Unannounced Care Inspection Report
29 August 2017

Balmoral View Care Centre

Type of Service: Nursing Home (NH)
Address: 5 The Manor, Blacks Road, Dunmurry, BT10 0NB
Tel No: 028 9062 9331
Inspector: Heather Sleator

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

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care and residential care for up to 39 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare **Responsible Individual(s):** Dr Claire Royston	**Registered Manager:** Mr Rosendo Soriano
Person in charge at the time of inspection: Mr Rosendo Soriano	**Date manager registered:** 5 May 2017
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH (E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill. Residential Care (RC) I – Old age not falling within any other category.	**Number of registered places:** 37 comprising: 20 – NH - I, PH, PH(E) and TI 15 – NH – DE 2 – RC-I

4.0 Inspection summary

An unannounced inspection took place on 29 August 2017 from 09.15 to 18.00 hours.

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

The term ‘patients’ is used to describe those living in Balmoral View Care Centre which provides both nursing and residential care.

The inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found in relation to staff recruitment practices; staff induction, training and development; adult safeguarding arrangements; infection prevention and control practices; risk management and and effective communication systems. The culture and ethos of the home promoted treating patients with dignity and respect. There was also evidence of good practice identified in relation to the governance and management arrangements, with the exception of auditing of patient care records; management of complaints and incidents; quality improvement processes and maintaining good relationships within the home. The environment of the home was conducive to the needs of the patients and was attractive and comfortable.

An area identified under regulation was in relation to ensuring the delivery of care is in accordance with patients assessed needs, meets his needs and reflects current best practice. This must be clearly evident in patient care records.

Areas requiring improvement were identified under the care standards and included; the robust auditing of patient care records; maintaining patient care records in a manageable manner so as current information is readily accessible and the establishment of a system that ensure the personal emergency evacuation plans retained in the home are current at all times.

Two standards have been stated for a second time; refer to section 6.2 for further information regarding this.

Patients said they were generally happy living in the home. Comments included, “Staff are friendly, open and trustworthy.” Further comments can be viewed in section 6.6 of the report.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	*5

*The total number of areas for improvement includes two standards which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Rosario Soriano, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the most recent inspection dated 1 June 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 1 June 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

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

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

During the inspection the inspector met with 10 patients individual and the remaining patients in small groups, seven staff and three patients' visitors/representatives. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

A lay assessor Alan Craig was present during the inspection and their comments are included within this report.

The following records were examined during the inspection:

- duty rota for all staff from 14 August to 27 August 2017
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction file
- three patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- staff supervision and appraisal planners
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

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

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 1 June 2017

The most recent inspection of the home was an unannounced medicines management inspection.

The completed QIP was returned and approved by the pharmacist inspector.

6.2 Review of areas for improvement from the last care inspection dated 23 February 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 46.2 **Stated:** First time	The registered provider should ensure that the storage arrangements at wash hand basins in patients' bedrooms should be reviewed in accordance with infection prevention and control procedures.	**Met**
	Action taken as confirmed during the inspection: The review of a number of patients' bedrooms evidenced that storage arrangements in patients' bedrooms had been resolved.	
Area for improvement 2 **Ref:** Standard 4.8 **Stated:** First time	The registered provider should ensure care plans evidence the desired daily fluid intake for individual patients and the action to be taken, and at what stage, should the desired target not be met.	**Not met**
	Action taken as confirmed during the inspection: The review of three patient care records did not evidence the effective management of hydration. This area for improvement has not been met and has been stated for a second time.	

Area for improvement 3 **Ref:** Standard 4.4 **Stated:** First time	The registered provider should ensure that the recommendations made by any other healthcare professional are adhered to.	**Not met**
	Action taken as confirmed during the inspection: The review of three patient care records di not evidence that the recommendations made by other healthcare professionals were consistently adhered to and/or care plans updated to reflect current recommendations. This area for improvement has not been met and has been stated for a second time.	
Area for improvement 4 **Ref:** Standard 4.9 **Stated:** First time	The registered provider should ensure that staff diligently record and report on all planned care interventions to meet patients assessed need within supplementary care records.	**Met**
	Action taken as confirmed during the inspection: The review of three patients supplementary care records evidenced staff were reporting in a more consistent and diligent manner.	
Area for improvement 5 **Ref:** Standard 6.1 and 6.6 **Stated:** First time	The registered provider should ensure staff complete training regarding the core values, for example, privacy, dignity and respect and how these values define their interaction with patients.	**Met**
	Action taken as confirmed during the inspection: The review of staff training records evidenced that staff had been in receipt of the identified training.	

