The Regulation and Quality Improvement Authority

Inspection Report

2 September 2021

Ben Madigan Care Home

Type of service: Nursing Home
Address: 36 Mill Road, Newtownabbey, BT36 7BH
Telephone number: 028 9086 0787

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Amore (Ben Madigan) Limited **Responsible Individual:** Mrs Nicola Cooper	**Registered Manager:** Mrs Tracey Henry Acting - no application required
Person in charge at the time of inspection: Rosemary Clarke - Quality Improvement Lead Sara Main – Acting Manager	**Number of registered places:** 64 A maximum of 34 patients within category of care NH-DE and located within the Dementia Unit.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill	**Number of patients accommodated in the nursing home on the day of this inspection:** 48
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 64 patients. The home is divided in three units over two floors. The Hillview Unit on the ground floor provides general nursing care for patients. The Bellevue and Coastview Units on the first floor provide care for patients with dementia. Within each unit patients have access to communal lounges and dining rooms.	

2.0 Inspection summary

An unannounced inspection took place on 2 September 2021 between 7.30 am and 5.30 pm. This inspection was carried out by two care inspectors and a pharmacist inspector.

Concerns were raised with RQIA by the Northern Health and Social Care Trust (NHSCT) and Belfast Health and Social Care Trust (BHSCT) on 27 August 2021 following complaints by relatives. These were in relation to management and staffing arrangements, governance, medication management, nutrition management, infection prevention and control (IPC)

measures, care records and communication with relatives. In response to this information RQIA decided to undertake an unannounced inspection.

The outcome of this inspection mirrored the significant concerns raised by the Trusts. The lack of effective management arrangements were found to be impacting on staffing levels, care delivery, medicines management, IPC measures, fire safety, communication systems and overall governance arrangements.

Given the concerns raised, a meeting was held on 9 September 2021 with the intention of issuing three Failure to Comply (FTC) notices under The Nursing Homes Regulations (Northern Ireland) 2005 in relation to:

- Regulation 8 (1) – relating to management arrangements in the home
- Regulation 10 (1) – relating to management and governance arrangements
- Regulation 20 (1) – relating to staffing arrangements

The meeting was attended by Nicola Cooper, Responsible Individual (RI), Sarah Perez, Managing Director, and Tracey Henry, Regional Manager /Acting Manager. Prior to the meeting the RI provided RQIA with details of the actions taken and these were discussed at the intention meeting. RQIA received assurance that a manager was to be appointed imminently and an administrator was due to commence. Plans were also in place to recruit staff to fill vacancies. RQIA decided not to issue the FTC Notices.

However, on 22 September 2021, Nicola Cooper, RI, informed RQIA that the proposed manager was no longer taking up the post. The Acting Manager was also unable to be present in the home due to unforeseen circumstances and could only maintain remote oversight. RQIA were already aware that the proposed administrator had not taken up their post as planned on 13 September 2021.

The concerns identified on inspection had not been resolved as planned and as a result RQIA made the decision to reconvene the FTC intention meeting on 28 September 2021.

The RI acknowledged that progress with the action plan had not been as fast as anticipated due to the manager post remaining vacant. The RI informed RQIA of the actions put in place to provide managerial cover and the progression of the action plan. As a result the FTC notices regarding Regulation 8 (1) and Regulation 20 (1) were not issued.

However, RQIA were not assured in relation to the robustness of the governance and oversight arrangements. As a result it was decided that one FTC notice would be issued under Regulation 10 (1) with the date of compliance to be achieved by 30 November 2021; FTC Ref: FTC000161.

Additionally, the following actions were agreed:

- The Regulation 29 monthly monitoring reports are to be submitted to RQIA until further notice
- RQIA are to be notified on each occasion that staffing falls below the planned staffing levels and the actions taken to address this
- The Acting Manager is to contact RQIA weekly to update in relation to staffing and staff appointments.

Despite the findings, patients spoken with said they felt well looked after in the home. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Comments received from patients and staff are included in the main body of this report.

