Unannounced Care Inspection Report
22 November 2016

Broadways Private Nursing Home

Type of Service: Nursing Home
Address: Broadway, Main Street, Larne, BT40 1LT
Tel no: 0282827 3464
Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Broadways Private Nursing Home took place on 22 November 2016 from 09:50 to 16:00 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subjected to regular review to ensure the assessed needs of the patients were met. Discussion with patients and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

The registered manager and staff spoken with demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibilities in general and specifically in relation to adult safeguarding.

A review of the home's environment was undertaken and included observations of a random sample of bedrooms, bathrooms, lounge/s, dining room and storage areas. The home was found to be warm, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts. Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

One requirement was made in relation to notifying RQIA of incidents/events occurring in the home in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 – regulation 30. Refer to section 4.3 for details.

Is care effective?

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process and both were reviewed as required.

Care records reflected the assessed needs of patients; were kept under review and where appropriate, recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians were included in the care plan. There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with relatives/representatives within the care records. Discussion with three relatives confirmed that they were kept informed of their loved one's care and treatment.

Observations and feedback from patients consulted evidenced that call bells were answered promptly and patients requesting assistance were responded to in a calm, quiet and caring manner. Staff stated that there was 'good teamwork'; this was evidenced through discussion and observation of interactions throughout the inspection process. Each staff member knew their role, function and responsibilities.

Effective communication with patients and their representatives was evident on a one to one basis as recorded in the care records. Patients consulted confirmed that they received "good care" and that the staff were "kind and attentive".

There were no areas for improvement identified within this domain. Refer to section 4.4 for details.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated knowledge of patients' wishes and preferences as detailed in the care plans reviewed and discussed with patients. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

It was evident from review of the information, observation of the home and discussion with staff and patients that management had responded to consultation with patients and relatives and improvements had been undertaken, or were planned, to improve the quality of care and experiences within the home.

Patients and their representatives and staff confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

RQIA consulted with patients, relatives and staff during the inspection and by the issuing of questionnaires. All patients and relatives spoken with commented positively regarding the care received and the staffs' caring and kind attitude. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Details of consultation with patients, staff and relatives can be viewed throughout the report and in particular within section 4.5.

A recommendation was made regarding the displaying of patient information. Refer to section 4.5 for details.

Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff easily described their role and responsibility in the home. In discussion, patients and relatives were also aware of the roles of the staff in the home and to whom they should speak to if they had a concern.

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 were knowledgeable of the complaints and adult safeguarding processes commensurate with their role and function.

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. These records also evidenced that the results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

Discussion and review of records evidenced that Regulation 29 monitoring visits were completed by the responsible individual in accordance with the Nursing Homes Regulation (Northern Ireland) 2015.

Based on the inspection findings detailed within the report, it was evident that Broadways Private Nursing Home was well led. However, compliance with the requirement and recommendation made will further enhance the quality of care, treatment and services provided.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	1

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

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

1.2 Actions/enforcement taken following the most recent estates inspection

The most recent inspection of the home was an announced premises management inspection undertaken on 24 May 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

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

There were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: Mrs Barbara Sloan	**Registered manager:** Mrs Jacqueline Davey
Person in charge of the home at the time of inspection:	**Date manager registered:** 7 March 2012
Categories of care: NH-PH and NH-I A maximum of two patients in category NH-PH.	**Number of registered places:** 33

3.0 Methods/processes

Prior to inspection we analysed the following information:

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

During the inspection the inspector spoke with eight patients individually and greeted others in small groups, five care staff, one registered nurse and two staff from housekeeping.

In addition questionnaires were provided for distribution by the registered manager; 10 for relatives, eight for patients and 10 for staff. Two patients, four relatives and nine staff returned their questionnaires within the timeframe specified. Details can be viewed in section 4.5.

The following information was examined during the inspection:

- three patient care records
- four patient additional care charts such as reposition charts, food and fluid intake charts
- staff roster from 1 – 27 November 2016
- staff training and planner/matrix for 2016
- two staff recruitment records including induction records
- complaints record
- compliments records
- incident and accident records
- record of quality monitoring visits carried out in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- records of audit/governance
- processes for consultation with staff, patients and relatives.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 24 May 2016

The most recent inspection of the home was an announced premises management inspection. The completed QIP was returned and approved by the estates inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next premises management inspection.

