

Unannounced Care Inspection Report 4 & 5 October 2016



Our Lady's Home

Type of Service: Nursing Home

Address: 68 Ard Na Va Road, Falls Road, Belfast, BT12 6FF

Tel no: 028 9032 5731

Inspector: Sharon McKnight

1.0 Summary

An unannounced inspection of Our Lady's Home took place on 4 October 2016 from 10:00 hours to 16:30 hours and 5 October 2016 from 09:45 hours to 16:45 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 the duty rosters and recommended the introduction of a cleaning schedule for housekeeping staff in one unit. We reviewed the systems to check that staff registration status with their professional bodies was maintained; a requirement was made.

Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding.

Extensive refurbishment of the dementia unit was ongoing at the time of this inspection. We discussed with staff the challenges of delivering care and maintaining the normal routine whilst the work was ongoing. A recommendation was made that a continuity plan was put in place.

Compliance with the requirements and recommendations made will further enhance the quality and standard of care and services delivered.

Is care effective?

We reviewed the systems and processes in place which support effective care delivery.

Following a review of care records areas for improvement were identified; three recommendations were made. We examined the systems in place to promote effective communication between staff and were assured that these systems were robust. Patients, relatives and staff were of the opinion that the care delivered was effective.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully. Numerous compliments had been received by the home from relatives and friends of former patients. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding issues affecting them. Patients spoken with commented positively in regard to living in the home.

Is the service well led?

There was a clear organisational structure evidenced within Our Lady's Home and staff were aware of their roles and responsibilities. A review of care observations confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide.

There was evidence of good leadership in the home and effective governance arrangements. Staff spoken with were knowledgeable regarding the line management structure within the home and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. There were systems in place to monitor the quality of the services delivered.

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	1	6

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mr Gavin O'Hare Connolly, responsible person and Ms Nora Curran, 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 26 May 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.

2.0 Service details

Registered organisation/registered person: Diocese Of Down and Connor / Gavin O'Hare-Connolly	Registered manager: Nora Curran
Person in charge of the home at the time of inspection: Day 1 Gavin O'Hare Connolly Day 2 Nora Curran	Date manager registered: 13 July 2016
Categories of care: NH-DE, NH-I, NH-PH, NH-PH(E), NH-TI A maximum of 67 patients in categories NH-I, NH-PH, NH-PH(E), NH-TI to be accommodated in the general nursing unit and a maximum of 19 patients in category NH-DE to be accommodated in the dementia unit. This home is also approved to provide care on a day basis to 4 persons in the general nursing unit and 1 person in the dementia unit.	Number of registered places: 86

3.0 Methods/processes

Prior to inspection we analysed the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report.

During the inspection we met with 15 patients individually and with others in small groups, one nursing sister, three registered nurses, four senior care assistants, eight care staff, the house keeper, four domestic assistants, the catering manager and three patient's relatives.

The following information was examined during the inspection:

- staff duty roster for the week commencing 2 October 2016
- eight patient care records
- staff training records
- staff induction records
- staff recruitment records
- records of staff NMC/NISCC registration
- complaints and compliments records
- incident and accident records
- records of audit

- records of staff meetings
- records of relatives meeting
- reports of monthly quality monitoring visits.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 26 May 2016.

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 12/13 January 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 Ref: Regulation 20(3) Stated: Second time	The registered person must ensure that any nurse who is given the responsibility of being in charge of the home for any period in the absence of the manager has been assessed as competent and capable to undertake this role.	Met
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of records evidenced that a competency and capability assessment had been completed with all nurses who were given the responsibility of being in charge of the home for any period in the absence of the manager. This requirement has been met.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 Ref: Standard 20 & 32 Stated: First time	It is recommended that further opportunities, to discuss end of life care, are created by the registered nurses. Any expressed wishes of patients and/or their representatives should be formulated into a care plan for end of life care. This should include any wishes with regard to the religious, spiritual or cultural need of patients'.	Met
	Action taken as confirmed during the inspection: Care records reviewed contained details of any expressed wishes for end of life care. This recommendation has been met.	
Recommendation 2 Ref: Standard 41.2 Stated: First time	It is recommended that systems are put in place to evidence that there are sufficient staff on each shift to meet the needs of the patients and ensure that patients receive the care they require at the time they require it.	Met
	Action taken as confirmed during the inspection: The registered manager provided examples of the indicators they used to evidence that there was sufficient staff to meet the needs of the patients. They confirmed that the dependency levels of patients were completed monthly. Staffing is further discussed in section 4.3. This recommendation has been met.	

