Unannounced Care Inspection Report
21 November 2016

Jordanstown

Type of Service: Nursing Home
Address: 1a Old Manse Road, Jordanstown, BT37 0RU
Tel no: 028 9085 2258
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Jordanstown took place on 21 November from 09.20 to 17.45 hours. This inspection sought to assess progress with any issues raised during and since the previous inspection. As a result of the inspection, RQIA were concerned that the quality of care and service within Jordanstown was below the minimum standard expected.

Following the inspection and the lack of progress identified since the last inspection on 18 July 2016, the registered persons were invited to attend a serious concerns meeting in RQIA on 25 November 2016, to discuss the inspection findings and to provide RQIA with a detailed and comprehensive action plan which illustrated how the home will return to compliance. RQIA were satisfied with the action plan provided. A further inspection will be undertaken to validate that compliance has been achieved and sustained.

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	3

The total number above includes three requirements which have been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Jean Steele, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Following the inspection and the lack of progress identified since the last inspection on 18 July 2016, the registered persons were invited to attend a serious concerns meeting in RQIA on 25 November 2016, to discuss the inspection findings and to provide RQIA with a detailed and comprehensive action plan which illustrated how the home will return to compliance.

Further inspection will be undertaken to validate that compliance has been achieved and sustained.

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 5 October 2016. Other than those actions detailed in the QIP there were no further actions required to be taken.

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: Four Seasons Healthcare/ Dr Maureen Claire Royston	**Registered manager:** Jean Elizabeth Steele
Person in charge of the home at the time of inspection: Jean Elizabeth Steele	**Date manager registered:** 1 April 2005
Categories of care: NH-I	**Number of registered places:** 53

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.

Questionnaires were distributed to patients, relatives and staff. We also met with five patients, three care staff, two registered nurse and five patients' representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- seven patient care records
- accident and incident records
- audits in relation to care records and falls
- complaints received since the previous care inspection
- staff induction, supervision and appraisal records
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- one staff recruitment and selection record.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 5 October 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector. This QIP will be validated by the pharmacist inspector at the next inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 18 July 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 20 (1) (a) **Stated:** First time	The registered persons must ensure that the provision of staffing in the home is reviewed to ensure that there is adequate staff on duty to meet the needs of the patients. This review must include the monitoring of care delivery and the response time to the nurse call system. The registered persons must inform RQIA of the outcome of the review. Records of the necessary action taken to address staff shortages should also be maintained.	**Not Met**
	Action taken as confirmed during the inspection: The staffing levels had been reviewed since the last inspection; however, the planned staffing levels were not consistently adhered to. This requirement was not met and has been stated for the second time. Refer to section 4.3.1 for further detail.	
Requirement 2 **Ref**: Regulation 19 (2) **Stated:** First time	The registered persons must ensure that records pertaining to enhanced criminal records checks with Access NI are available in the home at all times.	**Met**
	Action taken as confirmed during the inspection: A review of one personnel record confirmed that enhanced criminal records checks had been completed prior to commencement of employment. For agency staff, the registered manager received a profile which also included information on the Access NI check.	

Requirement 3 **Ref**: Regulation 30 91) (c) **Stated:** First time	The registered persons must ensure that RQIA is notified of any serious injury to a patient in the home.	**Met**
	Action taken as confirmed during the inspection: A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.	
Requirement 4 **Ref**: Regulation 15 (2) (a) and (b) **Stated:** First time	The registered persons must ensure care records are kept under review and reviewed at any time necessary to do so having regard to any change of circumstances and in any case not less than annually.	**Not Met**
	Action taken as confirmed during the inspection: A review of care records identified a lack of progress in relation to wound care; the management of modified diets; and the completion of pain assessments. This requirement was not met and has been stated for the second time. Refer to section 4.3.3 for further detail.	
Requirement 5 **Ref**: Regulation 13 (1) (a) **Stated:** First time	The registered provider must ensure that the nursing home is conducted so as to promote and make proper provision for the health and welfare of patients. Patients' personal care needs are required to be assessed and met. Records should be completed to evidence care delivered or not delivered.	**Not Met**
	Action taken as confirmed during the inspection: Records of hourly supervision checks were not recorded contemporaneously. A review of the supplementary care records, which include information on when patients received weekly showers, also identified continued gaps in recording. This requirement was not met and has been stated for the second time. Refer to section 4.3.2 for further detail.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 39.1 **Stated:** First time	The registered persons should ensure that all staff, including those who are newly appointed and agency staff, complete a structured orientation and induction; and records are retained.	**Met**
	Action taken as confirmed during the inspection: One completed induction programme was reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. Discussion with one agency staff member confirmed that they had also received a comprehensive induction.	
Recommendation 2 **Ref**: Standard 38.3 **Stated:** First time	The registered persons should ensure that two written references linked to the requirements of the job are obtained before commencement of employment.	**Met**
	Action taken as confirmed during the inspection: A review of one personnel record confirmed that written references had been received, prior to the staff member commencing employment.	
Recommendation 3 **Ref**: Standard 22.6 **Stated:** First time	The registered persons should ensure that the falls risk assessment is reviewed in response to patients' falls.	**Met**
	Action taken as confirmed during the inspection: A review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident.	
Recommendation 4 **Ref**: Standard 39.4 **Stated:** First time	The registered persons should ensure that training is provided to staff, as appropriate, in the principles of choice, dignity and respect which underpin the care standards for nursing homes, 2015.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and a review of staff training records confirmed that training had been provided on the principles of choice, dignity and respect.	