6.3 Inspection findings

6.4 Is care safe?

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

The registered manager confirmed the planned daily staffing levels for the home and that staffing was subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 14 August to 27 August 2017 evidenced that the planned staffing levels were adhered to. The review of the staffing rosters evidenced that there were ancillary staff on duty throughout the seven day period. Observation of the delivery of care and discussion with staff evidenced that patients' needs were met by the levels and skill mix of staff on duty.

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; four were returned prior to the issue of this report. All of the respondents answered 'yes' to the question "are there sufficient staff to meet the needs of the patients?" Seven relatives also responded via questionnaire and confirmed their satisfaction with the staffing arrangements.

A nurse was identified on the staffing rota to take charge of the home when the registered manager was off duty. A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the manager. The assessments were signed by the registered manager to confirm that the assessment process has been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home.

Discussion with the registered manager and a review of two staff personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Where nurses and carers were employed, their registrations were checked with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC), to ensure that they were suitable for employment. The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI and satisfactory references had been sought and received, prior to the staff member starting their employment.

The registered manager confirmed that newly appointed staff commenced a structured orientation and induction programme at the beginning of their employment. A review of two completed induction programmes evidenced that these were completed within a meaningful timeframe. We spoke with staff who confirmed that they were provided with a period of induction during which they were supernumerary. Staff commented positively on the induction they had received.

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the registered manager and reviewed. The review of the records evidenced that a robust system was in place to monitor the registration status of nursing and care staff.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and records were kept up to date. A review of staff training records confirmed that staff completed training modules on for example; basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. The records reviewed confirmed that the registered manager had a system in place to ensure staff met their mandatory training requirements.

A review of the supervision and appraisal schedule confirmed that there were systems in place to ensure that staff received supervision and appraisal. In discussion with staff they confirmed they were in receipt of regular supervision and an annual staff 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. The registered manager confirmed that they had attended training which included the role of the safeguarding champion and there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. The adult safeguarding policy reflected the new regional operational procedures.

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 informed the care planning process. Care records are further discussed in section 6.5.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since February 2017 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients and staff spoken with were complimentary in respect of the home's environment. The dementia unit was conducive to the needs of a person living with dementia and orientation cues and signposting to specific areas, for example; toilet facilities were in evidence. The lounge areas and dining rooms located at the entrance of the home had been tastefully decorated and were in keeping with the period of the building.

Infection prevention and control measures were adhered to. We observed the housekeepers equipment trolley and equipment was in accordance with the National Patient Safety Agency (NPSA) national colour coding scheme for equipment such as mops, buckets and cloths. Sluice rooms and bathroom/toilets were observed to be clutter free and well organised. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately.

Fire exits and corridors were observed to be clear of clutter and obstruction. The annual fire risk assessment of the home was undertaken in January 2017.

Discussion with the registered manager and a review of documentation evidenced that the recommendations of the report had been addressed or were in the process of being addressed. The review of the personal emergency evacuation plans (PEEP's) for patients in the home did not evidence that the information was current. This was brought to the attention of the registered manager who had addressed the issue before the end of the inspection.

However, this has been identified as an area for improvement under the care standards. The registered manager should establish a system to monitor the accuracy of the information on a regular basis.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the management and provision of staffing, recruitment and selection procedures, staff training and development, adult safeguarding and infection prevention and control.

Areas for improvement

The following areas were identified for improvement under the care standards in relation to the establishment of a system that ensure the personal emergency evacuation plans retained in the home are current at all times.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

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

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 informed the care planning process.

There were a number of examples of good practice found throughout the inspection in this domain. For example, 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 Specialists (TVN). However, the review of patient care records did not evidence that the recommendations made by the relevant professionals had been incorporated into the daily care of the patients, for example:

- The recommendations of the dietician in respect of a patient receiving nutrition via a percutaneous endoscopic gastrostomy tube (PEG) had not been adhered to and registered nurses continued to evaluate the care plan which had not been updated to reflect the professionals' recommendations.
- Care plans were also noted not to have been updated with the recommendations of a relevant professional regarding a patient's weight loss. The care plan was only revised approximately eight weeks later.
- A care plan detailing the specific interventions regarding the use of a restrictive practice were not being followed.
- The wound care management plan for a patient had not been updated following the recent visit from the relevant professional.
- Management of hydration; care records did not evidence that where a patient had been assessed as being at risk of dehydration the action to be taken in the event of the patient not attaining their desired daily fluid intake was not present. This was a recommendation of the previous inspection report of 23 February 2017 and has been stated for a second time in this report.

