Unannounced Care Inspection Report
31 August and 1 September 2016

Kingsway

Type of Service: Nursing Home
Address: 299 Kingsway, Dunmurry, Belfast, BT17 9EP
Tel no: 028 9060 9930
Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Kingsway Nursing Home took place on 31 August 2016 from 10:25 to 17:15 hours and 1 September 2016 from 07:00 to 13:00 hours.

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

Is care safe?

The acting manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. Review of the staffing rota from 22 August to 4 September 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients and relatives confirmed that they had no concerns regarding staffing levels although some patients did comment that staff 'were very busy'.

Staff consulted confirmed that planned staffing levels met the assessed needs of the patients. Staff also described that they worked well as a team to ensure patients' needs were met.

The acting manager was asked to consider how the patients' daily charts were stored. RQIA acknowledged that these files needed to be available to staff to enable contemporaneous recording of care delivered; and that the charts were in a robust file. It was agreed that management would consider options for how/where charts could be held to ensure patient privacy but enable staff to access them to record contemporaneously. A recommendation was made.

Is care effective?

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process. There was evidence registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. It was evident that the majority of patient care records reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Review of patient records and care planning evidenced that care was patient centred and relevant to ensure patients' assessed needs were met.

Observations of the care delivered over the course of the inspection evidenced that the needs of patients were met by the staff on duty and that the care was effective.

Staff confirmed they could raise any concerns with senior staff and were confident of support and, if required, confidentiality from the acting manager. All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

As discussed in section 4.3 observation of care delivery was found to meet patient needs. Staff were observed during the lunch time period to provide assistance on a one to one basis in accordance with best practice guidance.

Patients spoken with expressed their confidence in raising concerns with the home's staff and/or management. Patients were aware of who their named nurse was and knew the acting manager.

No areas for improvement were identified during the inspection.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent. It was evident that there were good relationships between patients and staff.

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

Review of records and discussion with the acting manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. Patients and their relatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

Consultation with patients individually, and with others in smaller groups, confirmed that living in Kingsway Nursing Home was a positive experience. Refer to section 4.5 for patient, relatives' and staff comments.

No areas for improvement were identified during the inspection.

Is the service well led?

Discussion with the acting manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided.

There was an effective system in place to ensure nursing staff were registered with the NMC; and that care staff were registered with NISCC. Care staff not registered with NISCC were required and supported to register.

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

As discussed in the preceding sections, it was evident that the acting manager managed systems of working within the home which were patient focused, impacted positively on the patient experience and involved and encouraged staff to deliver care appropriately to meet the assessed needs of patients. The acting manager had also implemented the evaluation of the 'falls log' and the monitoring of staff training and development to ensure standards of care and practice were met and maintained. There was evidence that the acting manager was available to patients, their relatives and operated an 'open door' policy for contacting her. This was commended.

No areas for improvement were identified during the inspection.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2*

*The above recommendations include one recommendation stated for a second time. Please refer to section 4.2 for details.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Lesley McKillen, Acting Manager, and Chris Walsh, Responsible Individual, 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 medicines management inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 13 April 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. 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 further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: Care Circle Limited Mr Christopher Walsh	**Registered manager:** See box below
Person in charge of the home at the time of inspection: Lesley McKillen – Acting Manager Nurse E Smyth – nurse in charge night duty 31 August 2016	**Date manager registered:** Mrs Lesley McKillen – Acting Manager
Categories of care: NH-I,PH, PH(E) and TI	**Number of registered places:** 69

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events 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 plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection the inspector spoke with 18 patients individually and with others in small groups, two relatives, 11 care staff, seven registered nurses, two housekeeping staff, one staff member from hospitality and one care manager.

In addition questionnaires from RQIA were provided for distribution by the acting manager; 10 for relatives/representatives; eight for patients and 10 for staff not on duty during the inspection. One staff questionnaire and eight patient questionnaires were returned within the timescale specified. Refer to section 4.5 for details.