Recommendation 5 **Ref**: Standard 7.1 **Stated:** First time	The registered persons should review the methods available for engagement with patients and relatives to ensure they are effective.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager confirmed that this had been reviewed. The registered manager explained that she had increased her availability to patients and their representatives and that she worked one evening shift per week, to ensure that she was available to talk with those visiting in the evening time. No complaints had been made via the Quality of Life (QOL) system.	
Recommendation 6 **Ref**: Standard 35 **Stated:** First time	The registered persons should ensure that audits completed on the QOL system are accessible at all times, to enable evaluation and inspection.	**Met**
	Action taken as confirmed during the inspection: All audits were available for inspection. Refer to section 4.3.5 for further detail.	

4.3 Inspection findings

4.3.1 Staffing Arrangements

Following the inspection undertaken on 18 July 2016, assurances were provided that the staffing levels of the home would be increased; and that additional support was being provided to the home by the 'resident experience team'.

The registered manager explained there were currently six registered nurse vacancies. These vacancies were being filled by agency nurses or permanent staff working extra hours. The registered manager explained that the agency nurses were 'block booked', to ensure continuity of care. A deputy manager had been recruited and was going through the appropriate checks before starting in post.

Since the previous inspection, the home had reassessed the dependency levels of patients using the Care Home Effective Support Service (CHESS) assessment tool, developed by Four Seasons Healthcare. The registered manager explained that this was reviewed on a regular basis and that the staffing levels had been planned to provide the staff numbers determined by the dependency assessments.

Although the patients consulted with did not raise any concerns on the day of the inspection, in relation to staffing levels, four staff members consulted with stated that the staffing levels were inadequate. Comments included 'we are short-staffed quite often', 'we could do with more staff', 'there are a lot of sick calls and sometimes the staff just do not show up' and 'there is a

lot of sickness going on in here'. Two staff members stated that as a result call bells were often left unanswered for long periods and that patients often received their medicines late.

A review of the staffing rota for the weeks commencing 7 and 14 November 2016 evidenced that the planned staffing levels were not consistently adhered to, with deficits identified on eight days out of the two week period reviewed. RQIA are concerned that this could potentially be a contributory factor to the deficits in record keeping, identified during the inspection. Staff were also of the opinion that communication was poorly maintained in the home and this was further evidenced in relation to the staff's knowledge of the patients' prescribed, modified diets. Refer to section 4.3.2 and 4.3.3 for further detail.

As discussed in section 4.2, a requirement was previously made in relation to the staffing arrangements of the home and has been stated for the second time.

Given that the patients are accommodated over three floors, the deployment of staff throughout the day was also examined. RQIA acknowledges that consideration was given to the care needs of the patients accommodated on the second floor; and that for most of the day, there was often only one patient residing on the second floor. The review of the staff allocation sheet identified that one staff member from the ground and first floors were allocated to provide care to the patients on the second floor and this was generally recorded. However, discussion with staff evidenced that this allocation related only to assisting the patients with their care needs 'first thing in the morning'; and that afterwards 'they all did it between them'.

A recommendation has been made in this regard. Refer to section 4.3.2 for further detail.

