



The **Regulation** and
Quality Improvement
Authority

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**Unannounced Care Inspection
of
Karina Lodge**

10 September 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 10 September 2015 from 11.15 to 17.45.

On the day of the inspection, areas for improvement and matters of concern were identified and are required to be addressed to ensure that care in the home is safe, effective and compassionate. These areas are set out in the Quality Improvement Plan (QIP) within this report. Please refer to section 1.2 below.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

There were no further actions required to be taken following the last care inspection on 20 May 2015.

1.2 Actions/Enforcement Resulting from this Inspection

An urgent action record regarding the completion of patient care plans was issued to Karina Lodge at the end of the inspection. These actions are required to be addressed without delay to ensure the safety and wellbeing of patients in the home. Following the inspection, the responsible person confirmed that the care plans of the identified patient had been completed.

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	10	4

The total number of requirements and recommendations above includes both new and those that have been 'restated'.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the responsible person as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Mr Thomas Girvan	Registered Manager: Mary A. Doherty
Person in Charge of the Home at the Time of Inspection: Monica Smyth (08.00 – 14.00) and Lisa Loughlin (14.00-20.00)	Date Manager Registered: 1 April 2015
Categories of Care: NH-I, NH-LD	Number of Registered Places: 15
Number of Patients Accommodated on Day of Inspection: 15	Weekly Tariff at Time of Inspection: £593

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection.

4. Methods/Process

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

Prior to inspection the following records were analysed:

- 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; and
- pre-inspection assessment audit

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- regulation 29 monthly monitoring reports
- staff training records;
- personnel records; and
- complaints records

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced finance inspection dated 26 January 2015. The completed QIP was returned and approved by the specialist inspector.

The estates inspector is also currently reviewing the content of the staff fire safety awareness training for the facility.

5.2 Review of Requirements and Recommendations from the Last Care Inspection on 18 February 2015

Last Care Inspection Statutory Requirements		Validation of Compliance
<p>Requirement 1</p> <p>Ref: Regulation 30 (1) (d)</p> <p>Stated: Second time</p>	<p>The registered person shall inform RQIA of any event in the nursing home which adversely affects the wellbeing or safety of any patient.</p> <p>This requirement is made in regard to the non-reporting of a patient's pressure ulcer.</p> <p>Action taken as confirmed during the inspection: A review of notifications confirmed that there had not been any notifications to RQIA regarding pressure ulcers since the last inspection. It was further clarified with the responsible person and the nurse in charge, the notifiable incidents that are required under RQIA's current processes.</p>	<p>Met</p>
<p>Requirement 2</p> <p>Ref: Regulation 24 (1)</p> <p>Stated: Second time</p>	<p>The registered person shall ensure that the home's complaint's procedure is reviewed and updated.</p> <p>Action taken as confirmed during the inspection: The home's complaints procedure has been reviewed. The responsible person agreed to amend the footer to this policy, in order to provide clarity on the date of revision.</p>	<p>Met</p>

<p>Requirement 3</p> <p>Ref: Regulation 20 (1) (c) (i)</p> <p>Stated: Second time</p>	<p>The registered person shall ensure that staff as appropriate are trained in the following areas:</p> <ul style="list-style-type: none"> • Pressure area care and prevention (care assistants) • Nutrition and Dysphagia (registered nurses and care staff). 	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>A review of training records confirmed that staff had completed training on nutrition and dysphagia. There was no evidence in the training records reviewed that training on pressure area care and prevention had been delivered to care staff. Following the inspection, the registered manager provided information confirming that the training had been provided.</p>		
<p>Requirement 4</p> <p>Ref: Regulation 17 (1)(2)(3)</p> <p>Stated: First time</p>	<p>The registered person must ensure effective systems are implemented for reviewing at least annually the quality of nursing and other services provided by the home.</p> <p>A copy of the report must be submitted to RQIA, when completed.</p>	<p>Not Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>The annual quality audit had not been completed since the last inspection. This requirement was not met and has been stated for the second time.</p>		

