The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
9 May 2016

The Somme

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Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of The Somme took place on 9 May 2016 from 09.30 to 18.15 hours. The inspection was undertaken in response to information that had been received by RQIA, from the Belfast Health and Social Care Trust, regarding the management of an adult safeguarding incident.

The purpose of this inspection was to seek assurances that there was proper provision for the care and welfare of patients in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes, July 2015. The inspection also sought to assess progress with any issues raised, during and since the previous 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 home was found to be clean, reasonably tidy, well decorated and warm throughout. Infection prevention and control measures were adhered to. The staff consulted confirmed that they received an induction and were coached and mentored through one to one supervision and annual appraisals. Staffing levels were subject to regular review to ensure the assessed needs of the patients were met. However, a recommendation has been stated to ensure that robust recruitment and selection processes are in place, to address deficits identified during this inspection. Whilst discussion with staff confirmed that they were knowledgeable regarding their specific roles in relation to adults safeguarding, a requirement has been stated in relation to one specific safeguarding incident that had not been managed or reported in line with regional safeguarding protocols. A requirement has also been stated to address a training need for the registered manager and the responsible person.

Is care effective?

There was evidence that patients had been repositioned in line with their care plan and there was no evidence that any patient had developed pressure damage in the home. A review of patients' care records and discussion with patients' representatives evidenced that there was regular communication, in regards to changes in the patients' general condition. There was evidence of effective teamwork; each staff member knew their role, function and responsibilities; and staff meetings were held on a regular basis. Patients and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. However, a review of care records identified weaknesses in relation to the completion of patients' risk assessments and care planning. Three requirements and two recommendations have been stated in this regard.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with patients confirmed that they were afforded choice, privacy, dignity and respect. Patients were supported to maintain friendships and socialise within the home and there was evidence that a range of activities were provided. Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. There was evidence that compliments had been received, which praised staff for their values, especially in regards to how end of life care was managed. Patients and their representatives provided positive comments in relation to the

care in the home and a number of comments are included in the report. Staff consulted with stated that they were dissatisfied with the level of communication in the home and the deployment of staff within the home. Following the inspection, a number of very negative comments were received and have been referred to the responsible person, for action.

Is the service well led?

There was a clear organisational structure within the home. Patients and their representatives commented positively regarding the responsiveness of the registered manager and comments are included in the report. The home was operating within the categories of care for which the home is registered and there was evidence that the policies and procedures for the home were subject to systematic review. Urgent communications and safety alerts were managed appropriately and there was evidence that complaints had been managed, in accordance with best practice guidance. However, a requirement has been made to ensure that a quality assurance report is completed, in accordance with regulation 17, of the Nursing Homes Regulations (Northern Ireland) 2005. A requirement has also been stated in regards to notifying RQIA of any serious injury sustained in the home, in accordance with regulation 30, of the Nursing Homes Regulations (Northern Ireland) 2005. One recommendation has been stated in regards to the need for care record audits to be further developed, to address the deficits identified during this inspection.

In considering the findings from this inspection and that seven requirements and four recommendations have been made regarding safe, effective and compassionate care, this would indicate the need for more robust management and leadership in the home.

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	7	4

Details of the QIP within this report were discussed with the registered manager and responsible person 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 dated 9 December 2015. Other than those actions detailed in the previous QIP there were no further actions required. 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. Refer to section 4.3 and 4.6 for further detail.

2.0 Service details

Registered organisation/registered person: Charles Jonathan Kitson	**Registered manager:** Gail Ellen Chambers
Person in charge of the home at the time of inspection: Gail Ellen Chambers	**Date manager registered:** 11 June 2014
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 41

3.0 Methods/processes

Specific methods/processes used in this inspection include the following:

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 returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with five patients, two care staff, two registered nursing staff and three patient's representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- six patient care records
- staff training records
- accident and incident records
- notifiable incidents
- audits
- records relating to Adult Safeguarding
- complaints records
- recruitment and selection records
- NMC and NISCC registration records