4.3.2 Care Practices

As discussed previously in section 4.2, a requirement was made in relation to patients' care needs. A review of the supplementary care records evidenced that records of hourly patient checks were not being maintained in line with best practice guidance, care standards and legislative requirements. Records in relation to hourly checks that are required to be undertaken for patients who were in their bedrooms on the second floor were not completed contemporaneously. For example, the staff member signed the hourly check chart for 15.00 hours, when the patient was actually checked at 15.30 hours. The review of the supplementary care records also did not evidence that all patients had been showered weekly, or more frequently, if required, in accordance with their care plans. Records of weekly showers/baths had not being consistently completed and staff did not record when patients 'refused' assistance with showers. The review of the records identified five patients who had not received a shower on a weekly basis and there were gaps of up to two weeks identified in the completion of the 'bath book'. One staff member consulted with also raised concerns that every patient was not getting a weekly shower. A requirement has been stated for the second time in this regard.

Serious concerns were identified regarding the health and welfare of patients and there was a lack of evidence within the care records to demonstrate that safe and effective care was being delivered consistently. For example, a review of one patient's care plan evidenced that there was insufficient detail to direct the care of the patient including, the date the urinary catheter was last changed and when it was next due. The registered manager was unable to provide appropriate assurances at the inspection; however, following the inspection, confirmed to RQIA, by email, the date the urinary catheter had last been changed.

Another patients' food and fluid intake records identified that, despite poor fluid intakes being

identified, these were not accurately or consistently documented in the daily progress notes. For example, one patient was identified as having a fluid intake target of 1250mls. Where this patient was identified as only having a fluid intake of 320mls, the entry in the daily progress notes only recorded, 'diet and fluids taken well'. On other days, where the fluid intake had been recorded in the daily progress notes, there was no evidence that appropriate action had been taken to mitigate against the risk of dehydration and there was no care plan in place. A requirement has been made in this regard.

4.3.3 Care Records

As discussed previously in section 4.2, a requirement was made in relation to deficits in the patients' care records. A review of care records identified a lack of progress in relation to the completion of assessments and care plans. For example, the wound care management record of one patient, was reviewed. The review of the care records identified that the wound dressing had not been changed in accordance with their care plan. For example, the wound dressing had been changed once in the week, when the care plan stated that it should have been changed twice.

Discussion with staff and a review of the care records also evidenced that robust systems were not in place, to ensure that patients who required a modified diet received the appropriate diet, as recommended by the speech and language therapist (SALT). This was evident where one patient was receiving the incorrect consistency of thickened fluids, contrary to the recommendations on the SALT assessment and choke risk care plan.

A review of the fluid intake charts also identified that the correct consistency had been amended with a red pen. A care staff member also informed the inspector that communication was poorly maintained in relation to changes in patients' treatment plans and provided an example of when they had been stopped from giving a patient bread to eat, by another carer, as the patient's swallowing ability had recently been reassessed.

Pain assessments had been completed for patients who required transdermal opioid pain relief; however, the review of the care records evidenced one patient's pain assessment had not been reviewed from June 2016.

The requirement in relation to the care records was not met and has been stated for the second time.

One patient was receiving end of life care. Although there was evidence that the patient's general practitioner had reviewed the patient's care and that a decision had been made, in consultation with the patient's representative, that no attempt should be made to resuscitate or to hospitalise the patient, there was no care plan in place to address the patient's end of life care needs. A recommendation has been made in this regard.

There was evidence of some improvements within the care records. Risk assessments and care plans were generally completed within the recommended timeframe following a patient's admission to the home. Where patients required to be fed via a percutaneous endoscopic gastrostomy (PEG) tube, a care plan was in place to direct staff on the management of the feeding system, including care of the PEG site.

The review of the accident and incident reports confirmed that the falls risk assessments and care plans were consistently completed when incidents occurred, care management and patients' representatives were notified appropriately.

The storage arrangements of the patient care records on the ground floor were reviewed. The patient care records were observed to be stored behind the desk which is facing the front entrance. This area was not consistently supervised and it was concerning that anyone passing through this area, could have access to the records. Concerns were also raised by a staff member in relation to the confidentiality of patient information, discussed at the handover meetings at the beginning of each shift in this area. This was discussed with the registered manager, who stated that the staff were meant to conduct the handover meeting in the visitor's lounge. A recommendation has been made in this regard.

4.3.4 Consultation

During the inspection, we met with five patients, three care staff, two registered nurse and five patients' representatives. Some comments received are detailed below:

Patients

"Everything is fine".
"It is very good here".
"I have no complaints".
"It is very good. They are very punctual".
"I have no criticisms".

Staff

"The care is very good, the patients' needs are met".
"I have no real concerns".
"We have no concerns".
"I feel well supported here".

Four staff commented regarding the impact that the staffing levels were having on patient care. Refer to section 4.3.2 for further detail.

Patients' representatives

"'I couldn't say a word against them".
"Everything is fine, they are a good crew".
"Things couldn't be better".
"I have no concerns".

