

Unannounced Care Inspection Report 25 April 2017



Lisadian House

Type of Service: Nursing Home

Address: 87 Moira Road, Hillsborough, BT26 6DY

Tel no: 028 9268 9898

Inspector: Sharon Loane

1.0 Summary

An unannounced inspection of Lisadian House took place on 25 April 2017 from 10.15 to 17.15 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 systems to ensure that care was safely delivered were reviewed. We examined staffing levels and duty rotas; recruitment practices; and staff training and development. Staff were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding.

Weaknesses were identified in the delivery of safe care, specifically in regards to falls management and a requirement has been made. Recommendations have also been made in regards to the recruitment and induction process.

Is care effective?

A review of three patient care records evidenced that in the majority these were completed and maintained to a satisfactory standard. Risk assessments and care plans were completed at the time of admission and reviewed on a regular basis. However, one care record examined had not been updated to reflect changes to the patient's treatment plan for the management of diabetes. A recommendation has been made.

Is care compassionate?

There was evidence of good communication in the home between staff and patients and patients were praiseworthy of staff. Staff interactions were observed to be compassionate and caring. Patients were afforded choice, privacy, dignity and respect. During the inspection, activities were provided and patients were observed participating at various levels and appeared to enjoy same.

Is the service well led?

There was a clear organisational structure evidenced within Lisadian House and staff were aware of their roles and responsibilities. Systems were in place to assure the quality of services provided in the home and in the majority of areas reviewed these were effective. However, a requirement has been made in relation to notifications and recommendations have been made in regards to auditing processes, policies and procedures and the management of urgent communications, safety alerts and notices.

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	2	6

Details of the Quality Improvement Plan (QIP) within this report were discussed with Esther Bell, 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 10 January 2017. 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: Elim Trust Corporation/Pastor Edwin Michael	Registered manager: Esther Bell
Person in charge of the home at the time of inspection: Esther Bell	Date manager registered: 14 January 2016
Categories of care: NH-I, NH-PH, NH-PH(E),NH-TI	Number of registered places: 45

3.0 Methods/processes

Prior to inspection we analysed the following records:

- 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 plan (QIP) from the previous care inspection
- the previous care inspection report
- pre-inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with five patients individually, five care staff, three registered nurses, domestic staff, two activities leaders and two relatives.

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

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- duty rotas for weeks commencing
- staff training records
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff recruitment records
- staff induction records
- competency and capability assessments of nurses
- staff register
- records of staff, patient and relatives meetings
- four patient care records
- complaints record
- records of quality audits
- monthly monitoring reports
- incident and accident records

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 10 January 2017

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

4.2 Review of requirements and recommendations from the last care inspection dated 14 December 2016

Last care inspection statutory requirements		Validation of compliance
<p>Requirement 1</p> <p>Ref: Regulation 13 (1) (a) (b)</p> <p>Stated: First time</p>	<p>The registered person must ensure that the nursing home is conducted to promote and make proper provision for the nursing, health and welfare and where appropriate treatment for patients.</p> <p>This requirement has been made with particular focus to the management of diabetes and bowel care.</p>	<p>Met</p>

	<p>Action taken as confirmed during the inspection: A review of care records and information evidenced that this requirement was met. Please refer to section 4.4 for further detail.</p>	
<p>Requirement 2 Ref: Regulation 20 (3) Stated: First time</p>	<p>The registered person must ensure that a competency and capability assessment is carried out with any nurse (including agency) who is given responsibility of being in charge of the home in the absence of the registered manager.</p> <p>Action taken as confirmed during the inspection: A review of competency and capability assessments for three registered nurses evidenced that this requirement was met. Please refer to section 4.3 for further detail.</p>	Met
Last care inspection recommendations		Validation of compliance
<p>Recommendation 1 Ref: Standard 36 Stated: Second time</p>	<p>It is recommended that all policies are dated when issued or reviewed.</p> <p>Action taken as confirmed during the inspection: A review of a sample of policies evidenced that they had been dated when issued and reviewed. These included: managing continence; management of records and recruitment and selection.</p>	Met
<p>Recommendation 2 Ref: Standard 39 Criteria 7 Stated: First time</p>	<p>The registered person should ensure that the current training arrangements are reviewed to ensure the effectiveness of training on practice and procedures.</p> <p>Action taken as confirmed during the inspection: A discussion with staff and a review of information confirmed that this recommendation was met. Training is provided via e-learning and face to face methods. Staff advised that this approach was more effective in regards to learning.</p>	Met
<p>Recommendation 3 Ref: Standard 35 Stated: First time</p>	<p>The registered provider should develop a system to ensure that checks are being conducted on a regular basis in relation to staff's registration status with NMC and NISCC. Records should be kept.</p> <p>Action taken as confirmed during the inspection: A review of information evidenced that this recommendation was met. Please refer to section 4.3 for further detail.</p>	Met