<p>Recommendation 3</p> <p>Ref: Standard 12</p> <p>Stated: First time</p>	<p>It is recommended that mealtimes throughout the home are reviewed to ensure that they are a positive experience for patients.</p> <hr/> <p>Action taken as confirmed during the inspection: The registered manager confirmed that an audit of the dining experience had been completed. Patients were complimentary regarding the meals and staff reported an improvement in the choice and quality of meals served. We observed the serving of meals in three of the units. No issues with the meal time experience were identified. This recommendation has been met.</p>	<p>Met</p>
<p>Recommendation 4</p> <p>Ref: Standard 12.1</p> <p>Stated: First time</p>	<p>It is recommended that the menu is reviewed to ensure that those patients who require a specialised or pureed meal are provided with choice at each meal and snacks at morning, afternoon tea and supper time.</p> <p>There should be evidenced of patient involvement in the review of the menu.</p> <hr/> <p>Action taken as confirmed during the inspection: Staff spoken with confirmed that a choice was available at each meal and at customary tea times for those patients who required a specialised or pureed meal. The registered manager confirmed that this had been included in the audit of the dining experienced. This recommendation has been met.</p>	<p>Met</p>
<p>Recommendation 5</p> <p>Ref: Standard 4.8</p> <p>Stated: First time</p>	<p>It is recommended that individual assessments to identify the appropriate continence aids to meet patients' needs are completed.</p> <hr/> <p>Action taken as confirmed during the inspection: Care records reviewed contained a continence assessment. This recommendation has been met.</p>	<p>Met</p>
<p>Recommendation 6</p> <p>Ref: Standard 4.7</p> <p>Stated: First time</p>	<p>The acting manager should ensure that reassessment is ongoing to ensure that the continence products meet the needs of the patient.</p>	<p>Met</p>

	<p>Action taken as confirmed during the inspection:</p> <p>The performance of the continence products in use was discussed with staff. Staff were of the opinion that the products met the needs of the patients; no issues were identified. This recommendation has been met.</p>	
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4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and advised that these levels were subject to regular review to ensure the assessed needs of the patients were met. As previously stated the registered manager provided examples of the indicators they used to evidence that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for week commencing 2 October 2016 evidenced that the planned staffing levels were adhered to. Nursing and care staff spoken with were generally satisfied that there were sufficient staff to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; five were returned following the inspection. Whilst all of the respondents were very satisfied or satisfied that there were sufficient staff to meet the needs of the patients three of the respondents answered no to the question "Are there sufficient staff to meet the needs of the patients?" There were two comments that if there were more staff they could spend more time on a one to one basis with the patients. These opinions were shared with the registered manager.

We also sought relatives' opinion on staffing via questionnaires. Whilst one relative replied yes to the question "Are you satisfied that staff have enough time to care for you relative?" they commented that "they could do with a few more staff to assist at mealtimes." This comment, and the unit it was in relation to, were shared with the registered manager.

Extensive refurbishment of the dementia unit was ongoing at the time of this inspection. We discussed with staff the challenges of delivering care and maintaining the normal routine whilst the work was ongoing. For example when the corridor ceilings were being painted all of the patients remained in the main lounge throughout the day; there was no access to the dining rooms so the patients also had their meals served in the lounge. On the second day of the inspection the main corridors were free from the ongoing work but staff had been instructed to continue caring for the patients in the one lounge area. Discussion with the nurse in charge of the unit and staff evidenced that there was no formal plan in place for the continuity of care during the ongoing work. We identified that, at times depending on what work was being completed, there was a significant increase in staff workload. This was discussed with the registered manager who confirmed that at times staffing had been increased. It was recommended that continuity plans were put in place to ensure any disruption to the delivery of care is kept to a minimum during the refurbishment work. Staff should be fully informed of the plans and agreed working practices. Consideration should be given to increasing staff on days when the normal routine is significantly disrupted.

An occupational therapist (OT) and OT assistant were employed to undertake functional and cognitive assessments and deliver therapeutic activities.

