Unannounced Care Inspection Report
15 September 2016

Slieve Dhu

Type of Service: Nursing Home
Address: 43 Bryansford Road, Newcastle, BT33 0DW
Tel no: 028 4372 5118
Inspector: Dermot Walsh

1.0 Summary

An unannounced inspection of Slieve Dhu took place on 15 September 2016 from 09.10 to 18.15.

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?

A safe system for the recruitment of staff was in place. Relevant checks had been carried out prior to the staff member commencing in post. One requirement and two recommendations have been stated for a second time within the safe domain. In addition, three requirements were made in relation to safeguarding, monitoring of professional registration and the use of bedrails. Six recommendations have been made to drive improvement in relation to staffing arrangements, staff training, management of odours and call bell responses.

Is care effective?

Staff were aware of the local arrangements for referral to health professionals. Patients and staff demonstrated confidence and awareness in raising any potential concerns to the relevant people. One recommendation has been stated for a second time in this domain in relation to patient/representative involvement in the care planning process. Further improvements were identified around care planning, access to minutes of staff meetings and nutritional screening. One requirement and three recommendations were made within this domain.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. Patients and their representatives were very praiseworthy of staff and a number of their comments are included in the report. Improvements were identified regarding patients' mealtimes and management responses to patient survey feedback. Two recommendations were made within this domain.

Is the service well led?

Appropriate certificates of registration and public liability insurance were on display. There was a clear organisational structure within the home. Copies of the monthly monitoring reports conducted by the provider were available for review and a notice was on display advising of this availability. One requirement and four recommendations will be stated for a second time in this inspection. In addition four requirements and 11 recommendations have been made regarding safe, effective and compassionate care. These requirements and recommendations also impact on the well led domain and this would indicate the need for more robust management and leadership in the home.

The term 'patients' is used to describe those living in Slieve Dhu which provides both nursing and residential care.

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	5*	15*

*The total number of requirements and recommendations made includes one requirement and four recommendations which have each been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mandy Lacey, 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 care inspection undertaken on 19 April 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Slieve Dhu Ltd Micheal Rodgers	**Registered manager:** Mandy Lacey
Person in charge of the home at the time of inspection: Mandy Lacey	**Date manager registered:** 11 March 2015
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI, RC-I	**Number of registered places:** 47

3.0 Methods/processes

Prior to inspection we analysed the following information:

- 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 previous care inspection report and the returned QIP
- pre inspection assessment audit.

During the inspection we met with eight patients individually and others in small groups, four patient representatives, two care staff, two registered nurses and one ancillary staff member.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff not on duty. Nine patient, nine staff and seven patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- five patient care records
- staff training records
- staff induction template
- complaints records
- incidents / accidents records since the last care inspection
- minutes of staff meetings
- a selection of audit documentation
- a staff recruitment file
- competency and capability assessments for nurse in charge
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- duty rota for the period 12 September to 18 September 2016.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 19 April 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 19 April 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person must ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection.	**Not Met**
	Action taken as confirmed during the inspection: During a review of the environment, non-compliance with best practice in infection prevention and control was observed. Please see section 4.3 for further clarification. This requirement has not been met and will be stated for a second time.	
Requirement 2 **Ref:** Regulation 12 (2) (a) **Stated:** First time	The registered person must ensure that patients have a means to summon help when required. The identified patient must have access to the call bell system when alone in their room.	**Met**
	Action taken as confirmed during the inspection: During a review of the environment the identified patient was observed with access to a nurse call system.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 41 **Stated:** First time	The registered person should ensure that the staff duty rota is maintained in accordance with the DHSSPS Care Standards for Nursing Homes 2015 and best practice guidelines.	**Partially Met**
	Action taken as confirmed during the inspection: The duty rota was verified by the registered manager and the nurse in charge and senior care assistants identified on the duty rota. However, the rota had not been completed using black ink as outlined in professional and best practice guidance. This recommendation has been partially met and will be stated for a second time.	