- staff induction, supervision and appraisal records
- staff, patients' and relatives' meetings
- staff, patients' and patients' representative questionnaires
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- policies and procedures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection, dated 9 December 2015. The completed QIP was returned and approved by the pharmacist inspector. There were no issues required to be followed up during this inspection and any action taken by the registered persons, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 14 August 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 39.8 **Stated:** First time	The registered person should ensure that staff are aware of regional guidance and best practice evidence which underpins their practice; commensurate with their role and function in the home. **Action taken as confirmed during the inspection**: A folder was available, which contained all relevant policies and guidance documents that staff referred to as required.	**Met**
Recommendation 2 **Ref**: Standard 4 **Stated:** First time	The registered person should ensure that following a nursing risk assessment that, as required, a care plan is devised to direct care delivery in the management of the assessed need. **Action taken as confirmed during the inspection**: A review of care records evidenced that care plans had been developed in relation to the risk of falls, pressure damage and the use of bedrails.	**Met**

4.3 Is care safe?

In discussion, the registered manager stated that there were systems in place for the safe recruitment and selection of staff. Where registered nurses were employed, their pin numbers were checked with the Nursing and Midwifery Council (NMC) to ensure that they had a current registration. Discussion with the registered manager and a review of the registration checks, confirmed that registered nurses' pin numbers were checked with the Nursing and Midwifery Council (NMC) on a regular basis, to validate their continued registration status.
The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI and a register was maintained which included the reference number and date received. Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. Two personnel files were reviewed and evidenced that the registration status of one care assistant had not been checked with the Northern Ireland Social Care Council (NISCC), as part of the recruitment process. Two written references had also been received from the applicants' previous employers; however, one was found not to have been from the applicant's most recent employer. This was discussed with the registered manager during feedback. A recommendation has been stated in this regard.

Staff consulted confirmed that they received induction; and shadowed experienced staff until they felt confident to care for the patients unsupervised. One staff member commented that the induction received was very good and it ensured that they had the basic knowledge needed to begin work.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A training matrix had been developed which provided clear information to enable the registered manager to review staff training and see when updates/refresher training were due. This confirmed that the majority of staff had received training in all mandatory areas. Training included e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult safeguarding. Observation of the delivery of care evidenced that training had been embedded into practice. Two staff members commented that they did not feel they learned much from the e-learning method of training. This feedback was communicated to the registered manager to address.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance or to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision and annual appraisals. Recommendations from serious adverse incidents that occurred in other organisations were also shared with staff. This is good practice and is commended.

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for week commencing 2 May 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication between the staff who delivered care was well maintained in the home and that appropriate information was communicated in the shift handover meetings. Discussion with the deputy manager confirmed that new staff would be given a more detailed handover report.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. A review of the safeguarding records identified that one incident had not been managed appropriately nor in accordance with the regional safeguarding protocols and the home's policies and procedures. This specific incident had occurred approximately 10 months prior to the inspection. The adult safeguarding team had not been notified in relation to this incident at the time and RQIA had also not been notified within the required timeframe. There were no records available regarding the extent of the investigation that was conducted internally and there was also no evidence of why the event had not been appropriately referred to the safeguarding team of the Trust. In discussion, the registered manager stated that on reflection, this incident should have been referred to the safeguarding team of the Trust; however, there was no evidence of dissemination of the lessons learned, with staff. A requirement has been stated to ensure that all potential or actual safeguarding incidents are reported in line with regional safeguarding protocols. Records pertaining to any allegation of abuse must be appropriately maintained.

Given the deficits identified above we were not assured that the management team were sufficiently knowledgeable regarding their own specific roles and responsibilities in relation to adult safeguarding. A requirement has been stated in this regard, to ensure that the registered manager and responsible person attend training in adult safeguarding.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

The recruitment and selection processes should be reviewed to ensure that there are robust systems in place to address the deficits identified during this inspection. A recommendation has been stated in this regard.

All actual or potential safeguarding incidents must be reported in line with regional safeguarding protocols. Records pertaining to any allegation of abuse must be appropriately maintained,
A requirement has been stated in this regard.

The registered manager and responsible person must attend training in adults safeguarding, to address the deficits identified during this inspection. A requirement has been stated in this regard.