In addition to nursing and care staff, staffing rosters confirmed that administrative, catering, domestic and laundry staff were on duty daily. Discussion with the housekeeping staff

identified that there had been some recent changes to the allocation of staff. One unit no longer had an individual member of staff allocated daily; instead the staff from other units rotated throughout the day to undertake the cleaning duties. We discussed how duties were allocated. Staff were clear regarding the areas and allocation of rooms which required daily cleaning. However there was no cleaning schedule in place for the deep cleaning of rooms and the allocation of tasks which were not required to be completed daily. Staff explained that they relied on communication between themselves to ensure that all areas of the unit were cleaned as required. A cleaning schedule should be put in place for the identified unit to ensure all areas are cleaned and provide staff with direction of who is required to undertake what. Completion of the cleaning schedule will also provide staff with traceability of tasks completed. No issues were identified with the standard of cleanliness in this unit.

In two of the returned questionnaires staff were of the opinion that the recent changes to the deployment of the housekeeping staff had reduced the cleanliness of the home. This was not evident during the inspection.

The registered manager explained that a registered nurse was identified to take charge of the home when the manager was off duty. The nurse in charge on day and night duty was clearly identified at the front of the staffing roster in each unit. It was also displayed in the foyer of the home and at each nurses station throughout the home. Due to the extensive geographical layout of the home the nurse in charge was provided with a bleep and mobile phone to enable staff to contact them. The nurse in charge was also provided with a file containing the duty rota for each unit, contact details for all staff and a copy of the contingency plans for emergency situations, for example evacuating the building and utility failure. Discussion with three registered nurses who were given the responsibility of being in charge of the home in the absence of the manager confirmed that they had been given the relevant information to undertake the role and were knowledgeable regarding management situations.

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 registered 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.

A review of two personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. The record maintained of Access NI checks was reviewed and evidenced that the certificate had been checked prior to the candidate commencing employment.

Discussion with the registered manager and a review of records evidenced that there were arrangements in place for monitoring the registration status of nursing and care staff with their relevant professional bodies. It was noted that the monthly record of checks made on 3 October 2016 stated "hold" against the record of one nurse. The nurse's registration had been due for renewal since the previous check had been completed. This was discussed with the registered manager who reported that this registration had not been renewed at the time and the registered nurse had undertaken nursing duties on two shifts when their registration had lapsed. Whilst RQIA acknowledge that appropriate action was taken by the registered manager when they became aware of the lapsed registration the systems in place were not effective and did not prevent this registered nurse practising whilst their registration had lapsed. We requested that the registered manager submit a notification to RQIA that a registered nurse undertook nursing duties on a number of shifts without a live registration with the NMC. This was submitted to RQIA by electronic mail prior to the conclusion of the inspection. Whilst no issues were identified with the registration status of the care assistants

with the Northern Ireland Social Care Council (NISCC) this system had the potential for a similar issue to occur with the registration of care staff. A robust system to check that staff maintain a live registration with the relevant professional body must be implemented. A requirement was made.

Discussion with the registered manager and staff and a review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Mandatory training was provided by the home in classroom based sessions. A training schedule was in place with sessions arranged every Wednesday throughout the year. Systems were in place to monitor staff attendance and compliance with training. These systems included a training matrix of which staff had attended training and signing in sheets to evidence staff attendance.

Training opportunities were also provided by the local health and social care trust. The registered manager confirmed that when they receive notification of training from the Trust the dates would be displayed in the home and staff would be encouraged to attend. Staff spoken with confirmed that they were provided with a range of training. Staff were of the opinion that the training provided was relevant to their role and responsibilities within the home. In one returned questionnaire a staff member made a comment that although they worked in the dementia unit they had not received any training in dementia

Review of patients' care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk.

The registered manager and staff clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. The registered nurses and care staff were aware of whom to report concerns to within the home. Annual refresher training was considered mandatory by the home.

A review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the registered manager and staff confirmed that there were systems in place to ensure that staff received support and guidance and to monitor staff performance, if required. Staff were coached and mentored through one to one supervision, competency and capability assessments and annual appraisals.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling, clean and appropriately heated. All of the relatives' responses in the returned questionnaires confirmed their satisfaction with the environment of the home. Staff comments have been discussed previously.

Fire exits and corridors were observed to be clear of clutter and obstruction. However, one exit, which was not a designated fire exit, had numerous items of equipment stored. This was discussed with the responsible person and registered manager who explained that the storage of equipment was a temporary arrangement and was a result of the current refurbishment work that was ongoing. Following discussion with an RQIA estates officer it was recommended that the use of the identified area for storage should be discussed with the fire risk assessor to

ensure that it does not compromise fire safety. RQIA should be informed of the outcome of this discussion.