The findings of this report will provide the manager and Responsible Individual with the necessary information to improve staff practice and the residents' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from residents, relatives, staff or the Commissioning Trust.

Throughout the inspection patients and staff were asked for their opinion on the quality of the care and their experience of living or working in this home. The daily life of patients within the home was observed and how staff went about their work. A range of documents were examined to determine whether effective systems were in place to manage the home.

Questionnaires and 'Tell Us' cards were provided to give residents and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

4.0 What people told us about the service

During the inspection we spoke with 21 patients, 12 staff, one relative and one visiting professional.

Patients spoke highly of the care that they received and about their interactions with staff. Patients confirmed that staff treated them with dignity and respect. Two patients said they would prefer to receive breakfast earlier while another patient commented on the lack of suitable management arrangements and how unsettling this was.

Staff said that did not know who was going to be in charge from one day to the next and that staffing levels were not sufficient. Staff said that although morale was low teamwork was good.

A relative told us that they had no concerns about the care provided, their loved one always looks well and their bedroom is kept clean and tidy. The relative was aware of how to report a concern and said that in their experience issues were resolved.

The visiting professional said staff were helpful and put recommendations regarding patients care needs into place. However, communication regarding patients can be an issue as there is

no manager and it is difficult to speak to the same nurse consistently due to shift patterns. In addition, there was often a wait to gain access into the home.

We did not receive any completed questionnaires within the timeframe indicated.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to the nursing home was undertaken on 22 January 2021 by a care inspector.

Areas for improvement from the last inspection on 22 January 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 27 (1) **Stated:** First time	The registered person shall ensure that a full audit of the home is completed to identify what refurbishment is required to bring the environment in the home up to an acceptable standard of décor.	**Met**
	Action taken as confirmed during the inspection: Review of the environment and the records of refurbishment/redecoration completed since the last inspection confirmed this area for improvement had been met.	
Area for Improvement 2 **Ref:** Regulation 27 (2) (c) **Stated:** Second time	The registered person shall ensure the furniture identified during this inspection is fit for purpose and not damaged. With specific reference to: • the identified drawer units • the identified mirror.	**Met**
	Action taken as confirmed during the inspection: Review of the environment evidenced that furniture was fit for purpose and in good condition.	

Area for Improvement 3 **Ref:** Regulation 20 (1) (a) **Stated:** First time	The registered person shall that the manager keeps staffing under close review to ensure there continues to be sufficient staff to meet the needs of the patients.	**Not met**
	Action taken as confirmed during the inspection: Discussion with staff, review of the duty rota and observation of the daily routine evidenced that this area for improvement had not been met. This area for improvement had been subsumed into the FTC notice issued under Regulation 10 (1).	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 44.1 **Stated:** First time	The registered person shall ensure that following completion of the environmental audit an action plan is put in place to address the deficits in a timely manner.	**Met**
	Action taken as confirmed during the inspection: Discussion with the maintenance person and review of the record of redecoration completed up to June 2021 confirmed that this area for improvement had been met.	
Area for improvement 2 **Ref:** Standard 8 **Stated:** First time	The registered person shall ensure that care partner arrangements are facilitated without delay and in accordance with DOH guidance.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and review of care partner risk assessments confirmed that this area for improvement had been met.	
Area for improvement 3 **Ref:** Standard 8.1 **Stated:** First time	The registered person shall ensure that improvements are made to the arrangements for patients to communicate with their loved ones and to ensure that relatives are informed and kept up date with the daily life of their loved ones.	**Not met**
	Action taken as confirmed during the inspection: Review of information received prior to the inspection and discussion with staff and review of the arrangements in place to support	

	patients during the inspection evidenced that this area for improvement had not been met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a robust system was in place to ensure that the required pre-employment checks were carried out for staff who were recruited in order to protect patients.

The management team said there were deficits in staffing levels within the home and that recruitment was underway for permanent staff; review of the duty rotas identified that there was a reliance on bank and agency staff to cover shifts. There were significant vacancies for nursing and care assistant staff. There were also vacant posts identified for the manager, deputy manager, administrator, activity co-ordinators and head chef.