The review of care records therefore did not evidence that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record. This has been identified as an area for improvement under the regulations.

The review of care records also evidenced that there was a substantial amount of information present in each record. The volume of the information led to difficulty in finding the current assessments and care plans. The care records should be reviewed and structured so as to enable staff to locate the current prescribed treatment plans and/or recommendations with ease. This was identified as an area for improvement under the care standards.

A number of care records are audited on a monthly basis as part of the organisations governance procedures. It was concerning that the issues identified on inspection had not previously been identified when audits were being completed. A more robust system for the auditing of patient care records should be established by the registered manager. This was identified as an area for improvement under the care standards.
Personal or supplementary care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans, the frequency of repositioning was recorded on the repositioning record and staff were reporting on the condition of the patient's skin.

Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005; the registered manager confirmed that the patient register was checked on a regular basis.

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

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective.

Staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The most recent staff meeting was 26 July 2017. Staff stated that there was effective teamwork with each staff member knew their role, function and responsibilities.

The serving of the midday meal was observed. Tables were attractively set with cutlery, condiments and napkins. Those patients who had their lunch in the lounge or their own bedroom were served their meal on a tray which was set with cutlery and condiments and the food was covered prior to leaving the dining room. The meals were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch. The day's menu was displayed in the dining room. Registered nurses were observed supervising and assisting patients with their meals and monitoring patients' nutritional intake. The serving of the midday meal in the dementia unit (Coleman) was observed to be in accordance with best practice for persons living with dementia.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication between residents, staff and relatives and the patients' dining experience.

Areas for improvement

The following area identified for improvement under the regulations was in relation to care records. Care records must be maintained in an up to date and accurate manner.

The following areas were identified for improvement under the care standards was in relation to ensuring accurate information is readily available within patient care records and establishing a robust auditing system of patient care records.

	Regulations	Standards
Total number of areas for improvement	1	2

6.6 Is care compassionate?

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

We arrived in the home at 09:15. There was a calm atmosphere and staff were busy attending to the needs of the patients. 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.

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. Staff were knowledgeable of patients' non-verbal cues and what they were trying to communicate; the positive non-verbal responses by patients confirmed staffs understanding was correct.

The lay assessor met with a number of patients during the inspection. Patients' comments to the lay assessor included:

"I've no complaints, they (staff) really do their best and nothing is a problem to them."
"Anytime I've needed help they've (staff) been there for me."
"I've had some difficulty adjusting to life here and staff have done their best to help and smooth things over."

Two patients felt the home was short staffed on occasions and one patient felt that the permanent staff in the home were very good and that agency staff did not always appear to know what to do. The comments received from the patients to the lay assessor were discussed with the registered manager who agreed to consider the issues raised.

We spoke with 10 patients individually, who commented:

“The staff are fantastic.”
“Very friendly staff.”
“Staff are excellent, very attentive.”
“Staff are very helpful, I’m comfortable here.”
“I’m very comfortable here and staff are very attentive.”
“This home is like a breath of fresh air.”
“Staff are very caring.”

We spoke with relatives who commented:

“Couldn’t get a better home.”
“Staff keep us informed of everything that’s happening with our (relative).”
“Very happy with the care in Balmoral View, staff are great.”
“Very happy with the care in Balmoral View, staff respond very quickly to the call bells.”
“I sleep better at night now knowing my (relative) is well cared for.”

We spoke with staff who commented:

“Good teamwork here.”
“Management are very supportive.”

Questionnaires

In addition 10 relative/representatives; eight patient and 10 staff questionnaires were provided by RQIA to the registered manager for distribution. At the time of issuing this report, four patients, four staff and six relatives returned their questionnaires within the specified timeframe.

Patients

Three patients indicated that they were either ‘very satisfied’ or ‘satisfied’ that the delivery of care was safe, effective and compassionate and that the service was well led. One patient indicated that they could not accurately indicate if care was compassionate and if the service was well led. The patient was ‘satisfied’ that care was safe although was ‘unsatisfied’ that care was effective.

Relatives

All six relatives who responded indicated that they were very satisfied that the delivery of care was safe, effective and compassionate and that the service was well led.

Additional comments included:

“Staff have made a very difficult situation very easy.”
“The care our (relative) has been given is excellent and the home is clean and fresh everyday.”
“The staff keep us informed when we visit or by telephone, if there are any changes they tell us which gives us peace of mind.”

