Unannounced Care Inspection Report
2 and 3 May 2017

The Cottage

Type of service: Nursing Home
Address: 25 Lodge Park, Coleraine, BT52 1UN
Tel no: 0287034 4280
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of The Cottage took place on 2 May 2017 from 09.50 to 16.30 hours. A second day of inspection took place on 3 May 2017 from 09.30 to 14.30 hours and was announced.

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?

There were areas of good practice identified throughout the inspection in relation to staff induction, training and development; adult safeguarding arrangements; infection prevention and control arrangements; and risk management.

Areas for improvement were identified in relation the staffing arrangements and recruitment processes; and the safe administration of medicines.

Is care effective?

There were areas of good practice identified in relation to effective communication systems with relatives and patients' involvement in the development of care plans.

Areas for improvement were identified in relation to the oversight registered nurses had of bowel records and urinary outputs; the reassessment of patients who are readmitted to the home, following hospitalisation; the review of patients' needs for pressure relieving equipment; the management of weight loss; and care planning.

Is care compassionate?

There were examples of good practice found throughout the inspection in relation to the provision of activities and a number of positive comments were received during the consultation process, which were complimentary of staff.

No areas for improvement were identified during the inspection.

Is the service well led?

There was some evidence of good practice identified in relation to the governance and management arrangements; there were good working relationships within the home and action had been taken to improve the effectiveness of the care since the previous care inspection.

Areas for improvement were identified in relation to the auditing arrangements; the management of CNO alerts; the staffing rota; the recording of complaints; and the staffs' level of awareness of the indicators of dehydration, infections and constipation. Consideration must also be given to the requirements and recommendations made in the safe and effective domains.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	*5	9

* The total number of requirements above includes one requirement that was previously stated as a recommendation.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Kathy Holmes, 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 inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 5 September 2017. 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.

2.0 Service details

Registered organisation/registered person: Merit Retail Limited Therese Elizabeth Conway	**Registered manager:** Kathleen Margaret Holmes
Person in charge of the home at the time of inspection: Kathleen Margaret Holmes	**Date manager registered:** 1 April 2005
Categories of care: NH-TI, NH-DE, NH-I, NH-PH, NH-PH(E) A maximum of 14 patients in category NH-DE to be accommodated in the designated dementia unit and a maximum of 3 patients in category NH-TI. The veranda on the first floor must not be accessed by any patients until the agreed remedial work has been completed.	**Number of registered places:** 67

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

A poster was displayed in the home, inviting feedback from patients and their representatives. During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with five patients, five care staff, two registered nurses, two domestic staff, seven patients' representatives and one visiting professional.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- eight patient care records
- staff training records for 2016/2017
- accident and incident records
- audits in relation to care records, falls and weight loss
- records relating to adult safeguarding
- one staff recruitment and selection record
- complaints received since the previous care inspection
- staff induction, supervision and appraisal records
- records pertaining to NMC and NISCC registration checks
- chief nursing officer (CNO) alerts
- systems for managing urgent communications, safety alerts and notices
- minutes of staff, patients' and relatives' meetings held since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a selection of policies and procedures.

4.0 The inspection

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

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be followed up during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 5 September 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 4, Criterion 1 **Stated:** First time	A recommendation has been made that the system to monitor the development of care plans, for patients who have been newly admitted to the home, is reviewed, to ensure that there is a robust monitoring system in place and that the care records are developed within the recommended timeframe.	**Met**
	Action taken as confirmed during the inspection: A review of patient care records confirmed that a range of validated risk assessments were completed as part of the admission process. The development of care plans was overseen by the registered manager, to ensure that they were completed within five days of admission to the home.	
Recommendation 2 **Ref**: Standard 4 **Stated:** First time	The registered persons must ensure that registered nurses review patients' bowel records on a daily basis and record any actions taken in the patients' daily progress notes. Entries should also be made when there have been no bowel movements, to ensure the accuracy of the records.	**Partially Met**
	Action taken as confirmed during the inspection: Although there was evidence that staff were recording when patients did not have bowel movements, a review of records confirmed that there was a lack of oversight of the records by registered nurses. This recommendation was not met and a requirement has now been made in this regard. Refer to section 4.5 for further detail.	
Recommendation 3 **Ref**: Standard 37.1 **Stated:** First time	The registered persons should ensure that the room used to store archived patient care records is secured at all times, to ensure that patient confidentiality is maintained.	**Met**
	Action taken as confirmed during the inspection: The room used to store confidential patient records was secured.	