Staff said that staffing levels were not satisfactory and that shifts were often not covered with the assessed number of staff required. They also said that, although morale was low and they were working under stressful conditions, teamwork was very good. Staff said they concentrated on ensuring the patients were well looked after but had a lack of sufficient time to attend to additional duties such as providing activities for patients and evaluating care records. It was also observed that the nurse in charge was frequently taken away from duties, such as the morning medication round, to attend to managerial and administrative issues.

During the morning it was observed that, after being assisted with their personal care needs, some patients had an excessive wait for breakfast. It was apparent that the morning routine and serving of breakfast required review to ensure that patients were provided with their breakfast at a suitable time. The daily routine should be flexible and responsive to patients' needs.

Staff told us that in the dementia unit planned staffing levels were regularly not met on night duty. As a result staff reported that the medication round finishes late and staff are often unable to take adequate breaks or carry out additional routine duties.

An area for improvement under the regulations regarding keeping staffing levels under review to ensure the needs of patients were met had not been met. This area for improvement was subsumed into the FTC notice issued under Regulation 10 (1). Additionally, as previously discussed in section 2.0, RQIA are to be kept informed if staffing levels fall below the planned staffing levels and the acting manager is to contact RQIA weekly with an update in relation to staffing and staff appointments.

5.2.2 Care Delivery and Record Keeping

Patients looked well cared for and were seen to be content and settled in the home. Staff received a handover at the start of each shift to ensure that they were aware of any changes in the needs of the patients. During the handover it was noted that staff were provided with a handover sheet which included relevant information regarding, for example, patients' nutritional

and moving and handling needs. Staff displayed their knowledge of individual patients' needs and preferences and were seen to be skilled in communicating with the patients.

It was apparent that there was a lack of managerial oversight regarding care records. Nursing staff said that they did not always have sufficient time to carry out regular evaluations of care records or maintain oversight of supplementary records. Review of a sample of care records evidenced that while daily evaluations were generally meaningful and detailed, on occasions, they were insufficient, generic and not person centred. There were gaps in the evaluation of risk assessments and care plans. An area for improvement was identified. Patients' care records were held confidentially in the home.

Supplementary records were up to date but details, such as, frequency of repositioning, staff signatures and dates, were not consistently recorded. An area for improvement was identified.

Where a patient was at risk of falling, measures to reduce that risk were put in place, for example, through the use of an alarm mat. However, review of the management of one fall evidenced appropriate actions were not consistently taken in keeping with best practice guidance. Examination of care records confirmed that registered nursing staff did not consistently record clinical and neurological observations after the fall and daily evaluation records did not consistently comment on the patients neurological status. An area for improvement was identified.

There was a system in place to ensure that accidents and incidents were notified to patients' next of kin, their care manager and to RQIA, as required. However, there was no evidence of a recent monthly analysis of accidents and incidents having been completed.

Review of wound care records evidenced that the recommendations of the Tissue Viability Nurse (TVN) regarding the dressing to be used and the frequency of dressing change were being followed. Wound care recording was contemporaneous.

The meals on offer looked and smelled appetising and staff were observed to provide patients with the level of assistance and/or encouragement they required at mealtimes. Staff demonstrated their knowledge of individual patient's likes and dislikes and dietary requirements. It was observed that meals in the Hillview Unit were served without plate covers in place to keep the food warm. This was brought to the attention of the manager for information and appropriate action.

Staff told us how they were made aware of patients' nutritional needs to ensure that patients received the right consistency of diet. Care records contained recommendations from the Dietician and the Speech and Language Therapist (SALT). However, there were gaps in the recording of patients' weights; an area for improvement was identified. Additionally, the nutritional care plan reviewed for one patient had not been updated to reflect the most recent recommendations of the Dietician; an area for improvement was identified.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was clean, tidy and fresh smelling throughout. The majority of patients' bedrooms were personalised with items that were important to them. It was observed that a few bedrooms were less personalised; staff said that some patients admitted during the COVID-19 pandemic had not had the usual family input into their bedrooms but this would be addressed going forward as families were now able to visit in bedrooms again.