Number of requirements	2	Number of recommendations:	1

4.4 Is care effective?

The home used an electronic system for assessing, planning and recording patients' care needs and a review of six patient care records evidenced that risks to patients were assessed on admission and then reviewed as required. Examples of such risk assessments include assessments in moving and handling, falls, wounds/pressure ulcers, nutrition, bed rails and choking.

One patient required a modified diet due to difficulties in swallowing. A review of the care record did not evidence that choke risk assessments had been completed and the specified consistency of the diet in the care plan differed from recommendations made by the Speech and Language Therapist (SALT). A requirement has been stated in this regard.

One patient who had been prescribed transdermal opioid patches did not have their pain level assessed, using a validated pain assessment tool and there was also no evidence that a care plan had been developed. A requirement has been stated in this regard.

A review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been recorded. However, one patient was observed to have a poor fluid intake in the four days preceding the inspection. On one day, where the patient's fluid intake had only been 500mls, the corresponding entry in the progress notes, stated 'diet and fluids taken'. Although a review of the patient's care plan evidenced that measures had been identified to address the patient's poor fluid intake, there was little evidence that the total fluid intake had been monitored or validated by the registered nurses nor was there any evidence of action taken to address the deficits. A requirement has been stated in this regard.

The care plans reviewed were not person-centred and although there was evidence of regular review, the information in the care plan was not always reflective of the patients care needs. For example, one patient's care plan outlined the patient's ability in regards to using a motorised wheelchair; however this patient was immobile and largely confined to bed. The care plan for one patient who required a modified diet, only stated 'as per SALT' and did not specify the prescribed consistency of food the patient required. A recommendation has been stated to ensure that registered nurses are updated on person-centred care planning/nursing process.

Although there was evidence of regular communication with patient representatives within the care records, in regards to changes in the patients' general condition, the input from patients and/or their representatives, in developing care plans was not evident. The deputy manager showed us a completed form, which evidenced one patient's involvement; however in three out of four patients' records, this had not been completed. A recommendation has been made in this regard.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and it provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between staff was effective. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend; however, the staff consulted with stated that minutes were not consistently made available. This was discussed with the registered manager, who provided assurances that the minutes were always disseminated to staff. The registered manager agreed to give more prominence to the minutes of staff meetings.

Discussion with the registered manager evidenced that patients and/or relatives meetings had not been held on a regular basis, although there was evidence that a meeting was planned. Questionnaires had been completed by patients and/or their representatives several months previous; however there was no evidence that the contents had been analysed. Refer to section 4.6 for further detail. Patients' representatives were also asked to comment regarding

the safety of their relative in the home. Patients and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management.

Areas for improvement

Advice/directions from the Speech and Language Therapist (SALT) must be accurately entered into care records and the specified diet provided as prescribed. A requirement has been stated in this regard.

Pain assessments must be completed for all patients, to clearly record the effectiveness of analgesia as appropriate. This information should be reflected in the patients' care plans. A requirement has been stated in this regard.

Patients' total fluid intake must be recorded in the daily progress notes, to evidence validation by registered nurses and to identify any action taken in response to identified deficits. A requirement has been stated in this regard.

Registered nurses should be updated on person centred care planning/nursing process through training or other means. A recommendation has been stated in this regard.

Patients and/or their representatives should be involved in the development of the care planning process, to ensure that care plans are person-centred. A recommendation has been stated in this regard.

Number of requirements	**3**	**Number of recommendations**:	**2**

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that they were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and their feedback had been listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day.

Patients consulted with stated that they knew how to use their call bells and stated that staff usually responded to their needs in a timely manner. Patients also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. A list of activities was available in each patient's bedroom.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment expressed by a relative stated that they had 'peace of mind, to know that (their relative) was in safe and very caring

hands'. Another compliments record also commented on the values held by staff and stated that these 'changes people's lives in ways you will never know'.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. All comments on the returned questionnaires were positive. Some comments received are detailed below:

Staff

Staff commented that they perceived communication in the home to be poorly maintained and expressed dissatisfaction with the way in which they were deployed within the home. Those consulted with stated that this had impacted on the continuity of care because they felt they were being moved regularly between units and did not get to fully know the patients' needs. These matters were discussed with the registered manager during feedback. Patients and/or their representatives did not raise any concerns in this regard.