Recommendation 2 **Ref:** Standard 39 **Stated:** First time	The registered person should ensure a system is in place to ensure mandatory training requirements are met in a timely manner.	**Met**
	Action taken as confirmed during the inspection: A system was in place to monitor mandatory training. However, further recommendations have been made in regards to training and are discussed under separate cover in sections 4.3 and 4.6.	
Recommendation 3 **Ref:** Standard 46 Criteria (1) (2) **Stated:** First time	The registered person should ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection.	**Not Met**
	Action taken as confirmed during the inspection: During a review of the environment, non-compliance with best practice in infection prevention and control was observed. Please see sections 4.3 and 4.6 for further clarification. This recommendation has not been met and will be stated for a second time.	
Recommendation 4 **Ref:** Standard 44 Criteria (13) (E21) **Stated:** First time	The registered person should ensure that all wardrobes are secured to the walls unless deemed unnecessary by way of individual risk assessment.	**Met**
	Action taken as confirmed during the inspection: During a review of the environment all wardrobes were observed to be secured to the walls.	
Recommendation 5 **Ref:** Standard 28 Criteria (1) **Stated:** First time	The registered person should ensure that topical preparations are only administered to the person for whom they are prescribed.	**Met**
	Action taken as confirmed during the inspection: Topical preparations observed in patients' bedrooms had been prescribed to the named patient who resided in the bedroom.	

Recommendation 6 **Ref:** Standard 4 Criteria (5) (6) (11) **Stated:** First time	The registered person should ensure that care records evidence patients and/or their representatives' involvement in the care planning of the patients care to meet their needs. If this is not possible the reason should be clearly documented within the care record.	**Partially Met**
	Action taken as confirmed during the inspection: Some care plans reviewed had evidence of patient/representative involvement in their development. Please see section 4.4 for further clarification. This recommendation has been partially met and will be stated for a second time.	
Recommendation 7 **Ref:** Standard 41 **Stated:** First time	The registered person should ensure that staff meetings are carried out at minimum quarterly and records are maintained to include detail of date, attendees, minutes of discussions and any actions agreed.	**Met**
	Action taken as confirmed during the inspection: There was evidence that a staff meeting had been conducted on 12 August 2016, although minutes of this meeting had not been made available to staff. This recommendation has been met; however, a new recommendation will be made to ensure that information ascertained within the meeting is shared with staff in a timely manner.	
Recommendation 8 **Ref:** Standard 7 **Stated:** First time	The registered person should ensure that the response to concerns raised at patients' meetings and the outcome of such responses are evidenced within records.	**Met**
	Action taken as confirmed during the inspection: A review of the minutes from previous patients' meeting evidenced that actions had been taken.	

Recommendation 9 **Ref:** Standard 7 **Stated:** First time	The registered person should ensure areas of dissatisfaction within the reviewed patient survey are identified and an action plan developed to address the identified issues where appropriate.	**Not Met** **No longer viable**
	Action taken as confirmed during the inspection: This recommendation could not be validated as the responses to the patient survey above have been mislaid and could not be located. A new recommendation has been made to ensure that any areas of dissatisfaction from responses in patient surveys are managed appropriately. Please see section 4.5 for further information.	
Recommendation 10 **Ref:** Standard 17 **Stated:** First time	The registered person should ensure a system is in place to manage urgent communications, safety alerts and notifications.	**Not Met**
	Action taken as confirmed during the inspection: A system had not been fully implemented to manage urgent communications, safety alerts and notifications. Please see section 4.6 for further clarification. This recommendation has not been met and will be stated for a second time.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and a review of the staffing rota for the period 12 September to 18 September 2016 evidenced that the planned staffing levels were adhered to. One patient consulted on inspection informed the inspector that they 'had to wait long times to go to the toilet at times'. This concern was shared with the registered manager. Two staff consulted were of the opinion that dependencies during mealtimes were very high. It was observed that breakfast didn't finish until 11.20 hours and lunchtime commenced at 12.00. Mealtimes are further discussed in section 4.5 of this report. This was discussed with the registered manager who confirmed that staffing levels were determined by 'occupancy'. There was no evidence available of patient dependency level checks having been conducted. A recommendation was made to ensure that the staffing arrangements in the home are determined by patient dependency levels and that records are maintained of the dependency checks.

A review of the duty rotas for week commencing 12 and 19 September 2016 evidenced the rota had not been completed using black ink in keeping with professional and best practice guidance. A recommendation made at the previous inspection regarding the completion of the duty rota has been stated for a second time. The duty rota had been verified by the registered manager.

Discussion with staff and review of records confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. An induction booklet was completed and signed by the new employee and the staff member responsible for inducting the new employee.