The management team confirmed that actions identified on the home's refurbishment plan had been undertaken as COVID-19 restrictions had allowed. The maintenance person provided a list of the redecoration undertaken in the home during the last year. The home was noted to be in good decorative order. Communal areas such as lounges and dining rooms were comfortable and welcoming for the patients. Furniture and fittings were observed to be in good condition.

Infection prevention and control (IPC) deficits were identified in relation to staff knowledge and practice regarding hand hygiene, use of personal protective equipment (PPE) and being bare below the elbow. Training in IPC measures has not been embedded into practice. Some patient equipment was seen to require more effective cleaning. There was a lack of managerial oversight of IPC measures. Concerns were also highlighted regarding staff knowledge regarding dilution of cleaning chemicals. Staff should have the required training to meet the needs of patients. Although this issue had been raised on previous occasions, any improvement made had not been sustained. The oversight of staff practice and IPC standards was lacking. Actions to address this have been included in the FTC notice issued under Regulation 10 (1). Concerns regarding the IPC deficits were shared with the Northern Health and Social Care Trust (NHSCT) following the inspection; Trust staff agreed to complete an improvement support visit.

There was evidence that the home participated in the regional COVID-19 testing arrangements for patients, staff and care partners.

Fire safety concerns were identified. Review of records confirmed the last fire risk assessment was completed on 3 December 2019; these assessments should be undertaken on an annual basis. A record of fire drills was maintained but there was no overview of this to identify which staff still needed to take part in fire drills. The management team were unable to evidence the date on which staff had last undertaken face to face fire training or the minimum numbers of staffing levels recommended as per the home's fire risk management plan. Actions to address this were included within the FTC notice. Following the inspection the manager confirmed that a Fire Risk Assessment was completed on 29 September 2021, all staff had completed fire drills and dates for face to face fire training have been arranged.

5.2.4 Quality of Life for Patients

Staff were seen to treat patients with respect and kindness. They did not rush the patients and made efforts to maintain their dignity and privacy at all times. It was positive to note that staff offered patients choices throughout the day, for example, where they wanted to sit and what they would like to eat and drink. Staff took time to ask patients how they were.

Patients looked comfortable and well cared for. Staff demonstrated their knowledge of patients' needs and abilities and also how to effectively communicate with the patients on a day to day basis regarding their care needs and preferred way to spend their day.

However, it was apparent that communication with patients regarding the management arrangements had not been adequate. One patient said that they found the frequent changes of manager to be a source of anxiety and that they no longer knew who was in charge.

Staff took time to ensure that TVs in the lounges were showing programmes that were of interest to the patients and that patients who were in their bedrooms had TV's or radios on if they wished.

The activity co-ordinator post was vacant and recruitment was ongoing. A weekly activity schedule was on display. Staff said they were expected to provide activities for the patients, however, they did not have capacity to assist with this important aspect of daily life due to the ongoing staffing issues in the home. Staff recognised that the lack of activity provision was detrimental to the patients' wellbeing. Staff also said that prior to the post being vacant activity provision had been impacted as the activity co-ordinator assisted with visiting and care partner arrangements on top of their existing duties. Patients should be offered a suitable programme of activities, they should be consulted about the activities they would enjoy and be interested in. While there is no activity co-ordinator in post there should be sufficient staff on duty to provide a programme of activities. Actions to address this have been included in the FTC notice.

Review of records evidenced that a relatives meetings had last been held in May 2021 via Zoom but attendance had been very low. NHSCT had informed RQIA that relatives had raised concerns about having difficulties getting into the home. The management team said that relatives had not been updated regarding the current management arrangements for the home. Improvements have not been made to the arrangements for patients to communicate with their loved ones and to ensure that relatives are informed and kept up date with the daily life of their loved ones. This area for improvement had not been met and has been stated for the second time.