<p>Recommendation 4</p> <p>Ref: Standard 41</p> <p>Stated: First time</p>	<p>The registered provider should ensure that staff meetings take place on a regular basis and at a minimum quarterly. Records are kept in accordance with Care Standards for Nursing Homes, April 2015.</p> <p>Action taken as confirmed during the inspection: A discussion with the registered manager, staff and a review of information evidenced that this recommendation was met. Please refer to section 4.3 for further detail.</p>	<p>Met</p>
<p>Recommendation 5</p> <p>Ref: Standard 7</p> <p>Stated: First time</p>	<p>The registered provider should ensure that the negative comments made by some patients during the inspection are recorded as complaints and are appropriately recorded, investigated and actioned as required.</p> <p>Action taken as confirmed during the inspection: A review of records maintained in regards to complaints evidenced that the negative comments made had been followed up by the registered manager. A record was available to evidence the actions taken and the outcomes achieved.</p>	<p>Met</p>
<p>Recommendation 6</p> <p>Ref: Standard 35</p> <p>Stated: First time</p>	<p>The registered provider should ensure that there are effective management systems in place to support and facilitate good management and leadership which involve and engage staff and promotes a positive culture and ethos of the home.</p> <p>Action taken as confirmed during the inspection: A discussion with staff and a review of information evidenced that this recommendation was met. The majority of staff spoken with were positive about the management and leadership of the home. Management systems have been developed which have facilitated and promoted more effective management and leadership of the home.</p>	<p>Met</p>
<p>Recommendation 7</p> <p>Ref: Standard 39</p> <p>Stated: First time</p>	<p>The registered person should provide training for staff commensurate with their roles and responsibilities in the following areas:</p> <ul style="list-style-type: none"> • the management of diabetes • bowel care management • the nursing process 	<p>Met</p>

	<p>Action taken as confirmed during the inspection: A discussion with the registered manager and a review of training records evidenced that training had been completed in regards to the management of diabetes and bowel care during December 2016. Training for registered nurses in regards to the nursing process was being sourced and post inspection an email correspondence was received to confirm that the training had been organised for 8 and 11 May 2017.</p>	
<p>Recommendation 8 Ref: Standard 39 Stated: First time</p>	<p>The registered person should ensure that staff receive 'awareness training' in the interim period until formal training is provided. A record should be kept of the training and information provided.</p> <p>Action taken as confirmed during the inspection: A discussion with the registered manager, staff and a review of information evidenced that systems were in place to ensure that new staff were provided with adequate information and supervision to ensure safe and effective practice.</p>	Met

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for weeks commencing 17 and 24 April 2017 evidenced that the planned staffing levels were generally adhered to. The nurse in charge of the home was identified on the staff duty rota. Competency and capability assessments for three registered nurses identified as given the responsibility of being in charge of the home were reviewed. The assessments had been reviewed December 2016 and were signed by the registered manager to confirm that the assessment process had been completed and they were satisfied that the registered nurse was capable and competent to be left in charge of the home. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; No questionnaires were returned by staff following the inspection.

Patients and relatives spoken with during the inspection commented positively regarding the staff and care delivery. Patients were satisfied that when they required assistance staff attended to them in a timely manner. Questionnaires were also issued for patients and relatives to complete. Two questionnaires were returned by relatives and none were returned by patients. Both responses received from relatives indicated that they were very satisfied that care was safe although additional comments made by one relative included that "sometimes there is not enough staff." This comment was shared with the registered manager.