Discussion with the registered manager and review of training records evidenced that a system was in place to monitor staff attendance at mandatory training. Information submitted to RQIA post inspection confirmed compliance in staff training as follows; moving and handling (91%), fire (90%), adult safeguarding (93%) and infection prevention and control (90%). However, on inspection a range of issues in non-compliance with best practice in infection prevention and control was observed and this will be discussed further in this section. The inspector was informed of an incident which had occurred in the home where staff failed to make a referral to the local Adult Safeguarding Team to review. Management in the home were not aware of the incident at the time when it had occurred. Although training had been completed across these areas of practice, shortfalls continued to be identified indicating that learning had not been embedded into practice and a recommendation has been made. A requirement has also been made to ensure all potential safeguarding risks are reported to the local Trust authority to allow for investigative or other follow up action to commence and ensure the health and safety of patients residing in the home.

A further recommendation was made to ensure that staff receive training/ supervision on the completion of incident/ accident notifications to RQIA. (see section 4.6).

A random review of restrictive practice evidenced assessments and care plans were in place in the patients' care records reviewed. The registered manager confirmed that consent was obtained from the patient's next of kin verbally. However, this was not always evidenced within the care records. Discussion with the registered manager confirmed that they had not received training on restraint and was also unable to confirm if staff had received training in this area of practice. A recommendation was made.

Competency and capability assessments of the nurse in charge of the home in the absence of the manager had been completed appropriately. The completed assessments had been signed by the registered nurse and verified by the registered manager as successfully completed.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of current nursing staff with the Nursing and Midwifery Council (NMC) was not appropriately managed. There was evidence of NMC registration checks conducted on 20 July 2016. However, two nurses' registrations were observed to expire on 31 July 2016. No further checks were evident from 20 July 2016. The two nurses were live on the register when the registration status was checked on the day of inspection. A requirement was made. The registered manager discussed the system in place to monitor the Northern Ireland Social Care Council (NISCC) registration for care staff.

A review of the recruitment process evidenced a safe system in practice. Relevant checks and interviews had been conducted prior to the staff member commencing in post.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. There was evidence that risk assessments informed the care planning process. However, in one patient's care record, a Malnutrition Universal Screening Tool (MUST) assessment had not been followed up appropriately by registered nurses. This will be further discussed in section 4.4.

Following a review of bed rail risk assessments it was concerning that registered nurses had not evidenced their decision to use bed rails when a high level of risk had been identified. The alternatives reviewed; the reason the alternatives were not used and the justification for the continued use of bedrails should be documented. One patient's care plan indicated the continued use of bedrails under close supervision. There was no indication of the frequency of supervision and no records of any supervision. A requirement was made. Discussion with the registered manager confirmed that they were in agreement with the continued use of bedrails for the patient reviewed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. Rooms and communal areas were clean and spacious. Fire exits and corridors were observed to be clear of clutter and obstruction.

The following issues were not managed in accordance with best practice guidelines in infection prevention and control (IPC):

- inappropriate storage in identified rooms
- un-laminated signage
- bedrails worn to bare wood
- pull cords in use without appropriate covering
- patients' chairs in need of repair/replacement
- shower chairs and toilet aids not effectively cleaned after use
- rusted commode chair in use

The above issues were discussed with the registered manager and an assurance was provided by the registered manager that these areas would be addressed with staff and measures taken to prevent recurrence. A requirement made in the previous inspection in relation to compliance with best practice in infection prevention and control has been stated for a second time. A recommendation made to ensure that management systems are put in place to ensure compliance with best practice in infection prevention and control has also now been stated for a second time.

During the review of the home environment, a malodour was detected in an identified patient's bedroom. The room was revisited later the same day and the malodour remained prevalent. A recommendation was made.

Nurse call bells were heard sounding for prolonged periods of time. On one occasion staff had been observed walking past the door of a room while the call bell was sounding. A recommendation was made to ensure regular audits of call bell response times are conducted to ensure a timely response when patients are summoning assistance.

Areas for improvement

It is required that all safeguarding incidents are reported immediately to the adult safeguarding team as per policy and professional guidance.

It is required that all NMC registrations within the home are checked and verified prior to the staff member lapsing from the professional register and at minimum the date of expiry.

It is required that when a patient is assessed as high risk from the use of bedrails, that the continued use of bedrails is justified within the patient's records and were close patient monitoring is required, this monitoring is evidenced within the patients' care records.

It is recommended that the staffing arrangements in the home are determined by an assessment of patient dependency levels and that records are maintained.