5.2.5 Medicines Management

Personal medication records and associated care plans

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, during medication reviews or hospital appointments. The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second nurse had checked and signed the personal medication records when they were written and updated to provide a check that they were accurate.

Copies of patients' prescriptions/hospital discharge letters were retained in the home so that any entry on the personal medication record could be checked against the prescription. This is good practice.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct nurses on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If nurses record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

The management of medicines prescribed on a "when required" basis for the management of distressed reactions for two patients was reviewed. Directions for use were clearly recorded on the personal medication records; however no care plan was in place for one resident. Supplementary ''when required'' medicine administration records were in place so nurses could document the reason for and outcome of administering medicines for distressed reactions.

Review of these records indicated the reason for and outcome of administration was not consistently recorded. An area for improvement was identified.

The management of pain was discussed. Nurses advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Patient pain assessments were filed in the medicines file. Review of these pain assessments found that they were incomplete and not up to date. Pain care plans were in place however these had not been reviewed since June 2021. Review of medicine administration records identified that the administration of analgesia was not reflective of the patient's latest pain score. An area for improvement was identified.

The management of insulin was reviewed. Care plans were in place when patients required insulin to manage their diabetes; however one patient had two care plans in place with conflicting insulin dosage information. The good practice of maintaining separate insulin administration records was acknowledged. Audits conducted on the day of the inspection identified robust arrangements for the management of insulin were not in place. Discrepancies were identified in relation to the administration of insulin for two patients. According to the home's insulin administration policy two nurses should be involved in the checking and administration of insulin. This policy was not being followed as only one nurse was involved in the administration of insulin. Actions to address this issue have been included in the FTC notice.

Medicine storage

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

The records inspected showed that medicines were available for administration when patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located.

The arrangements for the disposal of medicines were appropriate and records were maintained.

Administration of medicines and record keeping

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment. Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. The records were found to have been fully and accurately completed. The records were filed once completed and were readily retrievable for audit/review.

Application of topical medicines had been delegated to senior care assistants. Records of the administration of topical medicines were recorded on topical medicine administration records (TMARs). A sample of these records reviewed indicated two medicines had been documented

as out of stock with no evidence of follow up to source an alternative preparation. Discrepancies were identified between the prescribed topical medicine on the patient's personal medication record and the directions on the TMAR. Records in the TMAR file were not easily identifiable and require appropriate segregation so that each patient record can be easily identified. An area for improvement was identified.

Management of medicines on admission/re-admission to the home

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

The management of medicines for one patient who had a recent hospital stay and was discharged back to this home was reviewed. A hospital discharge letter had been received and a copy had been forwarded to the patient's GP. The patient's personal medication record had been updated to reflect medication changes which had been initiated during the hospital stay. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

Medicines management training

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported. Policies and procedures should be up to date and readily available for staff.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

Records of staff training in relation to medicines management, administration of thickening agents and application of topical medicines were available for inspection.

5.2.6 Management and Governance Arrangements

During the inspection it was confirmed that there was no permanent manager; the manager had recently left employment in the home without working a period of notice. The deputy manager had also left employment. The current acting manager was also the group's regional manager with additional responsibility for the oversight of other homes. The acting manager was therefore not in a position to provide full time, day to day, management cover in the home. Arrangements had been put in place to provide day to day management cover but this was being provided by various managers from other homes and was not consistent. On the day of the inspection the Quality Improvement Lead (QIL) and a manager from another home were in the home to support staff. There was also no home administrator in post; administrative cover provided was determined to be inconsistent. As a result staff were under significant pressure to not only undertake their caring duties but also management and administrative tasks. Management arrangements were not robust.

Staff demonstrated their understanding of their own roles and responsibilities in the home and of reporting any concerns about patient care or staffs' practices but said they were unsure who to report to as they did not know who was in charge from day to day. Staff said they were unsure of the current management arrangements. Communication with staff regarding management arrangements in the home was poor. This was discussed with the management team for information and appropriate action.