At the time of the inspection, observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty.

A review of two personnel files evidenced that overall these were maintained in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. However, interview notes were not available for one of the files reviewed. The registered manager confirmed that an interview had occurred and the notes were held at another office. A recommendation has been made.

Records confirmed that enhanced criminal records checks were completed with Access NI and the reference number and date received had been recorded.

A record of staff including their name, address, date of birth, position held, contacted hours, date employment commenced and ended (where applicable) was maintained in a staff register and provided an overview of the staff employed in the home.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff were appropriately managed in accordance with the Nursing and Midwifery Council (NMC). All registered nurses on the duty rota for the week of the inspection were on the live NMC register.

Similar checks were carried out for care staff registrations with the Northern Ireland Social Care Council (NISCC); however two staff members had not applied for registration, within the required timeframe after commencing employment. Information reviewed evidenced that this had been identified by the registered manager and followed up accordingly. A discussion was held with the registered manager regarding the importance of ensuring that staff are registered with NISCC within the required timeframe and appropriate actions are taken if staff fail to register.

A discussion with the registered manager and staff confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

Discussion with staff and a review of the staff training records confirmed that the registered manager had a system in place to monitor staff compliance with mandatory training requirements. A review of staff training records confirmed that training was delivered via e-learning (electronic learning) supported with face to face training for practical components. Staff advised that these systems were more effective for learning in comparison to previous methods. A recommendation made at a previous inspection in relation to training was met.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance or to ensure that staff received support and guidance. Some staff spoken with confirmed that they had received supervision and annual appraisal.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. The registered manager advised that they had been nominated as the safeguarding champion and had attended training on the new regional safeguarding policy and procedure to include the role of the adult safeguarding champion. The policy for the home in relation to same was to be updated to reflect same. This information will be reviewed at the next care inspection to ensure it has been successfully implemented.

Review of four patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. In the majority of information reviewed, there was evidence that risk assessments informed the care planning process. However, following a review of a bed rail risk assessment for an identified patient it was concerning that registered nurses had not evidenced their decision to use bed rails when a high level of risk had been identified.

A review of care records pertaining to the management of falls evidenced the following shortfalls. For example; one care record reviewed evidenced that despite the patient being identified as 'high risk of falls', no care plan was in place. A post-falls review had not been carried out to include the review of appropriate assessments and care plans. A review of records pertaining to the management of accidents and incidents evidenced that these were not being managed appropriately. Two different systems were in place for recording same which was not always consistent and /or accurate. Information recorded to include the patients daily progress notes was inadequate. In addition, there was a lack of evidence to demonstrate that appropriate actions had been taken by registered nurses following accidents were patients had sustained a potential head injury. Staff had not monitored the patients for any adverse side effects. RQIA had not been notified appropriately in regards to a number of incidents where medical advice and/or intervention had been sought. These shortfalls have the potential to impact negatively on the patients' health and welfare. A requirement has been made in regards to the shortfalls identified.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. However, appropriate actions had not been taken to address any deficits identified. For example; audits for a four month period evidenced the same shortfalls indicating that appropriate measures had not been taken to drive improvement. A recommendation has been made under the well led domain in regards to same.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the last inspection confirmed that not all of these had been appropriately managed as outlined above. A requirement has been made in relation to same under the well led domain.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, and lounge/s, dining room/s and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. A number of improvements had been made to the environment since the last inspection to include; new floor covering and re-decoration of bedrooms.

A number of "slings" observed appeared worn. A discussion with the registered manager confirmed that there was no formal system in place to check this equipment except for six monthly checks as required under "The Lifting Operations Equipment Regulations 1998 (LOLER). A recommendation has been made.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were in the majority adhered to however the storage of some commodes was inappropriate and not consistent with best practice guidance. This was discussed with the registered manager who agreed to take immediate actions. Post inspection, an email correspondence has been received by RQIA to confirm that appropriate actions have been taken to address this issue.

