Response	**Aveen Donnelly**	**Date Approved**	**05/08/2015**

Please ensure the QIP is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

Please provide any additional comments or observations you may wish to make below:

***Please complete in full and returned to RQIA nursing.team@rqia.org.uk ***