Review of records and discussion with the management team identified that there was no evidence of recent audit activity regarding, for example, accidents/incidents, patients' weights, restrictive practices, care records, hand hygiene, PPE or wounds. There was therefore no oversight to monitor the quality of care and other services provided in the home.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The Regional Manager was identified as the appointed safeguarding champion for the home. Review of records evidenced that there was a system in place to manage the safeguarding and protection of vulnerable adults.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The Regulation 29 reports reviewed contained an oversight of the monitoring of the quality of services provided in the home. However, without suitable management arrangements in place actions identified in the reports cannot be effectively addressed in order to drive the required improvements. Regulation 29 reports are to be submitted to RQIA on a monthly basis until further notice and should include monitoring arrangements and actions taken to achieve compliance with regulations.

It was apparent that the lack of robust and effective management arrangements was impacting on the care and services provided in the home. The inspection identified deficits in staffing levels and oversight of staffing, staff training, care delivery and record keeping. Additionally, there was a lack of oversight and governance of IPC measures, fire safety measures, medicines management, communication systems and overall governance arrangements. Actions to address these issues have been included within the FTC notice.

6.0 Conclusion

There was no permanent manager in the home and management arrangements were not robust. There was an evident lack of oversight and governance which was impacting on patients and staff as well as on the care and services provided in the home. Patients were not afforded a suitable activity programme and staff did not have the resources to provide this in the absence of an activity co-ordinator. Communication systems were not effective. The concerns raised by the Trusts were substantiated and the findings of the inspection were shared with the Trusts.

However, patients in the home looked well cared for and comfortable. The majority of patients spoken with did not express any concerns about their experience of life in the home.

The home was found to be clean, tidy, warm and well maintained. Some identified equipment required more effective cleaning. Deficits were identified in relation to staff knowledge and practice regarding hand hygiene, use of personal protective equipment (PPE) and being bare

below the elbow. Staff training in IPC measures had not been embedded into practice and there was a lack of oversight in this area.

Staff were helpful and friendly, although, it was obvious that they were under pressure and had not been kept well informed about management arrangements or cover.

As a result of this inspection one FTC notice was issued under Regulation 10 (1) with the date of compliance to be achieved by 30 November 2021. Actions to address the issues identified have been included within the notice.

The RI informed RQIA that they had made a decision to voluntarily cease admissions to the home as a result of the ongoing issues and in order to ensure that no additional pressures were put on staff. However, concerns remain regarding the lack of permanent management arrangements, oversight and governance arrangements and the impact this has on patients and staff.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	3	*6

*The total number of areas for improvement includes one under the standards which has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Rosemary Clarke, Quality Improvement Lead, and, Sara Main, Acting Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that nursing staff carry out clinical/neurological observations, as appropriate, for all patients following a fall and that all such observations/actions taken post fall are appropriately recorded in the patient's care record. Ref: 5.2.2
To be completed by: Ongoing from the date of the inspection	**Response by registered person detailing the actions taken:** A qualified staff meeting was held on the 13th October 2021 to address same. The above has been reiterated to ensure qualified staff follow the post falls pathway and recording of clinical /neurological observations are recorded following a fall. The care plan, risk assessment and falls log are to be updated also. This will be reviewed as part of the monhtly review of incidents and accidents to ensure compliance and appropriate follow up of residents deemed high risk of falls. This will also form part of the documentation audits.
Area for improvement 2 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that patients are weighed at appropriate intervals to ensure that timely referrals to the appropriate health care professional are made in the event of weight loss. Ref: 5.2.2
To be completed by: Ongoing from the date of the inspection	**Response by registered person detailing the actions taken:** Weights are recorded as a mimimum monthly and or fortnightly/weekly in line with BMI/MUST and recorded weight loss. Weights are recorded in a separate binded book and qualified staff have been requested to ensure this is cross-referenced in the plan of care, so gaps are not apparent. This is monitored by the documentation quality audit.