There were no issues identified with infection prevention and control practice.

Areas for improvement

Continuity plans should be put in place to ensure any disruption to the delivery of care is kept to a minimum during the refurbishment work. Staff should be fully informed of the plans and agreed working practices. Consideration should be given to increasing staff on days when the normal routine is significantly disrupted.

A cleaning schedule should be put in place for the identified unit to ensure all areas are cleaned as required and provide staff with the required direction of who is required to undertake what.

A robust system to check that staff maintain a live registration with the relevant professional body must be implemented.

The use of the identified area for storage should be discussed with the fire risk assessor to ensure that it does not compromise fire safety. RQIA should be informed of the outcome of this discussion.

Number of requirements	1	Number of recommendations	3
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4.4 Is care effective?

We reviewed the care records of seven patients; three in the general nursing unit and four in the dementia nursing unit. Care records were maintained on an electronic system.

General nursing unit:

A review of three patient care records evidenced that initial plans of care were based on the pre admission assessment and referral information. A comprehensive, holistic assessment of patients' nursing needs was in place for each patient. As previously discussed a range of validated risk assessments were completed as part of the admission process. Two of the care records were regularly reviewed regularly and updated, as required, in response to patient need. One care record had not been reviewed at the time of the patient's readmission to the home despite the patient's needs having significantly changed from the previous discharge. Care records should be reviewed at the time of each readmission to the home to ensure that they accurately reflect the needs of the patients. A recommendation was made.

Dementia nursing unit:

We reviewed five patient care records. Four patients had a comprehensive, holistic assessment of need completed; an assessment of need had not been completed for one patient at the time of their admission, a number of months prior to the inspection, or since. An assessment of patient need should be commenced on the day of admission and completed within five days of the admission. A recommendation was made.

We discussed the mobility needs of three patients who staff identified as at high risk of falls. Staff reported that they had been instructed these patients were not allowed to mobilise without

support. Each patient had a fall risks assessment in place which identified that two patients were assessed as moderate risk of falls and one was assessed a high risk. Each patient had a care plan with regard to mobility and history of falls. Only one care plan identified that the patient required supervision. The care which staff were being directed to deliver was not prescribed in the care plans.

Staff discussed the management of infection control issues for one patient. There was no reference in the care records of any condition or past medical history which required infection prevention and control measures. Again there was no care plan in place to prescribe the care that staff were being directed to deliver. Each patient's health, personal and social care needs should be set out in an individual care plan; the care plans should prescribe the interventions required to meet the patients' needs. A recommendation was made.

We reviewed the care record of a patient following a incident which was reported since the last care inspection; we discussed the learning from the incident with staff. A care plan was in place to manage the identified risk and staff were knowledgeable of the actions taken and learning implemented following the incident.

There were a number of care plans which contained unconditional interventions, for example "supervised at all times", "observed at all times." The importance of ensuring that interventions prescribed are realistic and achievable was discussed with the responsible person and the registered manager during feedback at the conclusion of the inspection.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians.

There was evidence within the care records of regular, ongoing communication with relatives. Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Additional records such as repositioning charts and food and fluid intake charts were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping.

Observations evidenced that call bells were answered promptly and patients requesting assistance in the lounge areas or their bedrooms were responded to appropriately. Patients were confident of the ability of staff to meet their need effectively and in a timely manner. Patients were satisfied that staff responded to call bells promptly. The serving of lunch was observed in the general nursing unit. Staff were observed to encourage and gently prompt patients to eat their meal in addition to providing full assistance to those patients who required this level of support. Lunch was observed to be well organised with all of the patients being attended to in a timely manner. There was a choice of dishes; all were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch.

The registered manager confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff spoken with confirmed that a verbal handover took place and a written handover report completed every 24 hours for the registered manager. In the questionnaires issued to staff we asked if they received an effective handover at the start of each shift. All of the respondents confirmed that they did.

The registered manager confirmed that staff meetings were held regularly with staff. Records of the issues discussed and agreed outcomes were maintained. The most recently recorded meeting was with the registered nurses on 30 September 2016. Minutes of these meetings, detailing who had attended and the areas discussed, were available.

Staff advised that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff confirmed that if they had any concerns, they would raise these with the unit sister/charge nurse or registered manager.

Areas for improvement

An assessment of patient need should be commenced on the day of admission and completed within five days of the admission.