Areas for improvement

Areas for improvement were identified in relation to the management of falls; recruitment and safety checks for “slings”.

Number of requirements	1	Number of recommendations	2
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4.4 Is care effective?

A review of three 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 in the majority informed the care planning process. Registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner’s (GP), Speech and Language Therapist (SALT), Dietician, and Tissue Viability Nurse (TVN).

As previously discussed in section 4.3, some shortfalls were identified in regards to the assessment and care planning process for falls prevention. These have been addressed under the safe domain.

We reviewed the management of wound care for one identified patient. Care records contained details of the prescribed regime. The delivery of wound care for the period 4 April to 20 April 2017 was reviewed. Care records reflected that the care delivered was in accordance with the regime of care as prescribed by the multidisciplinary team. A review of repositioning records for two patients evidenced that the repositioning schedule was carried out as directed in the patient’s care plan. All records reviewed were maintained to a satisfactory standard and reflected best practice guidelines.

A review of care records for an identified patient receiving treatment for the management of diabetes was undertaken. Although, a care plan was in place to direct care in this regard, it was evidenced that the insulin regime had been altered on two occasions; however the care plan had not been updated to reflect changes to the regime. A review of medication records confirmed that the patient had received the correct treatment. Blood sugar monitoring records evidenced that these were been monitored in accordance with the care plan. A recommendation has been made.

A review of weight monitoring records evidenced these were maintained to a satisfactory standard. There was evidence that patients’ weights were being monitored and recorded accordingly. Some of the records did not include the patients’ full personal details for example; surname. The importance of this information was discussed with the registered manager who agreed to take appropriate actions and monitor accordingly. Appropriate actions had been taken and included referrals to the dietician and General Practitioner (GP). There was evidence in the care records that recommendations made by the medical and healthcare professionals had been adhered to accordingly; for example food and fluid intake charts had been commenced and nutritional supplements were administered in accordance with the prescribed guidance.

A sample review of food and fluid intake charts for an identified patient evidenced that these were maintained to a satisfactory standard. There was good evidence that food and fluids were offered at regular intervals. Supplements were also being recorded. Charts evidenced that the total 24 hour intake was calculated and subsequently recorded in the patient’s daily progress notes. There was evidence that appropriate actions had been taken when intake was poor for example; communication with the dietician and /or general practitioner.

A review of a continence risk assessment for one patient evidenced that it included information in relation to both urinary and bowel management. The assessment outlined the patient's bowel pattern and type as per the Bristol Stool Chart. A review of bowel management records evidenced that the information recorded was consistent with the detail included in the risk assessment. It was noted that whilst the patient had no bowel movement for a nine day period, a review of daily progress notes evidenced ongoing monitoring by registered nurses. For example; entries included '7 days since last BO- no signs of discomfort' and 'no BO despite aperient given, abdomen soft'. Although, some laxatives had been administered as prescribed, other alternatives which had also been prescribed i.e. 'microlax enema' had not been given. A discussion with registered nurses was held in regards to the management plan for this area of need. They agreed going forward that care plans would include the parameters to indicate when it is appropriate to implement this prescribed intervention.

Discussion with staff evidenced that they were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and changes noted. A discussion with staff from the housekeeping team indicated that appropriate information was not always shared with them in a timely manner. This information was shared with the registered manager who agreed to address going forward.

The registered manager confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed. The most recent staff meeting was held on 30 January 2017. A recommendation made at a previous inspection in regards to same was met.

Discussion with the registered manager, relatives and a review of records evidenced that relatives' meetings were held and records were maintained. The most recent meeting held was 30 January 2017.

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

Areas for improvement

Areas for improvement were identified to ensure care plans are reviewed and kept up to date to reflect the patients assessed needs, treatment and care interventions required.

Number of requirements	0	Number of recommendations	1
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4.5 Is care compassionate?

There was a varied and busy activities programme in place which was coordinated by two activity leaders. The programme evidenced that not only do outside entertainers and arts and crafts groups come to the home but a range of activities outside of the home were provided. Opportunities were provided for patients to visit community facilities and events and these opportunities were greatly enjoyed by patients. Patients had attended an event "brainwave" organised by the Alzheimer's disease Society the day prior to the inspection. Patients' who had attended the event advised that they had enjoyed the day.