Recommendation 4 **Ref**: Standard 4 **Stated:** First time	The registered persons should ensure that comprehensive care plans are developed, as appropriate, for patients who have communication difficulties.	**Met**
	Action taken as confirmed during the inspection: A review of care records confirmed that care plans had been developed in relation to communication difficulties.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. However, a review of the staffing rota for the week commencing 21 April 2017 evidenced that on six of the seven days reviewed the staffing levels fell below those discussed with the inspector. The registered manager explained that this was due to unforeseen circumstances. Staff consulted with confirmed that support would be provided by the registered manager and activities therapist, when there was a staff absence; however, due to their working patterns, this support was only provided in the morning/afternoon shifts. The availability of replacement staff was in the main limited to weekends, which meant that when there was a shortage of staff during the working week there were insufficient bank staff available. In discussion, the registered manager advised that there were currently three care staff vacancies and that some care staff had been recruited and were going through the appropriate checks before starting in post.

Although discussion with staff and patients' representatives evidenced that there were no specific concerns regarding staffing levels, consideration must be given to the impact of staffing in the delivery of effective and compassionate care. Refer to sections 4.4 and 4.5 for further detail. A recommendation has been made that the number and ratio of staff on duty is reviewed to ensure that the patients' care needs are met at all times. This review should include a review of contingency arrangements to provide staff cover to ensure that patients needs are met.

Medicine for one patient was observed to be left in the dining room. This was brought to the attention of the staff, who advised that the medicine would be given to the patient, when they were eating their meal. Medicines must not be left unattended and registered nurses must only sign for the administration of medicines which they have actually administered. A requirement has been made in this regard. Following the inspection the registered manager confirmed to RQIA by email that supervision had been undertaken with staff, as appropriate; and that this matter had been discussed at the staff meeting held on 3 May 2017.

Staff recruitment records were available for inspection and were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks and satisfactory references were sought, received and reviewed prior to staff commencing work and records were maintained. Information regarding the candidates' reasons for leaving their current /most recent post was not recorded; this information should be sought for all positions where candidates have worked with children or vulnerable adults. This was discussed with the registered manager and a recommendation has been made in this regard.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare understanding and competence.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, undertook competency and capability assessments and completed annual appraisals.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. Overall compliance with training was monitored by the registered manager and this information informed the responsible persons' monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

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 the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC).

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. Plans were in place to ensure that the identified safeguarding champion was provided with the required training. A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately. Where any shortcomings were identified safeguards were put in place.

A range of risk assessments were generally completed as part of the admission process and were reviewed as required. The assessments included where patients may require the use of a hoist or assistance with their mobility and their risk of falling; the use of bedrails, if appropriate and assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties. However, areas for improvement were identified in the completion of risk assessments and care plans. Refer to section 4.4 for further detail.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident. Care management and patients' representatives were notified appropriately.

A review of the home's environment was undertaken and included observations of a number of bedrooms, bathrooms, storage areas, the dining room and lounge. The home was found to be warm, well decorated, fresh smelling and clean throughout. All those spoken with were complimentary in respect of the home's environment.

The registered manager confirmed that the veranda on the first floor was not accessible to patients and that the planned remedial work had not yet commenced.

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.

Areas for improvement

Areas for improvement were identified in relation the staffing arrangements and recruitment processes; and the safe administration of medicines.

Number of requirements	1	Number of recommendations	2

4.4 Is care effective?

The home used an electronic system for assessing, planning and evaluating patients' care needs. Review of eight patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required.

However, the review of care records, including risk assessments and care plans identified that they were not maintained and regularly reviewed in response to the changing needs of the patient. For example, a review of care records for one identified patient evidenced that there had been no recorded bowel function for ten days. Although this information had been recorded and reviewed by staff, there was no evidence that action had been taken by registered nurses until day six and there was no further action taken until prompted by the inspector. There was no bowel assessment in place to identify the normal bowel pattern for the patient and the care plan evaluations contained incorrect information. The lack of appropriate action in relation to bowel management had the potential to negatively impact on the patient's care and lead to a poor clinical outcome. This was disappointing as shortfalls in the bowel records had been raised at the previous care inspection. A requirement has now been made in this regard.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of fluid intake charts confirmed that patients' fluid intake had been monitored. Patient's total fluid intakes were evidently monitored by the registered nurses on a daily basis. However, some patients required to have their urine output monitored due to having urinary catheters in place. Although there was evidence that records of the total urine outputs were being recorded, there was no evidence that action had been taken by registered nurses, in response to poor urinary outputs; or where the urine was concentrated/showing signs of infection. This was discussed with the registered manager and has been incorporated into the above requirement.