4.2 Review of requirements and recommendations from the last care inspection Dated 21 March 2016

Last care inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 27(4) **Stated:** First time	The registered persons must ensure through a robust monitoring process that the home's fire safety precautions and procedures are adhered to in relation to the storage of equipment or other items on stair case landings. Evidence of the process must be available for inspection.	**Met**
	Action taken as confirmed during the inspection: Observation of the environment and review of monitoring records evidenced that this requirement had been met.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 36 **Stated:** Second time	The registered person should ensure that the home's policies and procedures are subject to a systematic three yearly review or more frequently, if relevant, to ensure they reflect national and regional guidance.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and review of selected records confirmed that this recommendation had been met.	

Recommendation 2 **Ref**: Standard 4 **Stated:** Second time	The registered person shall ensure that core care plans are reviewed in conjunction with the DHSSPS care standards for nursing homes, relevant evidenced based guidance for specific care needs and professional guidance for registered nurses.	**Met**
	Action taken as confirmed during the inspection: Review of three patient care records confirmed that this recommendation had been met.	
Recommendation 3 **Ref**: Standard 4.8 **Stated:** First time	The registered person shall ensure that a contemporaneous record of all nursing interventions, activities and procedures carried out is recorded for each patient. The outcomes of such actions should also be recorded, and any variance from the care plan explained and documented in accordance with NMC guidelines for registered nurses.	**Met**
	Action taken as confirmed during the inspection: Review of three patient care records, in full, and three patient's reposition charts confirmed that this recommendation had been met.	
Recommendation 4 **Ref**: Standard 35.6 **Stated:** Second time	The registered person shall ensure that an audit or review of the standard of record keeping is undertaken; that it is robust, traceable and takes account of legislative requirements; DHSSPS care standards for nursing homes and other related standards or guidance.	**Met**
	Action taken as confirmed during the inspection: Review of governance records confirmed that this recommendation had been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subjected to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 1 to 27 November 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Discussion with the registered manager and review of recruitment and induction records evidenced that newly appointed staff completed a structured orientation and induction

programme at the commencement of their employment. New staff were supported through their induction by a dedicated mentor and induction records evidenced the records to be completed in full and signed/dated appropriately. Recruitment practices were adhered to in line with legislative requirements. During discussion the registered manager confirmed that she and/or the responsible individual reviewed Access NI certificates prior to the person commencing their employment. However, this was not clearly recorded on the recruitment records reviewed. RQIA were satisfied that the checks were reviewed appropriately however, advice was given that the date of the Access NI review is recorded clearly.

Review of the training planner/matrix for 2016 indicated that training was planned to ensure that mandatory training requirements were met. Staff confirmed that they were required to complete mandatory training. Discussion with the registered manager and review of records evidenced that a system was in place to ensure staff attended mandatory training. Staff would be reminded verbally and through the displaying of training information of the scheduled training to ensure they attended. Records of staff attendance did not reflect recent training sessions and it was agreed that written confirmation of compliance levels for attendance at mandatory training would be emailed to RQIA. An email received from the registered persons on 28 November confirmed that compliance with mandatory training requirements would be achieved by the end of 2016. Dates of final training sessions for moving and handling, infection control, fire safety and adult safeguarding training were included in the information received.

The registered manager and staff spoken with demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibilities in general and specifically in relation to adult safeguarding.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC). Safety and medical alerts were reviewed on a regular basis and relevant notices were 'actioned' and/or disseminated to staff as required.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of records pertaining to accidents/incidents since 1 April 2016 confirmed that the number of falls and/or incidents occurring in the home was very low and records maintained evidenced that accidents and incidents were managed appropriately. Audits of falls and incidents were maintained and evidenced analysis of the data to identify any emerging patterns or trends. The registered manager confirmed that, if required, action plans would be developed to address deficits or concerns. One record reviewed evidenced that the appropriate action had been taken following review of the data to ensure the patient concerned received safe care.

Notifications to RQIA were also reviewed. Two out of six accidents/incidents occurring within the timeframe required to be notified to RQIA in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 – regulation 30. The details were discussed with the registered manager who agreed to submit retrospective notifications; a requirement was made.

A review of the home's environment was undertaken and included observations of a random sample of bedrooms, bathrooms, lounge/s, dining rooms and storage areas. The home was

found to be warm, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts. A refurbishment programme had been submitted to RQIA following the premises management inspection in May 2016. Work was ongoing as observed during this inspection. Discussion with patients, relative, staff and management confirmed that the work was managed appropriately to ensure disruption, to the day to day life of the home, was kept to a minimum. Some patients said that they enjoyed watching the men working. The registered persons confirmed that the plan was to have the works completed prior to Christmas.