The following information was examined during the inspection:

- three patient care records
- four patients' care charts such as repositioning, food intake and fluid intake records
- staff duty rosters from 22 August to 4 September 2016
- staff training and planner/matrix for 2016
- one staff recruitment record
- complaints record
- a selection of incident and accident records including audit processes

- record of quality monitoring visits carried out on behalf of the responsible individual in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- records of audit and governance relating to management of falls and complaints
- records pertaining to the management of adult safeguarding concerns
- records for checking nursing staff registration with Nursing and Midwifery Council (NMC) and care staff registration with the Northern Ireland Social Care Council (NISCC)
- nursing desk diaries

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 13 April 2016

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

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection inspection.

4.2 Review of requirements and recommendations from the last care inspection Dated 7 December 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 24 (1) (2) (3) & (4) **Stated:** Third and final time	The registered persons must have robust procedures in place for the management of complaints.	**Met**
	Action taken as confirmed during the inspection: Review of complaints records and discussion with the responsible individual and acting manager evidenced that this requirement had been met.	
Requirement 2 **Ref:** Regulation 27 (4) (b) & (d) (v) **Stated:** Second time	The registered person must ensure that adequate precautions against the risk of fire are in place and that robust systems are in place to review the adherence to these precautions.	**Met**
	Action taken as confirmed during the inspection: Observations evidenced that fire precautions were adhered to. Fire doors were not wedged or propped open.	

Requirement 3 **Ref:** Regulation 13 (4) (a); (5) (a) **Stated:** Second time	The registered person must ensure that robust systems are in place and enforced to ensure that medicine is securely stored at all times and in such a way that others are prevented from using it.	**Met**
	Action taken as confirmed during the inspection: Observations evidenced that medications were administered in a timely manner and in accordance with professional and legislative requirements.	
Requirement 4 **Ref:** Regulation 16 (1); 16 (2) (b) **Stated:** Second time	In relation to pain management the registered person shall ensure that a written nursing plan is prepared by a nurse in consultation with the patient or patient's representative as to how the patient's needs in respect of his health and welfare are to be met. The patient's plan must be kept under review.	**Met**
	Action taken as confirmed during the inspection: Review of patient records and discussion with nursing staff evidenced that this requirement had been met.	
Requirement 5 **Ref:** Regulation 19 (1) (a) (b) **Stated:** First time	The registered person shall – (a) maintain in respect of each patient a record which include the information, documents and other records specified in Schedule 3 relating to the patient; (b) ensure that the record referred to in sub-paragraph (a) is kept securely in the nursing home.	**Met**
	Action taken as confirmed during the inspection: Discussion with the responsible individual and acting manager; and observation of storage areas throughout the home evidenced that patient records were not stored inappropriately. Discussion did take place regarding where patients' daily charts should be kept and a recommendation was made. Refer to section 4.3 for details.	

Requirement 6 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff.	**Met**
	Action taken as confirmed during the inspection: Observation of the home's environment included review of a random sample of patients' bedrooms, bath and shower rooms, stores, lounge and dining areas; and observation of staff practice regarding the use of personal protective equipment (PPE) and handwashing technique confirmed that this requirement had been met.	
Requirement 7 **Ref:** Regulation 17 (1) (2) and (3) **Stated:** First Time	(1) The registered person shall introduce and ensure systems are maintained for reviewing at appropriate intervals the quality of nursing and other service provision in or for the purposes of the nursing home and that any such review is undertaken not less than annually. (2) The registered person shall supply to the RQIA a report in respect of any review conducted by him for the purpose of paragraph (1) and make a copy of the report available to patients. (3) The system referred to in paragraph (1) shall provide for consultation with patients and their representatives.	**Met**
	Action taken as confirmed during the inspection: Review of a report prepared in January 2016, following consultation with relatives/patient representatives, confirmed that areas for improvement were identified and action had been taken to address these areas. The report was available to patients, staff and relatives/representatives. Further consultation had taken place in July 2016 and results were being prepared by the organisation's head office. This requirement had been met. Discussion took place regarding how the data could be presented to enable anyone reading the reports to understand. Advice was provided, for example the use of a table/graphics to show "what you told us and what we did to improve". Management agreed to look at this.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 18, criterion 6 **Stated:** First time	Records of release schedules for patients using lap belts must be kept accurately and contemporaneously.	**Not Met**
	Action taken as confirmed during the inspection: Records were in place but staff had failed to record them since 28 August 2016. RQIA did acknowledge that observations and discussions with staff and one relative confirmed that lap belts were being managed appropriately. However, this recommendation has now been stated for a second time.	
Recommendation 2 **Ref**: Standard 18, criterion 7 **Stated:** First time	Regular audits of incidences of restraint and / or restrictive practices should be undertaken to monitor and where possible reduce their use.	**Met**
	Action taken as confirmed during the inspection: Records were in place and maintained appropriately.	