Area for improvement 3 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** Ongoing from the date of the inspection	The registered person shall review the administration of topical medicines to ensure these medicines are administered as prescribed and fully complete and accurate records of administration are maintained. Ref: 5.2.5
	Response by registered person detailing the actions taken: The process of recording on the TMARS has been reviewed and the importance of accurate recording emphasised to the care staff during a care staff meeting held on the 13/09/21 and daily during the Manager daily walkround. Staff to complete topical medication competencies. Completion of TMARS is also checked on medication quality walk rounds and issues addressed in real time with staff This is an area which requires continued focus on an ongoing basis.
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)	
Area for Improvement 1 **Ref:** Standard 8.1 **Stated:** Second time **To be completed by:** Ongoing from the day of the inspection	The registered person shall ensure that improvements are made to the arrangements for patients to communicate with their loved ones and to ensure that relatives are informed and kept up date with the daily life of their loved ones. Ref: 5.1 & 5.2.4
	Response by registered person detailing the actions taken: A letter has been forwarded to the relatives to update with regard to interim management arrangements for the home. New portable phones have been purchased to allow for a wider signal reach within the home. All staff have been advised of the prompt answering of phones and responsibilities with regard to same. We have recruited a new administrator who will lead on answering the phone during office hours. Relative meetings to be planned and where face to face is not possible we will review other methods such as zoom.

Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Ongoing from the date of the inspection	The registered person shall ensure that patients' care records are regularly evaluated and that daily records are consistently meaningful and informative. Ref: 5.2.2
	Response by registered person detailing the actions taken: Care plans are still being reviewed. We have made good progress with the re- evaluation of care plans and ensuring daily records reflect a meaningful and descriptive day. This area is monitored and reviewed by the documentation quality audits. To date, we have full reviewed 20 files, plan is in place to achieve the remainder All documentation is also reviewed monthly as a minumum by the Registered Nurse as part of the resident of the day process. More frequent reviews will take place in the event of an incident or change in need
Area for improvement 3 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Ongoing from the date of the inspection	The registered person shall ensure that all the required details are completed on patients' supplementary care records. Ref: 5.2.2
	Response by registered person detailing the actions taken: The supplementary care records have been reviewed and record the full details pertaining to each resident. This is monitored during the Manager daily walkround and Nurse in charge shift safety checks. We have noted improvement in the completion of same. An area of continued focus.
Area for improvement 4 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Ongoing from the date of the inspection	The registered person shall ensure that nutritional care plans are contemporaneously updated as and when recommendations from the Dietician and/or SALT change. Ref: 5.2.2
	Response by registered person detailing the actions taken: A full review of all of nutritional care plans has been completed and an updated list of dietitician and SALT reccommendations provided to the kitchen staff. Qualified staff have been advised that all amendments to be forwarded to the kitchen and a copy of the SALT reccomendations on receipt of any change. This process is further underpinned via flash meetings The recomendations for SALT are provided for all staff during handover, the handover record and a list of diets and consistency prescribed is displayed in the dining area for ease of reference and is reviewed each time there is change to someone dietary needs.

Area for improvement 5 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Ongoing from the date of the inspection	The registered person shall ensure care plans are in place for patients' prescribed medicines on a "when required" basis for the management of distressed reactions. The reason for and outcome of administration of medicines for distressed reactions should be consistently recorded. Ref: 5.2.5
	Response by registered person detailing the actions taken: Qualfied staff have reviewed the plan of care for residents with "as required" prescribed medications and record the outcomes of medication administered. This is reviewed during the monthly medication audit and will continue to be monitored through this process. Lessons learnt are discussed during the governance meeting and RN meetings
Area for improvement 6 **Ref**: Standard 4 **Stated:** First time **To be completed by:** Ongoing from the date of the inspection	The registered person shall ensure that care plans for the management of pain are in place and are regularly reviewed for patients who are prescribed medications for the management of pain. Ref: 5.2.5
	Response by registered person detailing the actions taken: The care plans for the management of pain have been reviewed and update of the care plans. This process is ongoing alongside the care plan review and evaluation. This will continue to be reviewed by the documentation audit process and medication audit.

Please ensure this document is completed in full and returned via the Web Portal

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Assurance, Challenge and Improvement in Health and Social Care