Fire exits and corridors were observed to be clear of clutter and obstruction. Discussion with management confirmed that staff had been advised to be more vigilant in relation to trip hazards and the blocking of fire exits while the refurbishment works were taking place.

In one bedroom an additional electric radiator was in use. The registered manager stated that a risk assessment had been completed for the use of this radiator but that the electric radiator was no longer required and should have been removed. The risk assessment was not available for review. The registered manager confirmed, by email, on 24 November 2016 that the risk assessment for the electric radiator had been undertaken. The risk assessment received was dated 22 November 2016.

Infection prevention and control measures were adhered to and equipment was appropriately stored. One waste disposal bag holder was noted to have rust on the base plate and one shower chair, in a bathroom, was observed to be rusted around the wheels and legs. During feedback the registered manager confirmed she had already replaced the shower chair and had 'stored' the rusted one in the bathroom for disposal; and that she would address the bag holder and remind staff to report similar concerns to be addressed.

Areas for improvement

A requirement was made that RQIA are notified of accidents/incidents or events occurring in the nursing home in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 – regulation 30.

Number of requirements	1	**Number of recommendations**	0

4.4 Is care effective?

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process and both were reviewed as required. For example, records in relation to the management of wounds/pressure ulcers indicated that when a patient was identified as being at risk of developing a pressure ulcer a care plan was in place to direct staff on the management of this risk. Where applicable, specialist healthcare professionals were involved in prescribing care in relation to the management of wounds.

Care records reflected the assessed needs of patients; were kept under review and where appropriate, recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians were included in the care plan. Advice was provided that staff need to take care to ensure they dated and signed any record in full, in accordance with legislative requirements and professional guidance from the Nursing and Midwifery Council for UK (NMC).

Observation of two electric pressure relieving mattresses evidenced that staff had to 'set' the pressure according to the patient's weight. One mattress was observed to be too high for the patient requiring it. Too high or too low a pressure setting has the potential to cause pressure damage rather than relieving it. Specific details of the findings were discussed with one registered nurse who immediately responded to the concern by informing staff and reviewing all electric mattresses in the home and confirming, to the inspector, that all were operating correctly. The registered nurse and the registered manager confirmed that this action would be recorded as a group supervision/learning session and would be conducted with other care staff, not on duty, to ensure all nursing and care staff were aware of the risks to patients if the settings were wrong. RQIA were satisfied that this concern had been managed appropriately.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records. Discussion with three relatives confirmed that they were kept informed of their loved one's care and treatment.

Observations and feedback from patients consulted evidenced that call bells were answered promptly and patients requesting assistance were responded to in a calm, quiet and caring manner.

Staff confirmed that they were kept informed of changes or concerns regarding patients' needs through the handover reports at the beginning of their shift. Staff also confirmed that regular staff meetings were held and that minutes were made available. Staff meetings were held in April and June 2016. Minutes were available but not reviewed on this occasion.

Staff stated that there was 'good teamwork'; this was evidenced through discussion and observation of interactions throughout the inspection process. Each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the registered manager. All grades of staff consulted demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

Effective communication with patients and their representatives was evident on a one to one basis as recorded in the care records. Patients consulted confirmed that they received "good care" and that the staff were "kind and attentive".

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated knowledge of patients' wishes and preferences as detailed in the care plans reviewed and discussed with patients. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent. However, patient names were displayed on a whiteboard at reception area, patient information and the diary were left on the desk at reception and accessible to anyone entering the home; and in one bedroom patient care information was displayed on the wall behind the bed.

Following discussion with the registered manager it was acknowledged that the refurbishment of the reception area was an opportunity to move the whiteboards to a more suitable location and a recommendation was made regarding the displaying of patient information generally.

All patients spoken with commented positively regarding the care they received and the staffs' caring and kind attitude. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. Views and comments recorded were analysed and an action plan was developed and shared with staff, patients and representatives. The consultation results and suggested improvements were displayed on the notice board outside the main lounge. It was evident from review of the information, observation of the home and discussion with staff and patients; that management responded to the consultation findings and had improved or planned to improve the quality of care and experiences within the home.