4.3 Is care safe?

The acting manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. Review of the staffing rota from 22 August to 4 September 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients and relatives confirmed that they had no concerns regarding staffing levels although some patients did comment that staff 'were very busy'.

Staff consulted confirmed that planned staffing levels met the assessed needs of the patients. Staff also described that they worked well as a team to ensure patients' needs were met.

Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. For example, the serving of the lunchtime meal in one unit and the serving of the breakfast in the other confirmed that patients' needs were met by staff in a timely, considerate and caring manner and that nursing staff ensured patients' needs were fully met.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Staff were mentored by an experienced member of staff during their induction period. Recruitment records for one staff member were reviewed and found to be completed in full and in accordance with legislative requirements. For example pre employments checks were

undertaken and two references received prior to the person's start date. Staff induction records were also in place.

Discussion with the acting manager and staff evidenced that a system was in place to ensure staff attended mandatory training. Review of the training matrix/schedule for 2016 indicated that training was planned in advance to ensure that mandatory training requirements were met. Training outcomes for 2016, had also been reviewed by the acting manager, when she had taken up her post, to ensure staff training needs were met. For example, the acting manager had identified that nursing staff undergoing induction and/or perceptership required some additional support therefore a registered nurse from a 'sister' home had been asked to provide this. A planner was in place to assist in managing the progress of inductions and development.

Staff consulted and the observation of care delivery and staff interactions with patients clearly demonstrated that knowledge and skills gained through training and experience were embedded into practice. Staff were confident in carrying out their role and function in the home. The acting manager and staff demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. RQIA were assured that 100% compliance in mandatory training requirements and training to support the needs of patients was the objective of management.

Discussion with the acting manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff with Nursing and Midwifery Council (NMC and care staff with the Northern Ireland Social Care Council (NISCC) were appropriately implemented and managed.

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. The acting manager was asked to consider how the patients' daily chartswere stored. RQIA acknowledged that these chartsneeded to be available to staff to enable contemporaneous recording of care delivered; and that the charts were in a robust file. It was agreed that management would consider options for how/where charts could be held to ensure patient privacy but enable staff to access them to record contemporaneously. A recommendation was made.

Review of management audits for falls since April 2016 confirmed that on a monthly basis the number, type, place and outcome of falls were listed. The purpose of the list was not clear as no evaluation of the data was evident. However, the acting manager had reviewed and evaluated this data for the month of July and August 2016, to date, and had recorded her evaluation in relation to any emerging patterns and trends.

Staff spoken with confirmed that nursing staff and care staff were knowledgeable of the actions to be taken in the event of an emergency. Review of accidents/incidents records confirmed that notifications were forwarded to RQIA appropriately.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms, sluices and storage areas. The home was found to be warm, well decorated, and clean throughout. Housekeeping staff were commended for their efforts. Housekeeping staff spoken with were knowledgeable of their role and function and of infection prevention and control measures.