<p>Requirement 5</p> <p>Ref: Regulation 29</p> <p>Stated: First time</p>	<p>The registered person must ensure that a visit to the home as outlined in Regulation 29 is undertaken at least once a month.</p> <p>A written report of the visit must be completed and retained for inspection. The report should reflect all aspects of quality monitoring in sufficient detail as to the standard of care being provided including the actions to be taken when deficits have been identified.</p>	<p>Not Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>The monthly monitoring reports were not available in the home. However, the responsible person confirmed that they were held at his personal address and returned the reports to the home on the day of inspection. It is a legislative requirement that records are retained at the nursing home premises. Given that previous enforcement action related to the retention of records, it was concerning that the regulation 29 monthly monitoring reports were not retained in the home. Assurances were provided by the responsible person that the monthly monitoring reports would be retained in the home.</p> <p>The Regulation 29 monthly monitoring reports of the three months preceding the inspection were reviewed. The content of the three reports reviewed did not provide sufficient detail to form an opinion of the standard of nursing provided in the home. The details of the areas for improvement, within the Regulation 29 reports, were discussed with the responsible person during feedback.</p> <p>This requirement was not met and has been stated for the second time.</p> <p>The Regulation 29 monthly monitoring reports are further discussed in section 5.3 of this report.</p>		

<p>Requirement 6</p> <p>Ref: Regulation 19 Schedule 3</p> <p>Stated: First time</p>	<p>The registered person must review the current system for recording information in the patient register and ensure all staff are aware of the system in use.</p> <p>The patient register must be kept up to date at all times.</p> <p>Action taken as confirmed during the inspection: A review of the patient register confirmed that it was up to date. There was evidence that the system for maintaining the register had been reviewed and discussion with the nurse in charge confirmed that they were knowledgeable regarding the system.</p>	<p>Met</p>
<p>Requirement 7</p> <p>Ref: Regulation 16 (1)</p> <p>Stated: First time</p>	<p>The registered person must ensure that a written nursing plan is prepared, as soon as possible following admission, in consultation with the patient or patient's representative as to how the patient's needs are to be met.</p> <p>Action taken as confirmed during the inspection: A review of two patient care records evidenced that care plans were not developed in a timely manner. One identified patient did not have any care plans in place 21 days after admission. This is poor practice. An urgent action record regarding the completion of patient care plans was issued to Karina Lodge at the conclusion of the inspection. Following the inspection, the responsible person confirmed that the care plans of the identified patient had been completed.</p> <p>This requirement was not met and has been stated for the second time.</p> <p>Other deficits regarding patient assessment and care plans were identified. Refer to section 5.3 for further information.</p>	<p>Not Met</p>

<p>Requirement 8</p> <p>Ref: Regulation 30 (1) (b)</p> <p>Stated: First time</p>	<p>The registered person must ensure that RQIA are notified of the outbreak of any infectious disease.</p> <hr/> <p>Action taken as confirmed during the inspection:</p> <p>As previously discussed the current processes for notifiable incidents were clarified with the nurse in charge and the responsible person. There had not been an outbreak of infection since the previous inspection. Discussion with the nurse in charge, confirmed that they were aware that this was reportable.</p>	<p>Met</p>
<p>Requirement 9</p> <p>Ref: Regulation 27 (2) (c)</p> <p>Stated: First time</p>	<p>The registered person must address the following:</p> <ul style="list-style-type: none"> • ensure that the bath in the identified bathroom is repaired or replaced and brought back into commission; and • ensure that the flooring in the identified shower room which was not sealed and could not be effectively cleaned is repaired or replaced <hr/> <p>Action taken as confirmed during the inspection:</p> <p>The bath and the flooring in the identified bathroom were replaced and the room was in use for patients.</p>	<p>Met</p>
<p>Requirement 10</p> <p>Ref: Regulation 14 (2) (c)</p> <p>Stated: First time</p>	<p>The registered person must ensure that unnecessary risks to the health or safety of patients are identified and so far as possible eliminated. The treatment room must be kept locked, when not in use.</p> <p>Cleaning materials must be appropriately stored in keeping with COSHH regulations.</p> <hr/> <p>Action taken as confirmed during the inspection:</p> <p>The treatment room was observed to be locked, when not in use. This element of the requirement has been met.</p> <p>Cleaning materials were observed in a number of bathrooms and toilet areas. Following prompting by the inspector, these were removed.</p> <p>This element of the requirement had not been met and has been stated for the second time.</p>	<p>Partially Met</p>