Following the inspection, a number of very negative comments were received within the returned questionnaires and have been referred to the responsible person, for action under separate cover.

Patients

'I want for nothing, it is absolutely very good'.
'The staff are brilliant'.
'They are very kind. Amazing. They couldn't do more'.
'Everything is very positive'.
'It is absolutely fabulous. Very good'.

Patients' representatives

'Excellent in all aspects'.
'I am made to feel like one of the family'.
'It is marvellous. Very good'.
'I have bragged about the care here'.

One patients' representative commented that too many staff seem to take their breaks at the same time and that delays of up to 30 minutes occurred during the staff break times. This was brought to the attention of the registered manager to address.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. Patients commented positively regarding the responsiveness of the registered manager and one patient commented that the registered manager was 'very

efficient, whilst being unobtrusive'. Patients stated that they had comfort in knowing that the registered manager was supervising the staff. Patients' representatives provided written responses in relation to how well the home was led; and all comments indicated that they felt the home was well-led. One compliment record reviewed included a statement commending the registered manager for striving so hard as an advocate for the patients.

Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. The registered manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis and staff consulted with confirmed that they had access to the home's policies and procedures.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies. Recommendations from serious adverse incidents that had occurred in other nursing homes were also shared with staff. This is to be commended.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients and their representatives confirmed that they were confident that staff and management would manage any concern raised by them appropriately. Patients were aware of who the registered manager was.

Although there was evidence that questionnaires had been given to patients and/or their representatives by the registered manager to ascertain their views on quality of nursing and other service provision, there was no evidence that this information had been analysed and an annual quality assurance report had not been completed for 2015, in accordance with regulation 17, of the Nursing Homes Regulations (Northern Ireland) 2005. A requirement has been stated in this regard.

A review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous inspection, confirmed that these were not consistently reported appropriately. For example, the review of incident reports identified three patients who had sustained injuries that were reportable under regulation 30, of the Nursing Homes Regulations (Northern Ireland) 2005. This was discussed with the registered manager. A requirement has been stated in this regard.

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, the registered manager outlined how the following audits were completed in accordance with best practice guidance:

- falls
- wound management
- medicines management
- care records
- cleaning
- hand hygiene
- infection prevention and control
- patients weights
- nutritional supplements
- complaints.

An audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. Advice was given in regards to the development of a formal action plan to ensure that identified actions were followed up.

The process for auditing care records was discussed with the registered manager, however, given that requirements and recommendations have been stated in relation to the completion of patients' risk assessments and care plans, RQIA were not assured of the effectiveness of the audits. A recommendation has been stated in this regard.

Discussion with the registered manager and review of records evidenced that, monthly quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 and copies of the reports were available for patients, their representatives, staff and trust representatives.

As discussed in section 4.3, one incident had not been managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures. Two requirements have been stated in this regard.

Areas for improvement

A quality assurance report must be completed, in accordance with regulation 17, of the Nursing Homes Regulations (Northern Ireland) 2005. A requirement has been stated in this regard.

Injuries sustained in the home must be notified to RQIA, in accordance with regulation 30, of the Nursing Homes Regulations (Northern Ireland) 2005. A requirement has been stated in this regard.

The system for auditing care records should be further developed to address the deficits identified during this inspection. A recommendation has been stated in this regard.

In considering the findings from this inspection and that seven requirements and four recommendations have been made regarding safe, effective and compassionate care, this would indicate the need for more robust management and leadership in the home.