Observation of the activities at the time of the inspection evidenced staffs’ knowledge of the importance of spending individual time with those patients who are unable to participate in more formal or group activities. This was good practice. Discussion with the registered 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 meetings are held at regular intervals. There was evidence of many notice boards throughout the home for relatives and visitors information. Information detailed included; the activities programme, up and coming events, information regarding staff and patient meetings and the home’s complaints procedure.

Consultation with patients individually, and with others in smaller groups, confirmed that living in Lisadian House was, a positive experience.

Comments included:

“The best home around, the staff are great.”
 “The staff are very kind and treat me respectfully.”

We met with two relatives who expressed their satisfaction with the care afforded by staff to their relatives.

Comments included:

“Happy with the care no concerns.”
 “Quality of the food is good.”

Staff also commented positively about working in the home.

Comments included:

“We were in the valley and are now in the mountain.”
 “The home is more stable.”

As previously discussed, questionnaires were left for distribution to patients, staff and relatives. At the time of issuing this report; no questionnaires were returned by either patients or staff.

Two questionnaires were returned by relatives. Both respondents indicated that they were very satisfied across all four domains reviewed. Additional comments were included and have been referred to throughout the report.

Other comments included:

“All members of staff are always smiling and cheerful. Always address my relative by her name and are interested in what she likes.”
 “Lisadian home is highly managed as a care home and my family and I fully endorse this, our mother has received excellent care in her 4 years here.”

Areas for improvement

No areas for improvement were identified in this domain.

Number of requirements	0	Number of recommendations	0
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4.6 Is the service well led?

The registration certificate was displayed in the entrance lobby. A certificate of public liability insurance was current and displayed.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Since the last inspection, the home has recruited a deputy manager and an additional sister. Staff were able to describe their roles and responsibilities. In discussion, patients and relatives were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Staff and representatives generally confirmed that they were confident that management would manage any concern raised by them appropriately. An issue raised at a previous inspection had been managed and dealt with accordingly. Audits of complaints identified any lessons learned and actions taken to drive quality improvement.

As discussed in section 4.3, a discussion with the registered manager and review of records evidenced that notifications of accidents and/or incidents had not been managed appropriately. A number of accidents and incidents that had occurred had not been reported to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. A requirement has been made in this regard.

Discussion with the registered 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, audits were completed in relation to infection prevention and control, incidents and accidents, the use of restrictive practice, adult safeguarding referrals, complaints and the environment. Whilst there were detailed audits in place and shortfalls had been identified, there was a lack of evidence to demonstrate that shortfalls had been addressed effectively. This was evidenced in regards to accidents and incidents. The quality auditing systems of the services provided by the home should evidence that identified shortfalls have been actioned appropriately to ensure quality improvements. A recommendation has been made.

Discussion with the registered manager and review of records for January to March 2017 evidenced that Regulation 29 monthly quality monitoring visits were completed in accordance with the regulations and/or care standards. The review of the reports evidenced that an action plan had been generated to address any areas for improvement.

A sample review of policies and procedures evidenced that some of these had not been reviewed within the three year time frame as outlined in the DHSSP's Care standards for Nursing Homes, 2015. A recommendation has been made.

Although, the registered manager advised that they reviewed urgent communications, safety alerts and notices, there were no systems and processes in place to ensure that this information was reviewed and made available to key staff in a timely manner. A recommendation has been made.

Areas for improvement

Areas for improvement have been identified in relation to notifications; auditing processes; policies and procedures and the management of urgent communications, safety alerts and notices.