"Our (relatives) minister informed the family that staff were very respectful to him when he visited."
"Have to say that from the manager to the cleaners and caretaker all the staff seem to work well as a team."

Staff

Three staff indicated that they were 'very satisfied' that the delivery of care was safe, effective and compassionate and six that the service was well led. One staff member indicated that they were 'satisfied' across the four domains. There were no additional comments made.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of the patients 'and the provision of activities.

Areas for improvement

No areas for improvement were identified in this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

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

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

Discussions with the staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. Staff described how they felt confident that the management would respond positively to any concerns/suggestions raised.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. There was a system in place to identify the person in charge of the home, in the absence of the manager.

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 Care Standards for Nursing Homes 2015. Staff, patients and patients' representatives spoken with and who responded via questionnaire that that were confident that staff/management would manage any concern raised by them appropriately, with the exception of one patient.

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 accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice. However and as discussed in section 6.5, the auditing of care records was not a robust process and has been identified as an area for improvement.

As a further element of its Quality of Life Programme, Four Seasons Healthcare operate a Thematic Resident Care Audit ("TRaCA") which home managers can complete electronically. Nursing homes which have attained the DCF accreditation complete the 'TraCA D' Information such as home governance, information governance, housekeeping, resident care and health and safety checks are recorded on various TRaCAs on a regular basis. This information was subject to checks by the regional manager once a month.

A review of the patient falls audit evidenced that this was analysed to identify patterns and trends, on a monthly basis. An action plan was in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection, confirmed that these were appropriately managed. There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. An action plan was generated to address any areas for improvement; discussion with the registered manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships within the home.

Areas for improvement

No areas for improvement were identified in this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Rosario Soriano, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.
Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

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

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 12 (1) (a) and (b) **Stated:** First time **To be completed by:** 16 October 2017	The registered person shall ensure the delivery of care is in accordance with patients assessed needs, meets his needs and reflects current best practice. Ref: Section 6.5
	Response by registered person detailing the actions taken: The delivery of care is in accordance with patients assessed needs,meets their needs,and reflects best practice.Registered Manager is monitoring the delivery of care on a daily basis in the home,through his daily walkabouts around the home,checking the 24 hour shift reports,and checking appropriate care plans are in place and actions being followed through.
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref:** Standard 4.8 **Stated:** Second time **To be completed by:** 23 October 2017	The registered provider shall ensure care plans evidence the desired daily fluid intake for individual patients and the action to be taken, and at what stage, should the desired target not be met. Ref: Section 6.2
	Response by registered person detailing the actions taken: Patients who are on monitoring for fluids intake have individual care plans which have the desired daily fluid intake,and actions taken are being recorded when the desired daily fluid target are not met.
Area for improvement 2 **Ref:** Standard 4.4 **Stated:** Second time **To be completed by:** 23 October 2017	The registered provider shall ensure that the recommendations made by any other healthcare professional are adhered to. Ref: Section 6.2
	Response by registered person detailing the actions taken: Recommendations made by healthcare professionals are being adhered to.The Registered Manager is monitoring this through care plan tracas.

Area for improvement 3 **Ref:** Standard 48.7 **Stated:** First time **To be completed by:** 23 October 2017	The registered provider shall ensure the the personal emergency evacuation plans (PEEP's) are maintained in an up to date manner and reflect the needs of patients' at any given time. Ref: Section 6.4
	Response by registered person detailing the actions taken: The personal emergency evacuation plans (PEEP's) have all been updated and are being maintained to reflect the needs of the patients.
Area for improvement 4 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** 23 October 2017	The registered provider shall ensure that patient care records contain readily accessible and structured information in respect of patients assessed need, including risk assessments and care plans. Information that is no longer current or applicable to the patient should be 'closed' and or moved to another part of the file to lessen any confusion. Ref: Section 6.5
	Response by registered person detailing the actions taken: The patients care records contain up to date structured and current information in respect of patients needs assessments, risk assessments and care plans. Information that is no longer required is filed awayThe Registered Manager is monitoring the care records through doing care tracas.
Area for improvement 5 **Ref:** Standard 35.6 **Stated:** First time **To be completed by:** 23 October 2017	The registered person shall ensure a robust system for the auditing of care records is established. Ref: Section 6.5
	Response by registered person detailing the actions taken: There is a robust system for auditing of care records in place.The Registered Manager has a care plan matrix in place to ensure that all care records in the home are being audited.

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

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