It is recommended that infection prevention and control training provided to staff, is embedded into practice.

It is recommended that training on incident management and notifications is provided to relevant staff to ensure that staff have the acquired knowledge to complete these both efficiently and effectively.

It is recommended that relevant staff are provided with training in the use of restrictive practices. Records should be retained.

It is recommended that the malodour in the identified room is managed appropriately.

It is recommended that audits of call bell responses are undertaken and records maintained of checks including any actions taken.

Number of requirements	3	Number of recommendations	6

4.4 Is care effective?

Review of five patient care records evidenced that a range of validated risk assessments were completed. Care plans had not always been personalised to meet the specific needs of the patients. For example, care plans reviewed in regards to personal care indicated '(patient's name) needs help with washing and dressing' without specifying the actual help and assistance required to direct the patients' care. One mobility care plan indicated the patient 'could take a few steps' though did not specify any assessed mobility aids required to safely assist the patient. Abbreviations had been used, for example (WZF), had been used within a patient's care plan to identify a mobility aid, which was not in keeping with professional guidance. A recommendation was made.

A generic statement on patient/representative involvement remained within the care plans reviewed but there was insufficient evidence, within the majority of three patients' care plans reviewed, of actual and meaningful patient/representative input into the care planning process. A recommendation made in the previous inspection has been stated for a second time.

Registered nurses were aware of the local arrangements and referral process to access relevant healthcare professionals, for example General Practitioner's (GP), speech and language therapist (SALT), dietician and tissue viability nurse (TVN). However, one patient's care records reviewed evidenced a MUST score of four on 31 July 2016 which would indicate a high risk of malnutrition. There was no evidence that the patient had been referred to a dietician at this time and/or commenced on a food and fluid intake chart. The next weight check was evidenced when the MUST assessment was repeated on 4 September 2016. A requirement was made. This was discussed with the registered manager and an assurance was given that the appropriate actions would be implemented immediately.

Discussion with the registered manager and a review of records confirmed that the last staff meetings were conducted on 12 August 2016 for registered nurses, carers and the housekeeping team. Minutes of the meetings were not available for staff to review. A recommendation was made to ensure that minutes taken from staff meetings are made available for all staff to review in a timely manner following the meeting.

Minutes from monthly patients' meetings were available for review. These were conducted by the Personal Activities Leader (PAL). Any concerns raised during these meetings were passed to the registered manager and there was evidence of actions taken to address the concerns within records from the previous two meetings. The registered manager confirmed that relatives meetings were scheduled twice yearly, though stated the previous meeting had no attendees.

The registered manager confirmed that they operate an 'open door policy' and are available to discuss any issues with staff, patients and/or relatives. The registered manager also confirmed that they would undertake a number of daily walks around the home and would avail of the opportunities to engage with patients and relatives at these times.

Staff consulted knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and/or the registered manager. Patients and representatives were confident in raising any concerns they may have with the staff and/or management.

Areas for improvement

It is recommended that care plans are written in a format which specifically directs individualised patient care and avoids the use of general terminology and abbreviations

It is required that when a MUST risk assessment identifies a high malnutrition risk, appropriate actions are taken and the patients' care records are updated to reflect these actions and the outcome of these actions.

It is recommended that nutritional screening for all patients is carried out monthly or more frequently depending on individual assessment.

It is recommended that minutes taken from staff meetings are made available for all staff to review in a timely manner following the meeting.

Number of requirements	1	**Number of recommendations**	3

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate and caring. 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.

On inspection two registered nurses, two carers and one ancillary staff member were consulted to ascertain their views of life in Slieve Dhu Nursing Home. Nine staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. One of the questionnaires was returned within the timescale for inclusion in the report.

Some staff comments were as follows:
"I love it here."
"I really do love it here."
"Some shifts are in need of more staff."
"I love working here."
"There is room for improvement but we work better together."

Patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Consultation with eight patients individually, and with others in smaller groups, confirmed that, in their opinion, the care was safe, effective, compassionate and well led. Nine patient questionnaires were left in the home for completion. Two of the patient questionnaires were returned within the timeframe for inclusion in the report.

Some patient comments were as follows:
"This place is terrific and friendly."
"It's fine here. The staff are very good and the food's good."
"Foods good and the staff are very nice."

Four patient representatives were consulted with on the day of inspection. Seven relative questionnaires were left in the home for completion. Two of the relatives'/representatives' questionnaires were returned within the timeframe for inclusion within the report.