Number of requirements	**2**	**Number of recommendations**:	**1**

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager and responsible person as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the 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 person/s meets legislative requirements based on 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to Nursing.Team@rqia.org.uk and assessed 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 person/manager 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 person/manager 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 30 (1) (d)(g) **Stated:** First time **To be completed by:** 06 July 2016	The registered persons must ensure that all safeguarding incidents are reported in line with regional safeguarding protocols. Records pertaining to any allegation of abuse must be appropriately maintained. **Ref: Section 4.3**
	Response by registered person detailing the actions taken: Registered persons shall ensure that all safeguarding records pertaining to any allegation are properly maintained.
Requirement 2 **Ref**: Regulation 20 (c) (i) **Stated:** First time **To be completed by:** 06 August 2016	The registered persons must ensure that they attend training on adult safeguarding. **Ref: Section 4.3**
	Response by registered person detailing the actions taken: The registered persons have completed an E-learning adult safeguard training and will attend further training in December in Cladyvilla
Requirement 3 **Ref**: Regulation 14 (1) (b) **Stated:** First time **To be completed by:** 06 July 2016	The registered persons must ensure that advice/directions from the Speech and Language Therapist (SALT) are accurately entered into care records and illustrate the specified diet provided as prescribed. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: Registered Nurses made aware to ensure SALT directives are accurately entered into Careplan and a record of the specified diet.
Requirement 4 **Ref**: Regulation 15 (2)(a)(b) **Stated:** First time **To be completed by:** 06 July 2016	The registered persons must ensure that pain assessments are completed for all patients requiring regular or occasional analgesia, as appropriate. This information should be reflected in the patients' care plans. **Ref: Section 4.3**
	Response by registered person detailing the actions taken: All Residents prescribed analgesia either regularly or occasional have a pain assessment chart in medicine kardex and RN informed to ensure that Careplan states same.

<table>
<tr><td rowspan="2">Requirement 5

Ref: Regulation 13 (1) (a)

Stated: First time

To be completed by: 06 July 2016</td><td>The registered persons must ensure that patients' total fluid intake are recorded in the daily progress notes, to evidence validation by registered nurses and to identify any action taken in response to identified deficits.

Ref: Section 4.4</td></tr>
<tr><td>Response by registered person detailing the actions taken:
RN given instructions to ensure that total fluid intake is recorded in progress notes and a record of intervention of any deficit.</td></tr>
<tr><td rowspan="2">Requirement 6

Ref: Regulation 17 (1)

Stated: First time

To be completed by: 06 July 2016</td><td>The registered persons must ensure that a quality assurance report is completed on an annual basis.

Ref: Section 4.6</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Registered persons will ensure that the annual quality assurance questionnaire is formulated into a report.</td></tr>
<tr><td rowspan="2">Requirement 7

Ref: Regulation 30 (1) (c)

Stated: First time

To be completed by: 06 July 2016</td><td>The registered persons must ensure that any head injuries sustained in the home are notified to RQIA.

Ref: Section 4.6</td></tr>
<tr><td>Response by registered person detailing the actions taken:
registered person will ensure that all head injuries are reported to the RQIA.</td></tr>
<tr><td colspan="2">Recommendations</td></tr>
<tr><td rowspan="2">Recommendation 1

Ref: Standard 38.3

Stated: First time

To be completed by: 06 July 2016</td><td>The registered persons should ensure that the recruitment and selection processes are reviewed to ensure that there are robust systems in place. This relates particularly to:

• checking care staff's current registration status with NISCC at the recruitment stage
• references received from the applicants' <u>most recent</u> employer

Ref: Section 4.3</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Registered person willl ensure that NISCC staus is checked at recuitment stage and printed monthly and records maintained. Registered person will endeavour to ensure that a reference for applicants is from most recent employer and will inform applicant of any difficulty.</td></tr>
</table>

Recommendation 2 **Ref**: Standard 39.4 **Stated:** First time	The registered persons should update registered nurses on person centred care planning/ nursing process through training or other means. Records of this should be retained. **Ref: Section 4.4**
To be completed by: 06 July 2016	**Response by registered person detailing the actions taken:** Registered person will update registered nurses on person centered careplanning and a record will be maintained of the training
Recommendation 3 **Ref**: Standard 4.5 **Stated:** First time	The registered persons should ensure that patients and/or their representatives are involved in the development of the care planning process. **Ref: Section 4.4**
To be completed by: 06 July 2016	**Response by registered person detailing the actions taken:** Residents and or their representatives will be encouraged to be involved in developing of careplans and a signed agreement maintained.
Recommendation 4 **Ref**: Standard 35.4 **Stated:** First time	The registered persons should ensure that the system for auditing care records is further developed to address the deficits identified during this inspection. **Ref: Section 4.6**
To be completed by: 06 July 2016	**Response by registered person detailing the actions taken:** The Careplan audit will be further developed to adress any deficits.

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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