Number of requirements	1	Number of recommendations	3
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5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed 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	
Statutory requirements	
<p>Requirement 1</p> <p>Ref: Regulation 13 (1) (a) (b)</p> <p>Stated: First time</p> <p>To be completed by: 31 May 2017</p>	<p>The registered persons shall ensure that treatment and other services provided to each patient meets his individual's needs, current best practice and where necessary provided by means of appropriate aids or equipment.</p> <p>This requirement is made with particular focus to the management of accident and incidents including falls.</p> <p>Ref: Section 4.3</p>
	<p>Response by registered provider detailing the actions taken: A step by step flow chart has been compiled and is on the wall of the Nurses' Office for reflection and guidance. Regular audits will be undertaken to convey good practice and areas for improvement.</p>
<p>Requirement 2</p> <p>Ref: Regulation 30 (1) (d) (f)</p> <p>Stated: First time</p> <p>To be completed by: 31 May 2017</p>	<p>The registered persons shall ensure that notifications are submitted to RQIA in accordance with legislative requirements and provider guidance.</p> <p>Ref: Section 4.3 & 4.6</p>
	<p>Response by registered provider detailing the actions taken: This is being completed.</p>
Recommendations	
<p>Recommendation 1</p> <p>Ref: Standard 38</p> <p>Stated: First time</p> <p>To be completed by: 31 May 2017</p>	<p>The registered persons should ensure that records are kept of all documentation relating to the recruitment process these should include; evidence of interview.</p> <p>Ref: Section 4.3</p>
	<p>Response by registered provider detailing the actions taken: Those not in file at time of inspection have been added in and all future candidates will have interview notes in file.</p>
<p>Recommendation 2</p> <p>Ref: Standard 47</p> <p>Stated: First time</p> <p>To be completed by: 30 June 2017</p>	<p>The registered persons should ensure that a system is developed and maintained to ensure "slings" used for moving and handling practice are safe for use.</p> <p>Ref: Section 4.3</p>
	<p>Response by registered provider detailing the actions taken: An inventory of all slings has been compiled and all slings are checked on a monthly basis to ensure they are in good repair.</p>

<p>Recommendation 3</p> <p>Ref: Standard 4 Criteria 7</p> <p>Stated: First time</p> <p>To be completed by: 30 June 2017</p>	<p>The registered persons should ensure that care plans are reviewed and updated to reflect patients changing needs.</p> <p>Ref: Section 4.4</p> <hr/> <p>Response by registered provider detailing the actions taken: The care plan highlighted at inspection has been amended. Care plans continue to be audited to ensure they reflect the changing needs of the individual residents.</p>
<p>Recommendation 4</p> <p>Ref: Standard 35 Criteria 17</p> <p>Stated: First time</p> <p>To be completed by: 30 June 2017</p>	<p>The registered persons should ensure that systems and processes are in place to ensure that urgent communications; safety alerts and notices, standards and good practice guidance are made available to key staff in a timely manner.</p> <p>Ref: Section 4.6</p> <hr/> <p>Response by registered provider detailing the actions taken: A file will be put in place to keep a record of all alerts etc sent to the Home and will be available to all key staff.</p>
<p>Recommendation 5</p> <p>Ref: Standard 36 Criteria 4</p> <p>Stated: First time</p> <p>To be completed by: 30 October 2017</p>	<p>The registered persons should ensure that policies and procedures are subject to a systematic three yearly review at a minimum (and more frequently if required), and the registered person ratifies any revision to (or the introduction of new) policies and procedures.</p> <p>Ref: Section 4.6</p> <hr/> <p>Response by registered provider detailing the actions taken: A system is in place for the review of all policies and procedures. These will be reviewed on a 3 yearly basis.</p>
<p>Recommendation 6</p> <p>Ref: Standard 28 Criteria 10</p> <p>Stated: First time</p> <p>To be completed by: 30 June 2017</p>	<p>The registered persons should ensure that the quality auditing systems of the services provided by the home should evidence that identified shortfalls have been actioned appropriately to ensure quality improvements.</p> <p>This recommendation has been made in regards to audits completed in relation to falls, accidents and incidents.</p> <p>Ref: Section 4.3 & 4.6</p> <hr/> <p>Response by registered provider detailing the actions taken: Audits continue as per the audit schedule. A step by step flow chart on how to manage falls, accidents and incidents has been compiled and is on the wall of the Nurses' Office for reflection and guidance. Further action to be taken if improvement is not noted in the next audit.</p>

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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