Some patient representatives' comments were as follows:
"I find the care here very good."
"Generally the care here is good."
"Staff tend to be busy around mealtimes and sometimes toileting can be difficult at these times."
"All staff have been very receptive to mum and the specific care she needs."

All comments from patients, staff and relatives/representatives both verbal and within responses to questionnaires were shared with the registered manager to review and action as appropriate.

The registered manager confirmed that statistical results from previous surveys conducted had been displayed on noticeboards within the home. It was disappointing that the records relating to a survey completed in 2015 and reviewed on the previous inspection had been mislaid. Comments from respondents, provided within the survey records, could have led to improvements within the home. A recommendation made in the previous inspection, regarding developing an action plan to address negative comments which were made within the respondents' feedback in the survey, could not be validated as these records had been mislaid. However, a new recommendation was made to ensure any areas of dissatisfaction within future patient surveys are identified and an action plan developed to address the identified issues where appropriate.

The serving of breakfast was observed in the dining room on the ground floor. Patients were given the choice of eating their meals in the dining room or in their own room. A menu was displayed on a noticeboard in the dining room with the day's meal selection. A choice of two meals for lunch and dinner was available and patients selected their preferred meal choice the day before. The cook confirmed that alternatives could be provided if the patients were not satisfied with the meal choice. A selection of condiments were available on the tables and a range of drinks were offered to the patients. One patient was seated at a table were a set of curtains was draped across the side of the table. Beside the curtains was a pile of patients' clothing protectors and two rolls of blue plastic aprons which staff would wear when serving and/or assisting patients with their meal. In the middle of the table were two displays of flowers which had withered. These items were removed at the request of the inspector.

A system was used in the home in which carers would notify the cook by phone when they were ready to collect a breakfast tray and bring it to the patient's room. The cook would then prepare the breakfast tray which contained, for example, porridge, tea and toast. The tray was left in an identified area in the dining room for collection and the carer would come to the dining room to transfer the breakfast to the patient's room. However, some trays were not collected for up to15 minutes affecting the temperature and taste of the food. These breakfasts were renewed prior to being served to patients when this observation was brought to staffs attention.

The serving of breakfast commenced at 08.00 hours. The final breakfast was served at 11.20 hours. It was noted that the serving of lunch commenced at 12.00. It was concerning that the morning routine did not allow for sufficient 'gaps' between meals times. A recommendation was made that the registered manager reviewed the management of mealtimes for all patients. This review should include the dependencies of patients and the level of support and assistance required to ensure that patients receive their meals in a timely manner and ensure adequate 'gaps' between meals.

Discussion with staff confirmed that the religious needs of patients were met through a religious service channelled to the home through speakers. Staff also confirmed that communion was administered daily to patients who wished to receive it.

Areas for improvement

It is recommended that comments made on feedback from surveys conducted on the service provided by the home, are reviewed and an action plan developed to address identified issues were appropriate.

It is recommended that the registered manager review the management of mealtimes for patients. This review should include the dependencies of patients and the level of support and assistance required to ensure that patients receive their meals in a timely manner and ensure adequate 'gaps' between meals.

Number of requirements	0	Number of recommendations	2

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. However, some staff were confused as to the extent of the role of domestic staff. This was discussed with the registered manager who agreed to review this role with staff.

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

The complaints procedure was appropriately displayed at the reception area in the home and was included within the 'patients' guide'.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were not submitted appropriately. Some notifications submitted had not been fully completed or contained insufficient information. RQIA had discussed this with the registered manager prior to the inspection to ensure all persons responsible for submitting notifications have received training. The registered manager confirmed on inspection that six staff had received additional training on the management of notifications and six staff required training. A recommendation was made in this regard in section 4.3.

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, monthly audits were completed in accordance with best practice guidance in relation to accidents, care records, complaints, wounds and infection prevention and control. However, the infection prevention and control audit was discussed and due to the continued non-compliance identified on inspection it was agreed that this system was not sufficiently robust. The registered manager agreed to review this system including providing audit feedback to staff. A recommendation made in the previous inspection has been stated for the second time.

Urgent communications, safety alerts and notices were reviewed by the registered manager on receipt and, where appropriate, were shared with staff. A system was not in place to ensure that all relevant staff had read the communication or had been notified appropriately. A recommendation made in the previous inspection has been stated for a second time.