In one identified bedroom the flooring was observed to be torn. This was brought to the attention of the acting manager during feedback on day one of the inspection. Arrangements

were made to have the flooring replaced and confirmed at the conclusion of the inspection. A spray bottle of green liquid, labelled 'ultrafresh' was observed on the drying rack in one sluice room. This was brought to the attention of the responsible person who immediately removed the spray bottle. There were no issues with the storage of chemicals observed in any other area of the home. RQIA were satisfied that management had addressed the issue and would remind staff of the importance of reducing risks to patients by locking cleaning products in the lockable cupboards provided in sluice rooms.

Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

A recommendation was made that management consider options for how and where patients' daily care charts are held to ensure privacy and to enable contemporaneous record keeping.

Number of requirements	0	**Number of recommendations**	1

4.4 Is care effective?

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process. There was evidence registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. It was evident that the majority of patient care records reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Review of patient records and care planning evidenced that care was patient centred and relevant to ensure patients' assessed needs were met.

Observations of the care delivered over the course of the inspection evidenced that the needs of patients were met by the staff on duty and that the care was effective. One example was that night duty staff assisted patients to rise before 08:00 hours only if they expressed a wish to do so. Night staff were clear that they were not required to get patients up to aid the routine of the home. Night staff were aware of patient wishes/needs and ensured that any patient up early was offered their breakfast.

Discussion with staff and observation of the handover from night to day staff, on day two of the inspection, confirmed that all nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff also confirmed that 'safety briefings' were held twice daily to share concerns and to receive advice, if required, from nursing staff. Staff meetings had been held on 1 and 2 August 2016 and minutes were made available. Staff said that communication between staff, at all levels, was effective and this ensured that patients' needs were met. Staff stated they knew they worked together effectively as a team because they communicated effectively and patients 'came first'. Staff stated that they felt proud to be able to make a difference to patients' quality of life.

Staff confirmed they could raise any concerns with senior staff and were confident of support and, if required, confidentiality from the acting manager. One example was given of the recent action taken to improve quality of life for a named patient requiring specific care which was

given by a registered nurse (RN). All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

A meeting with patients and relatives was planned for 7 and 8 September 2016 and as stated previously in section 4.2 the organisation had recently completed a consultation process with stakeholders in July 2016.

As discussed in section 4.3 observation of care delivery was found to meet patient needs. Staff were observed during the lunch time period to provide assistance on a one to one basis in accordance with best practice guidance.

Patients spoken with expressed their confidence in raising concerns with the home's staff and/or management. Patients were aware of who their named nurse was and knew the acting manager.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent. It was evident that there were good relationships between patients and staff.

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

Discussion with patients and staff and review of care records evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

As stated previously review of records and discussion with the acting manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. Patients and their relatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

Consultation with patients individually, and with others in smaller groups, confirmed that living in Kingsway Nursing Home was a positive experience.

Patient comments to the inspector included:

- "…food is fantastic." Patient went on to describe how the chef/cook spoke with them regarding their food preferences
- One patient referred to where they sat as "this is my spot… staff know this"
- "It is okay but it's not home… staff good but busy."

In addition, eight patient questionnaires were provided by RQIA for distribution by the registered manager. Eight were returned within the timeframe specified.

Patients indicated that they were either satisfied or very satisfied with the care they received. Five patients did record comments that sometimes they had to wait to receive care and two added that staff were busy. One patient said they had "just met the manager last week(very nice)…" The patient went on to say about the recent changes in management being "a bit confusing".

One relative spoken with was very positive in relation to the care delivered, the environment, staff attitude and management of the home. In addition, 10 relative/representatives' questionnaires were provided by RQIA to the registered manager for distribution. At the time of issuing this report none had been returned.