There was other evidence that care records were not reviewed in response to the changing needs of the patients. For example, where an identified patient was readmitted to the home, there was no evidence that the staff had reviewed the patient's need for specialist pressure relieving equipment, until this was brought to the attention of the registered manager and staff on the day of the inspection. The patient's risk assessments and care plans had also not been

reviewed, despite a change in their condition. Although we were satisfied that wound care had been delivered, the review of the records evidenced that a wound assessment had not been completed on readmission to the home; and there was no care plan in place to direct staff on the management of the wound. One requirement and one recommendation have been made in this regard.

Some people were at risk of losing weight due to a poor appetite or being unable to eat independently. Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. These weight records were audited regularly to ensure that any loss of weight was identified; however there was little evidence that appropriate action had been taken to address the concern. We saw in the weights audit that on 28 February 2017, one patient's weight was 70.95kg and on 25 April 2017 this was 65.9kgs. Although there was evidence that a referral had been made to the dietician, the weight loss had not been referred to the GP, for advice and guidance to help identify the cause of the patient's poor nutritional intake. The registered nurse consulted with stated that all the meals provided were fortified and that additional snacks/puddings and milkshakes were provided to patients who were identified as having lost weight; however this was not evidenced in the review of food and fluid records. The patient's weight loss was also not reflected in the care plan. A requirement has been made in this regard.

Although there was evidence that the majority of patients had care plans completed and reviewed regularly, the content of the care plans were not person-centred and there were examples of inaccuracies within the care plans. The concerns identified in patient care records should have been identified through the quality monitoring process in place. Discussion with the registered manager and a review of care record audits confirmed that any risk assessments and/or care plans which were overdue for review were flagged on the electronic system; however, the auditing process did not include a review of the content of the care plans. This is further discussed in section 4.6. A requirement has been made to ensure that the care plans are reviewed to ensure that they accurately reflect the patients' needs.

A review of the care records also evidenced that the registered nurses were not consistently recording care delivered to patients' PEG sites. A recommendation has been made in this regard.

There was evidence that the care planning process included input from patients and/or their representatives, where appropriate. There was evidence of regular communication with representatives within the care records.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. A mid-morning update was also provided where all staff involved in care delivery met to discuss any particular concerns. However, two care staff present at this meeting were noted to be completing their supplementary care records and were not concentrating on the information being discussed. One staff member consulted with was also unaware of the purpose of the meeting. This was relayed to the registered manager to address.

All those consulted with expressed their confidence in raising concerns with the home's staff/ management. Patients and representatives were aware of who their named nurse was and knew the registered manager. Meetings with staff, patients and relatives were held on a regular basis and records were maintained.

Areas for improvement

Areas for improvement were identified in relation to the oversight registered nurses had of bowel records and urinary outputs; the reassessment of patients who are readmitted to the home, following hospitalisation; the review of patients' needs for pressure relieving equipment; the management of weight loss; and care planning.

Number of requirements	4	Number of recommendations	2

4.5 Is care compassionate?

Consultation with patients individually, and with others in smaller groups, confirmed that living in The Cottage was, in general, a positive experience. Patients stated to the inspector that the staff were always polite and that they were afforded choice, privacy, dignity and respect. 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.

We observed the serving of the midday meal in the dining room during the course of the inspection. The observation of the mealtime service was that it was calm and organised activity. Dining tables were set attractively and were well-spaced so that people could move about freely and choose where they sat. The tables were appropriately set with a range of condiments and fluids in evidence. The day's menu was displayed on a white board in the dining room. We were able to evidence that patients, including those on a modified diet were afforded choice at mealtimes, either by reviewing the menu choice records or observing staff offering patients a visual choice of meal. Two staff remained standing whilst providing assistance to patients. This meant there were missed opportunities for meaningful engagement with patients. This was discussed with the registered manager, who agreed to address this with the individual staff members. Plans were also in place to conduct a dining audit and this was included in the most recent monthly quality monitoring report.