Last Care Inspection Recommendations		Validation of Compliance
<p>Recommendation 1</p> <p>Ref: Standard 5.3</p> <p>Stated: Second time</p>	<p>It is recommended that the pressure relieving equipment in use on patients' beds and when sitting out of bed be addressed in patients' care plans on pressure area care and prevention.</p> <p>Action taken as confirmed during the inspection: A review of three patient care records identified that pressure relieving equipment was included in two out of three care plans. Assurances were provided that the air mattress of one identified patient would be included in the care plan.</p>	Met
<p>Recommendation 2</p> <p>Ref: Standard 5.3</p> <p>Stated: Second time</p>	<p>It is recommended that a pain assessment is maintained in patients' care records (If applicable).</p> <p>Action taken as confirmed during the inspection: A review of two patients' care records evidenced that pain assessments were not reviewed since 21 April 2015. This is poor practice.</p> <p>A review of entries in both patients' progress notes and discussion with the nurse in charge confirmed that both patients' pain levels were being managed effectively. However, the care plans reviewed were not reflective of the information identified in the pain assessments. Refer to inspector comments in section 5.3.</p> <p>This recommendation was not met. A requirement has now been made.</p>	Not Met
<p>Recommendation 3</p> <p>Ref: Standard 12.3</p> <p>Stated: First time</p>	<p>It is recommended that a choice for snacks be included on the menu planner for patients on therapeutic diets.</p> <p>Action taken as confirmed during the inspection: Discussion with the responsible person and the nurse in charge confirmed that there was a choice of snack available for patients on therapeutic diets.</p>	Met

<p>Recommendation 4</p> <p>Ref: Standard 30.4</p> <p>Stated: Second time</p>	<p>The registered manager must ensure the nurse in charge competency assessments are completed on an annual basis.</p> <p>This template should also include wound care intervention.</p> <hr/> <p>Action taken as confirmed during the inspection:</p> <p>A copy of the nurse in charge competency assessment template was reviewed and it included a section on wound care intervention. Discussion with the nurse in charge and one registered nurse confirmed that the nurse in charge competencies had not been completed. However, there was evidence that plans were in place to complete these.</p> <p>This recommendation was not fully met, however as there was some evidence that plans were now in place to address matters it has been stated for the third time and final time.</p>	<p>Partially Met</p>
<p>Recommendation 5</p> <p>Ref: Standard 19.2</p> <p>Stated: First time</p>	<p>The following guidelines should be made available to staff and used on a daily basis:</p> <ul style="list-style-type: none"> • RCN continence care guidelines; • NICE guidelines on the management of urinary incontinence; and • NICE guidelines on the management of faecal incontinence <hr/> <p>Action taken as confirmed during the inspection:</p> <p>It was confirmed that the relevant guidelines, referred to above, were in place.</p>	<p>Met</p>

<p>Recommendation 6</p> <p>Ref: Standard 5.6</p> <p>Stated: First time</p>	<p>The registered manager should ensure that bowel function, reflective of the Bristol Stool Chart, should be recorded on admission as a baseline measurement and thereafter in the patients' daily progress records.</p> <hr/> <p>Action taken as confirmed during the inspection:</p> <p>A review of three patients' care records evidenced that continence assessments were not completed for two patients. Another patient's continence assessment had not been reviewed since 24 October 2014. There was no evidence that a baseline measurement of the patients' bowel function had been recorded. However, there was evidence that the Bristol Stool Chart was referenced in the patients' daily progress notes and there was a good system in place for recording bowel function. Refer to inspector comments in section 5.3.</p> <p>This recommendation was not been fully met and has been stated for the second time.</p>	<p>Partially Met</p>
<p>Recommendation 7</p> <p>Ref: Standard 17</p> <p>Stated: First time</p>	<p>Review the current system for the management of complaints to ensure that all complaints including expressions of dissatisfaction either written or verbal are recorded.</p> <p>The records should also include the actions taken to address the issues identified and the complainant's level of satisfaction with the action taken.</p> <hr/> <p>Action taken as confirmed during the inspection:</p> <p>The complaints records were reviewed and were appropriately maintained. There were no complaints recorded since the previous care inspection. Discussion with the responsible person and the nurse in charge confirmed that they were aware of the complaints procedure.</p>	<p>Met</p>