Comments made by staff during the inspection are included throughout the report. In addition, 10 staff questionnaires were provided by RQIA for distribution, by the registered manager, to staff not on duty during the inspection. Only one was retuned within the specified timeframe. The staff member did refer to the previous management team in relation to the lack of staff meetings. However, as stated staff meeting had been held by the acting manager on 1 and 2 August 2016. Other comments recorded had been discussed with management as part of the inspection process and RQIA are satisfied that management are aware of the concerns.

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?

Discussion with the acting manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern. Staff were able to identify the person in charge of the home when the acting manager was not on duty.

Staff, patients and relatives were complimentary in relation to how the acting manager led and managed the home and supported them on a daily basis. For example, staff commented that the acting manager was observed "out on the floor" and that she was aware of staff and patients' needs.

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

Discussion with the acting 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. Patients and relatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/relatives confirmed that they were confident that staff and management would manage any concern raised by them appropriately. One relative raised

concerns with the inspector, but confirmed that they were meeting with the acting manager. Discussion with the acting manager confirmed she was aware of the issues and had responded appropriately.

Staff were knowledgeable of the complaints and adult safeguarding process commensurate with their role and function. A review of notifications of incidents to RQIA April 2016 confirmed that these were managed appropriately. Discussion with the acting manager and review of records evidenced that systems were in place to ensure that notifiable events, complaints, and/or potential adult safeguarding concerns were investigated and reported to RQIA or other relevant bodies appropriately. During the inspection a disclosure was made to the inspector in relation to adult safeguarding concerns. The information was passed to the acting manager the responsible person and the patient's care manager as per local adult safeguarding protocols. Discussion and further correspondence received by RQIA, post inspection, confirmed that the management team had managed the disclosure appropriately.

Discussion with the acting manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, an audit was completed in accordance with best practice guidance in relation to falls, complaints and incidents/accidents.

Records pertaining to the record of accidents/falls in the home were reviewed from April 2016. Prior to the acting manager taking up post a log of falls that had occurred in the home had been maintained. This record did not include an evaluation of the data in relation to patterns, trends and frequency of falls. The acting manager did evidence that she had undertaken the evaluation of the data since taking up post. Records were reviewed.

There was an effective system in place to ensure nursing staff were registered with the NMC; and that care staff were registered with NISCC. Care staff not registered with NISCC were required and supported to register.

Review of reports and discussion with the acting manager evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and trust representatives.

As discussed in the preceding sections it was evident that the acting manager had managed systems of working within the home which were patient focused, impacted positively on the patient experience and involved and encouraged staff to deliver care appropriately to meet the assessed needs of patients. The acting manager had also implemented the evaluation of the 'falls log' and the monitoring of staff training and development to ensure standards of care and practice were met and maintained. There was evidence that the acting manager was available to patients, their relatives and operated an 'open door' policy for contacting her. This was commended. Compliance with the recommendations made will further enhance the patient experience and service provision.

Areas for improvement

No areas for improvement were identified during the inspection.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Lesley McKillen, Acting Manager, and Mr C Walsh, Responsible Individual, as part of the inspection process. The timescales commence from the date of inspection.

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

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

5.1 Statutory requirements

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

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

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

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref**: Standard 18, criterion 6 **Stated:** Second time **To be completed by:** 30 September 2016	Records of release schedules for patients using lap belts must be kept accurately and contemporaneously. **Ref: Section 4.2** **Response by registered provider detailing the actions taken:** Discussions have been had with registered nursing staff and the responsibilty for the management of lap belts has been passed to them.In addition the one remaining resident in the home who utilises a lap belt has been referred for review by OT
Recommendation 2 **Ref**: Standard 5 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should consider options for how and where patients' daily care charts are held to ensure privacy to enable contemporaneous record keeping. **Ref: Section 4.3** **Response by registered provider detailing the actions taken:** A review has been conducted to seek the balance for the need for confidentiality whilst ensuring contemporaneous record keeping .A staff meeting is planned at which the staff will be advised to place the files within the residents room or at a discreet central location as close as possible to the point of care.

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

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