There was a dedicated person employed to assist patients with activities and the patients consulted with stated that there was always something for them to do. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

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. The annual quality audit was in progress and will be reviewed at future inspection. Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

During the inspection, we met with five patients, five care staff, two registered nurses, two domestic staff, seven patients' representatives and one visiting professional. Some comments received are detailed below:

Staff

"The care is very good and there is a homely touch here".
"I am quite happy, the patients get what they need".
"It is good here, I would even say the patients are spoilt".
"This is my favourite job, working with the best team ever".

"It is all very good".
"I love it here, the patients get everything they need".
"I am happy".

Patients

"I am very happy here, I get more than I need and the nurses are very good to me".
"I couldn't say a word about them, they are very good".
"It is usually very good, the staff are always ahead of me, in knowing what I need".
"It is fine here".

One patient commented in relation to the staffing levels, stating that the home can be short staffed at times. Refer to section 4.3 for further detail.

Patients' representatives

"They are very good".
"Everything is alright".
"It is class, like heaven compared to other homes".
"The staff are A1, just wonderful".
"It is generally very good".
"I have no concerns".

We also issued ten questionnaires to staff and relatives respectively; and eight questionnaires were issued to patients. Four staff, four patients and six relatives had returned their questionnaires, within the timeframe for inclusion in this report. Some comments received are detailed below:

Patients: although all respondents indicated that they were either 'very satisfied' or 'satisfied' that the care was safe, effective and compassionate; and that the home was well-led, one respondent wrote that they had a fear of fire (since childhood) and that they worried how they would get out of the home; another patient expressed concerns in relation to being incontinent. Following the inspection, these comments were relayed to the registered manager.

Staff: respondents indicated that they were either 'very satisfied' or 'satisfied' that the care was safe, effective and compassionate; and that the home was well-led; one staff member indicated that there were not sufficient staff to meet the needs of the patients.

Relatives: although all respondents indicated that they were either 'very satisfied' or 'satisfied' that the care was safe, effective and compassionate; and that the home was well-led, three respondents provided written comment, in relation to the staffing levels. Following the inspection, these comments were relayed to the registered manager. Refer to section 4.3 for further detail.

Any comments from patient representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Discussion with the registered manager and observation on the day of the inspection confirmed that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was also current and displayed.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern. All those consulted with described the registered manager in positive terms. Comments included 'she is very approachable' and 'she sorts things immediately'. Staff were able to identify the person in charge of the home in the absence of the registered manager.

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. It was evident that some action had been taken to improve the effectiveness of the care. Three of the four recommendations previously made were met.

As discussed in section 4.3, discussion with the staff confirmed that the registered manager provided support, when there were staff shortages. However, this was not clearly recorded on the duty rotas. This was discussed with the registered manager. A recommendation has been made in this regard.

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. However, the review of the patients' meeting identified comments made by two patients in relation to staff attitude. This should have been recognised as a complaint. A recommendation has been made in this regard.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately. Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Actions had been taken where patterns were identified. This information informed the responsible individual's monthly quality monitoring visit in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. However, given the requirements and recommendations made under the domain of effective care, we were not assured of the effectiveness of the audits. A recommendation has been made in this regard.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. However, the system in place to manage Chief Nursing Officer (CNO) alerts regarding staff that had sanctions imposed on their employment by professional bodies, was not sufficiently robust. This was discussed with the registered manager. A recommendation has been made in this regard.

Discussion with the registered manager and review of records evidenced that monthly quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. The monthly quality monitoring report provided an overview of areas that were meeting standards and areas where improvements were required and an action plan was generated to address any areas for improvement. Discussion with the manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

Areas for improvement

Areas for improvement were identified in relation to the auditing arrangements; the management of CNO alerts; the staffing rota; the recording of complaints; and the staffs' level of awareness of the indicators of dehydration, infections and constipation.

Consideration must also be given to the requirements and recommendations made in the safe and effective domains.