<p>Recommendation 8</p> <p>Ref: Standard 26.4, 26.5 & 26.6</p> <p>Stated: First time</p>	<p>Ensure that policies and procedures are centrally indexed, are version and date controlled and are subject to a systematic three yearly review.</p> <hr/> <p>Action taken as confirmed during the inspection:</p> <p>There was evidence that the policies and procedures were centrally indexed. Discussion with the responsible person confirmed that a process had been established to review the home's policies and procedures on a phased basis.</p> <p>Advice was given regarding the version controlling process and RQIA will continue to monitor this during future inspections.</p>	<p>Met</p>
<p>Recommendation 9</p> <p>Ref: Standard 34</p> <p>Stated: First time</p>	<p>Review the practice of storing incontinence products in the corridor and keep incontinence products covered until point of use to prevent the risk of spread of infection.</p> <hr/> <p>Action taken as confirmed during the inspection:</p> <p>There was no evidence that incontinence pads were stored in the corridors.</p>	<p>Met</p>

5.3 Additional Areas Examined

Care Records

Five patients' care records were reviewed. One newly admitted patient did not have any care plans developed 21 days after admission. An urgent action record regarding the completion of patient care plans was issued to Karina Lodge at the conclusion of the inspection and the requirement has been stated for the second time, as discussed in section 5.2. Following the inspection, the responsible person confirmed that the care plans of the identified patient had been completed.

Other deficits regarding patient assessments and care plans were identified.

Two identified patients did not have risk assessments completed for nutrition, continence, pain, moving and handling and falls management. There was also evidence in the care records reviewed that falls risk assessments had not been consistently updated. A requirement has been made.

It was concerning that one identified patients who did not have a nutritional risk assessment in place was on a therapeutic diet and was prescribed supplements. This information was also not present in the patient's care plan. There was no evidence that the patient had been weighed 13 days after admission. This is poor practice. An urgent action record was issued at the end of the inspection, to ensure that the identified patient's weight was taken. Following the inspection, the responsible person confirmed that the patient had been weighed and that all care plans were in place.

As discussed previously in section 5.2, one patient's continence assessment had not been updated since 24 October 2014 and two patient's pain assessments had not been reviewed since 21 April 2015. The care plans reviewed were not person-centred and did not reflect the information identified in the assessments. For example, there was no evidence in two care plans, of the location or type of pain experienced by the patients and where specific behaviour was identified on the pain assessment as being an indicator of pain, this information was not included in the care plan. A requirement has been made.

Care file audits were not available on the day of the inspection. Following the inspection the registered manager confirmed that care file audits were completed and indicated that the records were maintained at her personal address. It is a legislative requirement that records are retained at the nursing home premises. Given that previous enforcement action related to the retention of records, it was concerning that the care file audits were not retained in the home. It is also concerning that the registered manager was aware that the care plans of the two newly admitted patients had not been completed. Copies of care file audits were forwarded to RQIA, following the inspection. A review of the care file audits evidenced that the auditing process was not robust and provided no traceability regarding the patients care record that had been audited. Where deficits were identified, there was no evidence of follow up with the registered nurses. Following the inspection, details of the areas for improvement within the care file auditing records were discussed with the registered manager. A requirement has been made to address this.

Given the inspection findings, it is also recommended that the registered manager review the current process for review of care plans, including the named nurse system.

Record Keeping

One patient's weight was monitored on a monthly basis. However, the weights were recorded in a 'weights book' and were not transcribed into the patient's care record. There was also evidence in one patient care record that nursing staff had recorded entries using the month, rather than the actual date.