Discussion with the registered manager confirmed that monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. A notice displayed on a noticeboard confirmed that copies of the reports were available for patients, their representatives, staff and trust representatives.

One requirement and four recommendations will be stated for a second time following this inspection. In considering the findings from this inspection and that four requirements and 11 recommendations have been made regarding safe, effective and compassionate care in addition to the requirements and recommendations stated for a second time, this would indicate the need for more robust management and leadership in the home.

Areas for improvement

No new areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mandy Lacey, 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 13 (7) **Stated:** Second time **To be completed by:** 17 September 2016	The registered person must ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. **Ref: Section 4.2, 4.3**
	Response by registered provider detailing the actions taken: All issues identified during the inspection have been dealt with and systems are now in place to ensure risks are minimised.
Requirement 2 **Ref:** Regulation 14 (4) **Stated:** First time **To be completed by:** 17 September 2016	The registered provider must ensure that all safeguarding incidents are reported/referred immediately to the adult safeguarding team as per policy and professional guidance. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Systems are now in place to ensure that staff are aware of what constitutes a safeguarding issue and how to report them in a prompt manner.
Requirement 3 **Ref:** Regulation 19 (2) Schedule 4 (6)(a) **Stated:** First time **To be completed by:** 17 September 2016	The registered provider must ensure that all staffs NMC registrations within the home are checked and verified prior to the staff member lapsing from the professional register and at minimum the date of expiry. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Systems are in place so that nurses renewal dates are monitored and when due, the nurse receives a letter from the Registered Manager reminding them that their NMC renewal is due. They are asked to inform the Registered Manager when they have renewed their registration and this is then verified and confirmed.

Requirement 4 **Ref:** Regulation 13 (1)(a)(b) **Stated:** First time **To be completed by:** 30 September 2016	The registered person must ensure that when a patient is assessed as high risk from the use of bedrails, that this is kept under review and that where close patient monitoring is required that this is reflected in the care records. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Nurses review bed rail risk assessments on a monthly basis or sooner if there is a change in the residents condition. If a resident is assessed as being at a high risk, they are monitored regularly and this is now recorded on a chart.
Requirement 5 **Ref:** Regulation 12 (1)(a)(b) **Stated:** First time **To be completed by:** 17 September 2016	The registered person must ensure that when a MUST risk assessment identifies a high malnutrition risk, appropriate actions are taken and the patients' care records are updated to reflect these actions and the outcome of these actions. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: One-to-one documentation training was given to each Nurse by the Registered Manager and the importance of completing a MUST risk assessment was reiterated and that appropriate actions are taken and documented.
Recommendations	
Recommendation 1 **Ref:** Standard 41 **Stated:** Second time **To be completed by:** 30 September 2016	The registered person should ensure that the staff duty rota is maintained in accordance with the DHSSPS Care Standards for Nursing Homes 2015 and best practice guidelines. **Ref: Section 4.2, 4.3**
	Response by registered provider detailing the actions taken: Staff duty rota is completed completely in black as per relevant guidelines.
Recommendation 2 **Ref:** Standard 46 Criteria (1) (2) **Stated:** Second time **To be completed by:** 30 November 2016	The registered person should ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection. **Ref: Section 4.2, 4.3, 4.6**
	Response by registered provider detailing the actions taken: Infection Control training is scheduled for January 2017. All identified areas have been dealt with and systems are in place to ensure the infection control standards are high in the home.

Recommendation 3 **Ref:** Standard 4 Criteria (5) (6) (11) **Stated:** Second time	The registered person should ensure that care records evidence patients and/or their representatives' involvement in the care planning of the patients care to meet their needs. If this is not possible the reason should be clearly documented within the care record. **Ref: Section 4.2, 4.4**
To be completed by: 30 November 2016	**Response by registered provider detailing the actions taken:** Systems are now in place where residents and their next of kin confirm that they were involved in the care planning process and that they are happy that their needs will be met. This will be done during the pre-admission assessment.
Recommendation 4 **Ref:** Standard 41 **Stated:** First time	The registered person should ensure that minutes taken from staff meetings are made available for all staff to review in a timely manner following the meeting. **Ref: Section 4.2, 4.4**
To be completed by: 31 December 2016	**Response by registered provider detailing the actions taken:** Meetings are help every three months and a member of the admin staff is present so that minutes are taken and distributed in a timely manner following the meeting.
Recommendation 5 **Ref:** Standard 17 **Stated:** Second time	The registered person should ensure a system is in place to manage urgent communications, safety alerts and notifications. **Ref: Section 4.2, 4.6**
To be completed by: 30 November 2016	**Response by registered provider detailing the actions taken:** A file is already in place and nurses have been reminded that it is there and to be checked regularly.
Recommendation 6 **Ref**: Standard 41 **Stated:** First time	The registered person should ensure that the staffing arrangements in the home are determined by patient dependency levels and that records are maintained of the dependency checks. **Ref: Section 4.3**
To be completed by: 30 November 2016	**Response by registered provider detailing the actions taken:** Monthly dependency checks are now audited and staffling levels are reflected in the results of these checks