Care records should be reviewed at the time of each readmission to the home to ensure that they accurately reflect the needs of the patients.

Each patient's health, personal and social care needs should be set out in an individual care plan; the care plans should prescribe the interventions required to meet the patients' needs.

Number of requirements	0	Number of recommendations	3
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4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding patients' likes and dislikes and individual preferences.

Patients spoken with commented positively in regard to the care they received and were happy in their surroundings. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. The staff confirmed that whilst socialisation between patients was promoted, each had a choice as to how they spent their day and where they preferred to sit throughout the day.

Relatives confirmed that they were made to feel welcome into the home by all staff. They were confident that if they raised a concern or query with the registered manager or staff, their concern would be addressed appropriately.

Numerous compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

"...it is the special little touches of care, the warmth and patience which mean so much, a smile, a chat or a little squeeze of the hand are greatly appreciated."

“Heartfelt thanks to all the wonderful staff. We will never forget you.”

We spoke with the relatives of three patients who all commented positively with regard to the standard of care, the attentiveness of staff and communication in the home.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and relatives and inform them of issues and initiatives affecting the home. Monthly meetings with held with relatives. An agenda was set by the responsible person and registered manager with issues from relatives welcomed under “any other business.” In one returned questionnaire a relative commented that although they found it difficult to attend the monthly meetings they could “call into the front office and find out what is going on.” A record of who attended and the issues discussed was maintained.

Consultation with patients individually, and with others in smaller groups, confirmed that living in Our Lady’s Home was a positive experience.

Patient comments to the inspector included:

‘You couldn’t say anything about the care, it’s great.’

‘I’m happy with everything.’

‘It’s all great.’

‘You only have to ask and the staff will help’

Twelve relative questionnaires were issued; five were returned within the timescale for inclusion in this report. The respondents indicated that they were very satisfied or satisfied that the care was safe, effective and compassionate. One comment provided with regard to the provision of staff have been discussed within the domain of safe in section 4.3.

Ten questionnaires were issued to nursing, care and ancillary staff; five were returned prior to the issue of this report. All of the staff were either very satisfied or satisfied the care was safe, effective and compassionate. Comments received from staff included:

“We are always training and always learning.”

“I can honestly say the elderly are very well cared for and looked after.”

“The service users are always first priority.”

Comments provided regarding staffing are discussed within the domain of safe care in section 4.3. Comments regarding leadership in the home are discussed in section 4.6.

Areas for improvement

No areas for improvement were identified during the inspection.

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

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were displayed and available in the reception area of the home.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home.

Staff spoken with were knowledgeable regarding the line management arrangements and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Staff were also knowledgeable of who the nurse in charge of the home was when the registered manager was off duty.

The registered manager explained that they had regular contact with the patients and were available, throughout the day, to meet with them if needed. Records evidenced that a consultation exercise had been undertaken with the relatives in the dementia unit prior to the refurbishment. The relatives were informed of the options for the refurbishment, including picture images of the proposed colour schemes. Seven responses were received with a unanimous decision reached.

Patients spoken with were aware of who the registered manager was and that she was available in the home to speak with. We also sought relative and staff opinion on leadership in the home via questionnaires. All of the relatives were very satisfied or satisfied that the service was well led.

Five staff completed questionnaires; four of the respondents indicated they were satisfied that the service was well led, one staff member was unsatisfied. Comments received from staff included:

"The leadership is excellent and its all about team work."

"Management are not approachable, you have to make an appointment to see them after a certain time regarding issues."

"To see management you must make an appointment, most of the time you are kept waiting. Very unapproachable."

These opinions was shared with the registered manager who explained that whilst they had day to day contact with staff they were required to pre arrange a time to meet on a one to one basis with her. The registered manager explained that this was to ensure there was sufficient time to discuss the person's issues and for the discussion to take place in a suitable location. The registered manager suggested that further discussion at a staff meeting would be useful to ensure staff understood the rationale for these arrangements.

Patients and relatives spoken with were aware of how to raise a complaint and were confident that staff and/ or management would address any concern raised by them appropriately. A record of complaints was maintained. The record included the date the complaint was received, the nature of the complaint, details of the investigation and action taken, if any. The record also indicated how the registered manager had concluded that the complaint was closed.

There were numerous thank you cards and letters received from former patients and relatives; examples of these have been included in the previous domain.

There were arrangements in place to receive and act on health and safety information, urgent communications, safety alerts and notices; for example from the Northern Ireland Adverse Incident Centre (NIAIC).