One patient's consent for the use of bedrails was not in place. Discussion with the registered nurse confirmed that the patient had given verbal consent and was unable/unwilling to sign the consent form. The registered nurse stated that they did not know how to document verbal consent in this regard.

There were two patients' needs assessments and one patient's admission profile that did not indicate the signature of the staff member who had completed them. One patient's wound observation chart did not indicate the grade or location of the wound that was treated. This is not in line with professional recording guidelines on record and record keeping.

There was also evidence that core care plans were in place and that registered nurses attempted to personalise the care plans by only inserting the patients' names.

In view of inspector findings, a requirement has been made that registered nursing staff, as required, receive training in care planning. This training should also include the legal aspects of care planning and record keeping.

Personnel records

Five personnel records were reviewed and a number of deficits were identified. It was evidenced that two written references relating to the person, including a reference from the person's present or most recent employer, (if any) were not obtained in three of the five records reviewed. Two personnel records evidenced that application forms had not been completed. A requirement has been made to address this.

Regulation 29 Monthly Monitoring Report

As previously discussed in section 5.2, the regulation 29 monthly monitoring reports of the three months preceding the inspection were reviewed. The content of the three reports reviewed did not provide sufficient detail to form an opinion of the standard of nursing provided in the home and the details of the areas for improvement, within the regulation 29 reports, were discussed with the responsible person during feedback.

The date the monitoring visit was conducted had not been entered on the reports. The report also did not indicate the length of time the monitoring visit took place. There were no action plans and no reference to previously conducted monitoring reports. A review of the three reports did not evidence that they had been reviewed by either the responsible person or the registered manager. This was concerning. There was also no evidence that a review of the requirements and/or recommendations made by RQIA had been included in the reports. A recommendation has been made.

Environment

A general inspection of the home was undertaken which included inspection of a random sample of bedrooms, bathrooms shower and toilet facilities, sluice rooms, storage rooms and communal areas were examined. In general the areas examined were found to be clean, reasonably tidy and well decorated and warm throughout.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the responsible person and Lisa Loughlin, registered nurse, 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/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.

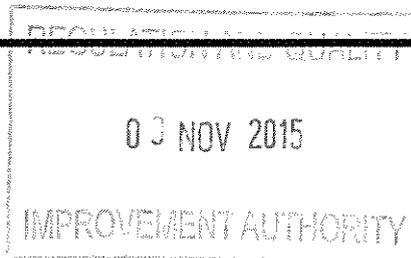
It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Statutory Requirements

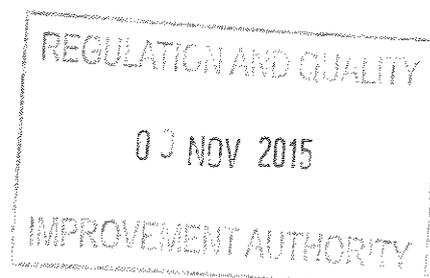
<p>Requirement 1</p> <p>Ref: Regulation 17 (1)(2)(3)</p> <p>Stated: Second time</p> <p>To be Completed by: 08 November 2015</p>	<p>The registered person must ensure effective systems are implemented for reviewing at least annually the quality of nursing and other services provided by the home.</p> <p>A copy of the report must be submitted to RQIA, when completed.</p> <p>Ref: Section 5.2</p> <hr/> <p>Response by Registered Persons Detailing the Actions Taken:</p> <p>An annual review of nursing and other services is in place and a copy included with this QIP.</p>
<p>Requirement 2</p> <p>Ref: Regulation 29</p> <p>Stated: Second time</p> <p>To be Completed by: 08 November 2015</p>	<p>The registered person must ensure that a visit to the home as outlined in Regulation 29 is undertaken at least once a month.</p> <p>A written report of the visit must be completed and retained for inspection. The report should reflect all aspects of quality monitoring in sufficient detail as to the standard of care being provided including the actions to be taken when deficits have been identified.</p> <p>Ref: Section 5.2</p> <hr/> <p>Response by Registered Persons Detailing the Actions Taken:</p> <p>The Home has been visited regularly and reports have been inspected. However a new format for inspection visits will be introduced in Nov. 2015</p>