Recommendation 7 **Ref**: Standard 46, criterion (4) **Stated:** First time **To be completed by:** 31 December 2016	The registered person should ensure that infection prevention and control training provided to staff is embedded into practice. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Each member of staff has received a copy of the Infection Control Policy. Further training is scheduled for January 2017. All staff are aware of their responsibilities with regards to maintaining a high level of infection control and prevention.
Recommendation 8 **Ref**: Standard 39 Criteria (4) **Stated:** First time **To be completed by:** 30 November 2016	The registered person should ensure that training on incident management and notifications is provided to relevant staff to ensure that the staff member can manage these safely and effectively. **Ref: Section 4.3, 4.6**
	Response by registered provider detailing the actions taken: Nurses receive training as part of their induction when completing RQIA incident forms. Further training was given during the Nurses Meeting on 12th August. One-to-one documentation has been given to the nurses since this inspection and completion of incident forms has been discussed once again. Nurses have been advised to complete the form and a member of the management team are to review the form, prior to it being sent to the RQIA.
Recommendation 9 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 21 September 2016	The registered person should ensure that all relevant staff have received training on restraint and restrictive practice and when restraint and/or restrictive practice are used, they are managed in accordance with legislative, professional and best practice guidance. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: DOLS and restrictive/restraint training is scheduled for 11th November. Systems are currently being put in place to ensure the home is compliant with guidelines and policies.
Recommendation 10 **Ref**: Standard 44 Criteria (1) **Stated:** First time **To be completed by:** 30 November 2016	The registered person should ensure that the malodour in the identified room is managed effectively. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The carpet in the identified room has been replaced with vinyl which has rectified the malodour problem.

Recommendation 11 **Ref**: Standard 16 **Stated:** First time **To be completed by:** 30 October 2016	The registered manager should urgently review patients' satisfaction levels with the call bell response times. This review should include response times at or nearing change of shifts. The review should clearly record outcomes and any follow up action required for improvement. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The Registered Manager has commenced call bell time audits. Staff are aware of the importance of answering the buzzers in a timely fashion.
Recommendation 12 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 30 September 2016	The registered person should ensure care plans are written in a format which specifically directs individualised patient care and avoids the use of general terminology and abbreviations in accordance with professional guidance. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Each nurse has had individual training with the Registered Manager and have been advised that there should be no generic comments made. All care plans should be personalised and individualised.
Recommendation 13 **Ref**: Standard 12 Criteria (4) **Stated:** First time **To be completed by:** 30 September 2016	The registered person should ensure that nutritional screening for all patients is carried out monthly or more frequently depending on individual assessment. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Each nurse has had individual training with the Registered Manager and is aware that MUST assessments must be completed on admission and reviewed monthly as per changes, whichever is sooner.

Recommendation 14 **Ref:** Standard 7 **Stated:** First time **To be completed by:** 31 March 2017	The registered person should ensure areas of dissatisfaction within any patient surveys conducted are identified and an action plan developed to address the identified issues where appropriate. **Ref: Section 4.2, 4.5**
	Response by registered provider detailing the actions taken: Patient satisfaction surveys are currently being completed for 2016/17. The Registered Manager will ensure that any issues raised from these will be dealt with appropriately.
Recommendation 15 **Ref**: Standard 12 **Stated:** First time **To be completed by:** 30 November 2016	The registered manager should review the management of mealtimes for patients; This review should include the dependencies of patients and the level of support and assistance required to ensure that patients receive their meals in a timely manner and ensure adequate 'gaps' between meals. **Ref: Section 4.5**
	Response by registered provider detailing the actions taken: A majority of residents are now fed in the dining room where there is a member of staff available at all times. Meal times have been reviewed to ensure adequate gaps.

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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