One patients' representative commented that the staffing levels were 'a bit scarce, especially at the weekends'. Refer to section 4.3.1 for further detail.

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. No staff or patients returned questionnaires. Four relatives had returned their questionnaires, within the timeframe for inclusion in this report. All respondents indicated that they were either 'very satisfied' or 'satisfied' that the care was safe, effective and compassionate; and that the service was well led. No written comments were received.

4.3.5 Governance and Management Arrangements

Discussion with the registered manager and observation of patients during the inspection 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.
All those consulted with knew who the registered manager was and stated that she was available to them at any time if the need arose. There was a clear organisational structure within the home; however, there were six registered nurse vacancies, including the deputy home manager's role and there was high agency usage. The registered manager confirmed that they were actively recruiting to fill these posts.

The registered manager had been registered with RQIA since 1 April 2005. Following the last inspection, undertaken on 18 July 2016, assurances were given that support would be provided to the registered manager by the 'resident experience team', to address the deficits identified in the last inspection. Discussion with the registered manager during this inspection, confirmed that although this had been provided initially, the 'resident experience team' were not offering as intense support because improvements had been evidenced within the monthly quality monitoring reports, undertaken in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Although some action had been taken to improve the effectiveness of the delivery of care, three requirements that were previously made, have been stated for the second time. Serious concerns were also identified regarding the health and welfare of patients and there was a lack of evidence within the care records to demonstrate the consistent delivery of safe and effective care. It was also concerning that the monthly quality monitoring report, undertaken on 21 October 2016 had identified that 'nursing documentation was not consistently up to date' and that 'RQIA requirements and recommendations were not being fully addressed'. The regional manager stated that plans were in place to provide support to the registered manager, to address the identified concerns; however, the inspection took place before this had commenced.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails.

The home also has an electronic governance system, which includes Thematic Resident Care Audits ("TRaCAs"). Information in areas, such as home governance, information governance, housekeeping, resident care and health and safety checks are recorded on various TRaCAs on a regular basis. This system is designed to support the "find and fix" approach. Some of the TRaCA audits completed by the regional manager identified that there were deficits in the audits completed by the registered manager, for example, in the falls and complaints audits. These matters were being followed up by the regional manager.

A TRaCA on wound care management also identified that an identified patient's wound dressing had only been changed once, rather than twice in the week. However, by the time that this was identified, the patient had been discharged. The review of the monthly quality monitoring report also indicated that August and September's TRaCA's still required to be addressed. The registered manager explained that a small number of 'linked actions' remained outstanding as they were still in progress.

Given the inspection findings, we were not assured about the effectiveness of the systems that were in place to monitor and report on the quality of nursing and other services provided. A requirement has been made in this regard.

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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/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

4.3.6 Environment

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. The majority of patients' bedrooms were personalised with photographs, pictures and personal items.

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

A recommendation has been made that the allocation of staff to the second floor, is further developed and recorded, to include those staff who have responsibility for care delivery and regular patient supervision checks.

A requirement has been made that the home is conducted to make proper provision for the nursing, and where appropriate, treatment and supervision of patients. This relates particularly to, but is not limited to, the management of patients' food and fluid intake and the safe and effective management of patients with urinary catheters.

A recommendation has been made that a care plan is developed, in consultation with the patients and/ or their representatives, as appropriate, to meet the patients' end of life care needs.

A recommendation has been made that the storage arrangements of patients' care records; and the location of the shift handover meetings are reviewed, to ensure that patients' rights to confidentiality and privacy are respected at all times.

A requirement has been made that the systems in place to monitor and report on the quality of nursing and other services provided are reviewed, to ensure that action is taken in a timely

manner, to address identified shortfalls. This relates to the individual audits, completed by the registered manager; the TRaCA's; and the monthly quality monitoring visits, undertaken in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Number of requirements	2	Number of recommendations	3