Number of requirements	0	Number of recommendations	5

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Kathy Holmes, 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 13(4) **Stated:** First time **To be completed by:** immediate from the date of the inspection	The registered persons must ensure the safe administration of medicines. Medicines must not be left unattended and registered nurses must only sign for the administration of medicines which they have actually administered. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: All RNs have been made aware of safe and correct procedures for the administration of medicines. These are regularly audited and observed by the home manager
Requirement 2 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** immediate from the date of the inspection	The registered persons must ensure that registered nurses have oversight of the urinary output and bowel records, to ensure that indicators of infection, dehydration and constipation are identified and acted upon; this information should be included in the daily progress notes. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: A system is in place which audits urinary output and bowel records that highlights action taken. Records are completed in cases where abnormal indicators are noted as evidence of actions taken.
Requirement 3 **Ref:** Regulation 15 (2) (a) and (b) **Stated:** First time **To be completed by:** immediate from the date of the inspection	The registered persons must ensure that the assessment of patient need is kept under review and revised to reflect patients' changing needs; this refers particularly to patients who have been readmitted to the home following a period of hospitalisation. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Clinical risk assessments are reviewed for residents readmitted to the home following hospitalisation. This is monitored as part of the homes auditing system
Requirement 4 **Ref:** Regulation 12 (1) (a) and (b) **Stated:** First time **To be completed by:** 30 June 2017	The registered persons must ensure that the treatment to patients reflect their current needs. This refers specifically to the management of patients who have been identified as losing weight. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: A system is in place which identifies and manages residents at risk of losing weight. This is monitored as part of the homes auditing system

Requirement 5 **Ref:** Regulation 16 (1) and (2) **Stated:** First time **To be completed by:** 30 June 2017	The registered persons must ensure that patients' care plans accurately reflect the current and/or changing needs of the patient and evidence is present of regular meaningful evaluation of care. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Care plans reflect current and/or changing needs of patients and actioned in the evaluation of care.
Recommendations	
Recommendation 1 **Ref**: Standard 41 **Stated:** First time **To be completed by:** immediate from the date of the inspection	The registered persons should review the number and ratio of staff on duty to ensure that the patients' care needs are met at all times. This review should also include contingency arrangements for covering staff shortages during the working week. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Contingency arrangements are in place to cover staff shortages during the working week to meet care needs
Recommendation 2 **Ref**: Standard 38 **Stated:** First time **To be completed by:** 30 June 2017	The registered persons should ensure that recruitment records include information to explain the reasons for leaving previous employment. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Recruitment records now include the reasons for leaving previous employment
Recommendation 3 **Ref**: Standard 23.5 **Stated:** First time **To be completed by:** immediate from the date of the inspection	The registered persons should ensure that registered nurses review the need for specialist pressure relieving equipment, as part of the readmission process or in response to the changing needs of patients. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Nurse in Charge Competency has been reviewed to include how and when to access specialist equipment
Recommendation 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 30 June 2017	The registered persons should ensure that the care records reflect care delivered in respect of the care of PEG sites. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Care records reflect care delivered in respect of the care of PEG sites

Recommendation 5 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 30 June 2017	The registered persons should ensure that the clinical hours worked by the registered manager are clearly recorded on the staffing rota. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: Clinical hours worked by the Registered Manager are recorded on off-duty rota.
Recommendation 6 **Ref**: Standard 16.11 **Stated:** First time **To be completed by:** 30 June 2017	The registered persons should ensure that any concerns raised during patients' or relatives' meetings are recognised as such; and should be recorded in the home's complaints record and managed in accordance with the DHSSPS Care Standards for Nursing Homes 2015. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: Any concerns raised during patients' or relatives' meetings are recorded as a complaint and actioned.
Recommendation 7 **Ref**: Standard 35.4 **Stated:** First time **To be completed by:** 30 June 2017	The registered persons should that the auditing processes are further developed to ensure that shortfalls identified during this inspection are identified and follow up action taken to address any identified deficits. This refers specifically to the care records; bowel records; urinary output records; and patients' weights audits. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: A robust auditing system is in place which addresses key clinical risks
Recommendation 8 **Ref**: Standard 35.18 **Stated:** First time **To be completed by:** 30 June 2017	The registered persons shall implement a robust system to manage Chief Nursing Officer (CNO) alerts regarding staff who have sanctions imposed on their employment by professional bodies **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: A system is in place to manage alerts and CNO alerts

Recommendation 9 **Ref**: Standard 35.4 **Stated:** First time **To be completed by:** immediate from the date of the inspection	The registered persons should ensure that care staff are aware of the indicators of dehydration, urinary infections and constipation; and the importance of reporting appropriately to the registered nurses. Evidence of how this is addressed with staff must be retained in the home for inspection.
	Response by registered provider detailing the actions taken: Supervision has been completed with staff to enable them to identify the indicators of dehydration, urinary infections and constipation and the importance of reporting any abnormalities

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

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