<p>Requirement 3</p> <p>Ref: Regulation 16 (1)</p> <p>Stated: Second time</p> <p>To be Completed by: 08 November 2015</p>	<p>The registered person must ensure that a written nursing plan is prepared, as soon as possible following admission, in consultation with the patient or patient's representative as to how the patient's needs are to be met.</p> <p>Ref: Section 5.2</p> <hr/> <p>Response by Registered Persons Detailing the Actions Taken:</p> <p>The registered nurses have been spoken to regarding the standards which states that a nursing care plan must be in place 5 days after admission. The nurse in charge starts the care plan and it is followed through by the night staff until it is completed.</p>
<p>Requirement 4</p> <p>Ref: Regulation 14 (2) (c)</p> <p>Stated: Second time</p> <p>To be Completed by: 08 November 2015</p>	<p>The registered person must ensure that unnecessary risks to the health or safety of patients are identified and so far as possible eliminated.</p> <p>Cleaning materials must be appropriately stored in keeping with COSHH regulations.</p> <p>Ref: Section 5.2</p> <hr/> <p>Response by Registered Persons Detailing the Actions Taken:</p> <p>Staff were all spoken to regarding COSHH regulations and in particular the safe storage of cleaning materials.</p>
<p>Requirement 5</p> <p>Ref: Regulation 15 (2) (a)</p> <p>Stated: First time</p> <p>To be Completed by: 08 November 2015</p>	<p>A pain assessment must be maintained in patients' care records, if applicable.</p> <p>A recommendation has been made on two previous occasions.</p> <p>Ref: Section 5.2</p> <hr/> <p>Response by Registered Persons Detailing the Actions Taken:</p> <p>The Abbey pain scale is now in place and there is a care plan for patients on opioid medication. All staff to enter on progress notes when an analgesic is administered and its effectiveness.</p>



<p>Requirement 6</p> <p>Ref: Regulation 15 (2) (a) and (b)</p> <p>Stated: First time</p> <p>To be Completed by: 08 November 2015</p>	<p>The registered persons must ensure that each patient has a comprehensive and holistic assessment completed to accurately identify their individual needs and provide the necessary information to advise and direct care.</p> <p>Ref: Section 5.3</p> <hr/> <p>Response by Registered Persons Detailing the Actions Taken:</p> <p>A comprehensive and holistic assessment is now in place for each patient.</p>
<p>Requirement 7</p> <p>Ref: Regulation 16 (1)</p> <p>Stated: First time</p> <p>To be Completed by: 08 November 2015</p>	<p>The registered persons must ensure that care plans are in place to direct the care required to meet the assessed needs of the patients. Interventions must be individualised and patient centred.</p> <p>Ref: Section 5.3</p> <hr/> <p>Response by Registered Persons Detailing the Actions Taken:</p> <p>Individualised and patient centred care plans are in place.</p>
<p>Requirement 8</p> <p>Ref: Regulation 17 (1)</p> <p>Stated: First time</p> <p>To be Completed by: 08 November 2015</p>	<p>The registered manager must ensure that care records are audited, using a robust system that provides traceability of audit.</p> <p>Ref: Section 5.3</p> <hr/> <p>Response by Registered Persons Detailing the Actions Taken:</p> <p>A care record audit has been implemented and is now in place for individual patients. Three care plans to be audited each month as suggested by RQIA inspection.</p> <p>A copy of the audit sheet is enclosed for approval.</p>