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Jean Steele, 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 web portal 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:** Second time **To be completed by:** 19 January 2017	The registered persons must ensure that the provision of staffing in the home is reviewed to ensure that there is adequate staff on duty to meet the needs of the patients. This review must include the monitoring of care delivery and the response time to the nurse call system. The registered persons must inform RQIA of the outcome of the review. Records of the necessary action taken to address staff shortages should also be maintained. **Ref: Section 4.2 and 4.3.1**
	Response by registered provider detailing the actions taken: The staffing has been reviewed and at an occupancy of 44 residents or above the staffing has been agreed as 11 staff in the morning and 8 staff in the afternoon. Call bell response time will be monitored and recorded on the QOL daily walkabout audit and will be discussed at all Residents Meetings. Actions taken to address staff shortages will be recorded.
Requirement 2 **Ref:** Regulation 15 (2) (a) and (b) **Stated:** Second time **To be completed by:** 19 January 2017	The registered persons must ensure care records are kept under review and reviewed at any time necessary to do so having regard to any change of circumstances and in any case not less than annually. **Ref: Section 4.2 and 4.3.3**
	Response by registered provider detailing the actions taken: Supervision has been conducted with all RN staff in relation to importance of maintaining records and updating information. Care profiles have been reviewed by the RE Clinical Facilitator and updates have been evidenced. Weekly QOL Resident TRACAs are being completed and actioned within a designated time frame - these actions are being evidenced by the RE Team Support Manager. Regional Managers TRACAS are being conducted on the Regulation 29 Visit and are being actioned and evidenced by the RE Team Support Manager.
Requirement 3 **Ref:** Regulation 13 (1) (a) **Stated:** Second time **To be completed by:** 19 January 2017	The registered provider must ensure that the nursing home is conducted so as to promote and make proper provision for the health and welfare of patients. Patients' personal care needs are required to be assessed and met. Records should be completed to evidence care delivered or not delivered. **Ref: Section 4.2 and 4.3.2**
	Response by registered provider detailing the actions taken: Residents personal Care records have been reviewed to ensure full information of care delivery is recorded and highlighlights any deficits of care delivery. . These care records are being reviewed weekly by the

	Registered Manager and RE Team Support Manager. This will be further monitored by the Regional Manager on the Regulation 29 visit.
Requirement 4 **Ref:** Regulation 13 (1) (b) **Stated:** First time **To be completed by:** 19 January 2017	The registered persons must ensure that the home is conducted to make proper provision for the nursing, and where appropriate, treatment and supervision of patients. This relates particularly to, but is not limited to, the management of patients' food and fluid intake and the safe and effective management of patients with urinary catheters. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: 3 Residents have been identified as requiring catheter care and catheter management. The catheter care management has been reviewed by the RE Team Clinical faciliator and all information is current and uptodate. 14 Residents have been identified as requiring a modified diet or liquids. A full review of all nutritional risk assessments, careplans and SLT recommendations and kitchen notifications has been undertaken. Supervision has been conducted with care assistant staff to reinforce staff knowledge of the Residents' assessed need. A full review of hydration management has been undertaken. Residents have been identified as requiring fluid balancing due to specific clinical condit ions or fluid intake monitoring for hydration management. 24 hours oral intake outcomes are recorded on 24 hour summary sheet for the Registered Manager's attention and recorded into the progress notes. Residents' not achieving their daily oral intake after 3 days will be referred to their GP for advice.and this is being monitored by the Registered Manager and RE Team Support Manager.
Requirement 5 **Ref:** Regulation 17 (1) **Stated:** First time **To be completed by:** 19 January 2017	The registered persons must ensure that the systems in place to monitor and report on the quality of nursing and other services provided are reviewed, to ensure that they are accurate; and that action is taken in a timely manner, to address identified shortfalls. This relates to the individual audits, completed by the registered manager; the TRaCA's; and the monthly quality monitoring visits, undertaken in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. **Ref: Section 4.3.5**
	Response by registered provider detailing the actions taken: Regional Managers TRACAS are being conducted on the Regulation 29 Visit and are being printed off and actioned and improvements are evidenced by the RE Team Support Manager.

Recommendations	
Recommendation 1 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 19 January 2017	The registered persons should ensure that the allocation of staff to the second floor, is further developed and recorded, to include those staff who have responsibility for care delivery and regular patient supervision. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: The daily allocation record has been reviewed and has been developed to include supervision by those responsible for Care delivery and hourly patient supervision.
Recommendation 2 **Ref**: Standard 32.1 **Stated:** First time **To be completed by:** 19 January 2017	The registered persons should ensure that a care plan is developed, in consultation with the patients and/or their representatives, as appropriate, to meet the patients' end of life care needs. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: Residents identified as having End of Life needs have a careplan in place.
Recommendation 3 **Ref**: Standard 5.8 **Stated:** First time **To be completed by:** 19 January 2017	The registered persons should ensure that the storage arrangements of patients' care records; and the location of the shift handover meetings are reviewed, to ensure that patients' rights to confidentiality and privacy are respected at all times. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: Storage of patients care records are held in a locked cupboard at ground floor nurses station. Shift handover meetings have been reviewed to ensure best patice with regards to patients rights to confidentiality and privacy.

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