Patients and their representatives and staff confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

Consultation with eight patients individually, and with others in smaller groups, confirmed that living in Broadways Nursing Home was a positive experience. Patients said that they enjoyed the view from the lounge or their bedroom, the care they received and the quality of the food was good. All stated clearly that the staff "were great". It was evident that patients knew staff and the management team well and patients referred to themselves and staff as "part of the big family of Broadways". Patients also knew the registered manager and called her by her first name and stated that she and Barbara, the responsible individual, were great girls". Patients also commented positively regarding the quality and choice of food provided.

Relatives spoken with were confident that their loved ones were well cared for, that they were kept informed and some stated that it was lovely to be in a home with staff who knew them and their loved one and that you knew them inside and outside the home. Relatives said that the homely atmosphere and the standard of care provided was "very good".

In addition to speaking with patients, relatives and staff RQIA provided questionnaires for distribution by the registered manager after the inspection. Ten issued for staff and relatives/representatives and eight for patients. At the time of writing this report two patients, four relatives and nine staff returned their questionnaires within the timeframe specified.

Patient questionnaires

Both patients indicated that they were 'very satisfied' that their care was safe, effective and compassionate and that the nursing home was well led. There were no additional comments recorded.

Relatives' questionnaires

Two relatives recorded 'very satisfied' and two recorded 'satisfied' in relation to the care their loved ones received in Broadways Nursing Home. There were no additional comments recorded.

Staff questionnaires

Five staff indicated that they were 'very satisfied' that the care delivered in Broadways nursing home was safe, effective, compassionate and well led. Two staff recorded that they were 'satisfied' and two recorded a mixture of 'very satisfied' and 'satisfied' under each area questioned. There were no additional comments recorded.

Areas for improvement

A recommendation was made that patient information and records should be maintained in a confidential manner to ensure the privacy and dignity of patients is upheld.

Number of requirements	0	**Number of recommendations**	1

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 easily described their role and responsibility in the home. In discussion, patients and relatives were also aware of the roles of the staff in the home and to whom they should speak to if they had a concern.

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. Patients spoken with confirmed that they were aware of the home's complaints procedure and that they were confident that staff/management would address any concern raised by them appropriately.

Staff were knowledgeable of the complaints and adult safeguarding processes commensurate with their role and function. Discussion with the registered manager and review of records evidenced that systems were in place to ensure that, complaints, and/or potential adult safeguarding concerns were investigated and reported to RQIA or other relevant bodies. However, as discussed in section 4.3 a requirement was made in relation to two accidents/events not notified to RQIA.

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, care records, infection prevention and control, environment and complaints. These records

also evidenced that the results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice. For example the improvement in patient record keeping and care planning was evident through review of patient records and from a review of the registered manager's care record audit and subsequent action taken to address identified deficits. Advice was provided regarding the attention to detail when altering any entry to a record to ensure the original entry could still be read and that dates should be recorded in full.

Discussion and review of records evidenced that Regulation 29 monitoring visits were completed by the responsible individual in accordance with the Nursing Homes Regulation (Northern Ireland) 2015. Records confirmed the details of the visits and an action plan was in place to ensure any improvements required were addressed. Subsequent reports evidenced that the previous action plan was reviewed.

There was an effective system in place to ensure nursing staff were registered with the nursing and Midwifery Council; and that care staff were registered with the Northern Ireland Social Care Council (NISCC). New care staff not registered with NISCC were required and supported to register.

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

Based on the inspection findings detailed in the preceding domains, review of records, systems and processes; and comments from patients and staff it was evident that Broadways Private Nursing Home was well led. However, compliance with the requirement and recommendation made will further enhance the quality of care, treatment and services provided.

Areas for improvement

No new areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Jacqueline Davey, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Statutory requirements	
Requirement 1 **Ref**: Regulation 30 **Stated:** First time **To be completed by:** Immediate action required.	The registered provider must ensure that RQIA are notified of accidents/incidents or events occurring in the nursing home in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 – regulation 30. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The Manager will ensure that the RQIA are notified of all accidents/incidents/events occuring within the Home. Staff have been reminded via nursing memo that they are responsible for notifying RQIA of any accidents/incidents/events in Manager's absence.

Recommendations	
Recommendation 1 **Ref**: Standard 6 **Stated:** First time	The registered provider should that patient information and records should are maintained in a confidential manner to ensure the privacy and dignity of patients is upheld at all times. **Ref: Section 4.4**
To be completed by: Immediate action required.	**Response by registered provider detailing the actions taken:** White boards have been relocated to clinical room. Storage for all diaries, charts etc. has been created at reception and staff have been reminded of the importance of confidentiality and privacy.

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

The Regulation and Quality Improvement Authority

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