<p>Requirement 9</p> <p>Ref: Regulation 20 (1) (c)</p> <p>Stated: First time</p> <p>To be Completed by: 08 November 2015</p>	<p>The registered persons must ensure that registered nursing staff, as required, receive training in care planning.</p> <p>This training should also address the deficits in contemporaneous recording observed in this inspection, in accordance with NMC guidelines for record keeping and should include the legal aspects of care planning and record keeping.</p> <p>Ref: Section 5.3</p>
<p>Requirement 10</p> <p>Ref: Regulation 21 (1) (c) and 21 (5) (d) (i)</p> <p>Stated: First time</p> <p>To be Completed by: 08 November 2015</p>	<p>Response by Registered Persons Detailing the Actions Taken:</p> <p>Information regarding this topic was requested and received from Rosemary Wilson. It was group discussed by the RIN's working in Karina Lodge and each RIN received a copy of the topic contents.</p> <p>The registered persons must ensure that for all staff, recruited since 2005 and currently employed in Karina Lodge, they have obtained in respect of each person the information and documents specified in paragraphs 1 to 7 of Schedule 2.</p> <p>An audit of the recruitment records must be submitted to RQIA with the returned QIP. Actions requiring follow up should be clearly indicated with evidence of matters addressed.</p> <p>Ref: Section 5.3</p> <p>Response by Registered Persons Detailing the Actions Taken:</p> <p>An audit of recruitment records is enclosed. Staff have been notified regarding any deficits and the process of obtaining the documents is in place.</p>



Recommendations	
<p>Recommendation 1</p> <p>Ref: Standard 30.4</p> <p>Stated: Third and final time</p> <p>To be Completed by: 08 November 2015</p>	<p>The registered manager must ensure the nurse in charge competency assessments are completed on an annual basis. This template should also include wound care intervention.</p> <p>Confirmation that nurse in charge competency assessments have completed for all registered nurses must be submitted to RQIA with the returned QIP.</p> <p>Ref: Section 5.2</p> <p>Response by Registered Persons Detailing the Actions Taken:</p> <p><i>Nurse-in-charge competency assessments have been completed and are submitted to R.Q.I.A. for approval.</i></p>
<p>Recommendation 2</p> <p>Ref: Standard 5.6</p> <p>Stated: Second time</p> <p>To be Completed by: 08 November 2015</p>	<p>The registered manager should ensure that bowel function, reflective of the Bristol Stool Chart, should be recorded on admission as a baseline measurement and thereafter in the patients' daily progress records.</p> <p>Ref: Section 5.2</p> <p>Response by Registered Persons Detailing the Actions Taken:</p> <p><i>Patients bowel function is recorded on admission stating usual type and a daily record is kept on each individual care plan</i></p>
<p>Recommendation 3</p> <p>Ref: Standard 4.2</p> <p>Stated: First time</p> <p>To be Completed by: 08 November 2015</p>	<p>The registered manager should review the process for review of care plans, including the named nurse system.</p> <p>Ref: Section 5.3</p> <p>Response by Registered Persons Detailing the Actions Taken:</p> <p><i>Named Nurses have been identified. Assessments must be evaluated monthly. Audits by nurse Managers are carried out to ensure the effectiveness of the system.</i></p>

<p>Recommendation 4</p> <p>Ref: Standard 35.16</p> <p>Stated: First time</p> <p>To be Completed by: 08 November 2015</p>	<p>The responsible person must ensure that any requirements and/or recommendations made by RQIA are included in the regulation 29 monitoring report and evidences progress made by the home, ensuring compliance against the identified matters.</p> <p>The regulation 29 monthly monitoring reports should be submitted to the inspector within 5 working days of the beginning of each new month. This should commence immediately and continue until further notice.</p>
<p>Response by Registered Persons Detailing the Actions Taken:</p> <p><i>Requirements and Recommendations will be included in the new format for Reg. 29.</i></p>	

<p>Registered Manager Completing QIP</p>	<p><i>Mina Doherty</i></p>	<p>Date Completed</p>	<p><i>6-11-15.</i></p>
<p>Registered Person Approving QIP</p>	<p><i>[Signature]</i></p>	<p>Date Approved</p>	<p><i>6-11-15</i></p>
<p>RQIA Inspector Assessing Response</p>	<p><i>Aileen Donnelly</i></p>	<p>Date Approved</p>	<p><i>20/11/2015</i></p>

Please ensure the QIP is completed in full and returned to RQIA Office