The registered manager discussed the systems she had in place to monitor the quality of the services delivered. A programme of audits was completed on a monthly basis. Areas for audit included the environment, health and safety issue and the occurrence of accidents and incidents. Records evidenced that where an area for improvement was identified there was evidence of re-audited to check that the required improvement had been completed.

The unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. An action plan was generated to address any identified areas for improvement.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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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 with Mr Gavin O'Hare Connelly responsible person and Nora Curran, registered manager, 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

Requirement 1

Ref: Regulation 20(1)(a)

Stated: First time

To be completed by:
2 November 2016

The registered person must ensure that staff employed are suitably qualified. Robust systems to check that registered nurses and care staff maintain a live registration with their professional body must be implemented.

Ref: section 4.3

Response by registered provider detailing the actions taken:

There is a robust system in place that flags any staff with 4 weeks until renewal - where a letter and reply slip is sent to the registrant for completion confirming responsibility for renewal and registration. This is inclusive of monthly Registered Manager sign off and Monthly Registered Person Audit.

Recommendations

Recommendation 1

Ref: Standard 35.5

Stated: First time

To be completed by:
2 November 2016

It is recommended that continuity plans are put in place to ensure any disruption to the delivery of care is kept to a minimum during the refurbishment work. Staff should be fully informed of the plans and agreed working practices. Consideration should be given to increasing staff on days when the normal routine is significantly disrupted.

Ref section 4.3

Response by registered provider detailing the actions taken:

A schedule of works and continuity plan was in place, however this was not fully communicated to all staff. The refurbishment was required to bring the dementia care unit to a standard conducive to quality, evidence based care intervention, and will be completed by 6th November 2016. This involved inclusive collaboration with residents, relatives and staff to ensure a collaborative design that is evidenced in best practice.

Recommendation 2

Ref: Standard 44.1

Stated: First time

To be completed by:
2 November 2016

It is recommended that a cleaning schedule is put in place for the identified unit to ensure all areas are cleaned as required and provide staff with the required direction of who is required to undertake what.

Ref section 4.3

Response by registered provider detailing the actions taken:

A cleaning schedule is in place in for each unit. Cleanliness remains of a high standard across the home.

<p>Recommendation 3</p> <p>Ref: Standard 48</p> <p>Stated: First time</p> <p>To be completed by: 2 November 2016</p>	<p>It is recommended that the use of the identified area for storage should be discussed with the fire risk assessor to ensure that it does not compromise fire safety. RQIA should be informed of the outcome of this discussion.</p> <p>Ref section 4.3</p> <p>Response by registered provider detailing the actions taken:</p> <p>This was addressed immediately. Room cleared and evidence supplied to RQIA. The fire risk assessment was fully consulted and not evidencing this area as a risk. The room is now clear as per Management, as has been as a store for some 10+ years. Completed</p>
<p>Recommendation 4</p> <p>Ref: Standard 4.7</p> <p>Stated: First time</p> <p>To be completed by: 2 November 2016</p>	<p>It is recommended that the care records are reviewed at the time of each admission to the home to ensure that accurately reflect the needs of the patients.</p> <p>Ref section 4.4</p> <p>Response by registered provider detailing the actions taken: Reviewing admission process to include admission checklist and readmission from hospital. Monthly audit ongoing with random Unit Sister audit - Completed.</p>
<p>Recommendation 5</p> <p>Ref: Standard 4.1</p> <p>Stated: First time</p> <p>To be completed by: 2 November 2016</p>	<p>It is recommended that an assessment of patient need is commenced on the day of admission and completed within five days of the admission.</p> <p>Ref section 4.4</p> <p>Response by registered provider detailing the actions taken: Every resident has a comprehensive nursing assessment and individual risk assessment on admission to the organisation. All other assessments are now completed within 5 days of admission. Completed.</p>
<p>Recommendation 6</p> <p>Ref: Standard 4</p> <p>Stated: First time</p> <p>To be completed by: 2 November 2016</p>	<p>It is recommended that each patient's health, personal and social care needs are set out in an individual care plan; the care plans should prescribe the interventions required to meet the patients' needs.</p> <p>Ref section 4.4</p> <p>Response by registered provider detailing the actions taken: The particular Unit has now had a full review to ensure all care records are in keeping with a person-centred nursing model, and are inclusive of resident and relative input to ensure holistic care needs are met. - Completed.</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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