Glenkeen House
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Randalstown
BT41 3JX

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Unannounced Care Inspection
of
Glenkeen House

3 August 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 3 August 2015 from 09.45 to 17.30.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

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

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

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 02 December 2014.

1.2 Actions/Enforcement Resulting from this Inspection

An urgent action record regarding the assessment and care planning of one identified patient was issued to Glenkeen House at the end of the inspection. An urgent action record was also issued regarding five specialist wheelchairs that were in a state of disrepair. These actions are required to be addressed without delay to ensure the safety and wellbeing of patients in the home.

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	4	7

The details of the Quality Improvement Plan (QIP) within this report were discussed with the Preschela Bagio, Nurse in Charge, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Hutchinson Homes Ltd / Janet Montgomery and Naomi Carey	**Registered Manager:** Jacqueline Elizabeth McShane
Person in Charge of the Home at the Time of Inspection: Preschela Bagio	**Date Manager Registered:** 1 April 2005
Categories of Care: NH-LD, NH-I, NH-PH, RC-I, RC-MP(E), RC-PH(E)	**Number of Registered Places:** 40
Number of Patients Accommodated on Day of Inspection: 40	**Weekly Tariff at Time of Inspection:** £520 to £623

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

4. Methods/Process

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

Prior to inspection the following records were analysed:

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

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with three patients, three care staff, three domestic staff, two nursing staff and three patient's visitors/representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- seven patient care records
- staff training records
- supervision records
- complaints records
- regulation 29 monitoring reports
- policies for communication and end of life care
- policies for dying and death and palliative and end of life care

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 02 December 2014. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the last care Inspection on 02 December 2014.

Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 12.4 **Stated:** First time	It is recommended that the registered person must ensure that the daily menu is displayed in a suitable format so that patients/residents know what is available at each mealtime	**Met**
	Action taken as confirmed during the inspection: The daily menu was displayed in a suitable format, however concerns were identified regarding the meal-time experience. Refer to inspector comments in section 5.5. A new requirement is made to address this.	
Recommendation 2 **Ref**: Standard 12.5 **Stated:** First time	It is recommended that the registered person must ensure that a variety of hot and cold drinks and snacks are offered to the patients/residents midmorning	**Not observed**
	Action taken as confirmed during the inspection: This was not observed and is carried forward for inspection at future inspection.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

Current policies and procedures were not available on the day of inspection. However, following the inspection, the required policies and procedures were forwarded to RQIA. A policy and procedure was available on communicating effectively which reflected current best practice, including regional guidelines on Breaking Bad News. Discussion with two registered nursing staff confirmed that they were knowledgeable regarding this policy and procedure.

Training had not been formally provided in communicating effectively with patients and their families/representatives, however, following the inspection the registered manager confirmed that communication was included in the staff's induction programme. Training in palliative care included the procedure for breaking bad news, as relevant to staff roles and responsibilities.

Is Care Effective? (Quality of Management)

Care records reviewed reflected patient individual needs and wishes regarding the end of life care. Recording within records included reference to the patient's specific communication needs.

There was evidence within the records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs and that options and treatment plans were also discussed, where appropriate.

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Two registered nurses consulted demonstrated their ability to communicate sensitively with patients and/or representatives when breaking bad news.

Is Care Compassionate? (Quality of Care)

Discussion with the nurse in charge and staff confirmed that staff were able to deliver bad news sensitively/effectively.

Three patients consulted and discussion with three patient representatives confirmed that patients were offered choice and were involved in decision making about their care, on a daily basis.

Staff were observed to be responding to patients in a dignified manner. Patients who were in bed appeared to be comfortable and assistance was provided to patients who required it.

A review of compliments records confirmed that patients' representatives were appreciative of the efforts staff made towards them whilst their relative was receiving end of life care.

Areas for Improvement

There are no recommendations made under this standard.

Number of Requirements:	**0**	**Number of Recommendations**:	**0**

5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

As previously discussed, current policies and procedures were not available on the day of inspection. However, following the inspection, the required policies and procedures were forwarded to RQIA. The policies and procedures on the management of palliative and end of life care and death and dying were reviewed. These documents did not reflect best practice guidance such as the GAIN Palliative Care Guidelines, November 2013 and the DHSSPSNI (2010) *Living Matters: Dying Matters.*

Following the inspection, the registered manager confirmed that 7 out of 8 registered nurses had completed training in palliative and end of life care. Plans were in place for all care staff to attend palliative care training.

Discussion with two registered nursing staff and a review of two care records confirmed that:

- there were arrangements in place for staff to make referrals to specialist palliative care services
- staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken

There was no formal protocol for timely access to any specialist equipment or drugs in place, however discussion with the nurse in charge and one registered nurse confirmed that they were proactive in ensuring that adequate supplies were in stock and that the staff ordered medication in anticipation of need, to manage potential symptoms.

There was no specialist equipment, in use in the home on the day of inspection. Discussion with the nurse in charge confirmed that update training in the use of syringe drivers would be accessed through the local healthcare trust nurse, if required.

There was no palliative care link nurse identified, however all registered nursing staff had attended training on palliative care. Following inspection, the registered manager confirmed that plans were in place to nominate a registered nurse to undertake this role.

Is Care Effective? (Quality of Management)

A review of seven care records evidenced that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. Six out of seven care records included the management of hydration and nutrition, pain management and symptom management. Refer to inspector comments in section 5.5.

There was evidence in the records reviewed that the patient's wishes and their social, cultural and religious preferences were also considered. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

A key worker/named nurse was identified for each patient approaching end of life care.

Discussion with the nurse in charge, staff and a review of two care records evidenced that environmental factors had been considered. Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying.

A review of notifications of death to RQIA during the previous inspection year identified that all deaths were notified appropriately.

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of two care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences regarding end of life care. Two registered nursing consulted demonstrated an awareness of patient's expressed wishes and needs as identified in their care plan.

Arrangements were in place in the home to facilitate, as far as possible, in accordance with the persons wishes, for family/friends to spend as much time as they wish with the person. Staff described how meals and refreshments would be provided to family members during this period.

From discussion with the nurse in charge, staff and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives during this time. There was evidence within compliments/records that relatives had commended the management and staff for their efforts towards the family and patient.

Discussion with the nurse in charge and a review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

Staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death. One staff member described how a guard of honour was formed by staff, as a deceased patient was leaving the home.

From discussion with the nurse in charge and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included support from more experienced staff and reflection on a patient's time spent living in the home.

Information regarding support services was available and accessible for staff, patients and their relatives. This information included leaflets from Marie Curie entitled '*End of Life Guide'* and another leaflet that outlined the changes that occurred before death.

Areas for Improvement

A policy on palliative and end of life care should be further developed in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines* and should include the out of hours procedure for accessing specialist equipment and medication. A policy on death and dying should be developed in line with current best practice, such as DHSSPSNI (2010) *Living Matters: Dying Matters.*

The policies and guidance documents listed above, should be made readily available to staff.

Number of Requirements:	**0**	**Number of Recommendations:**	**1**

5.5 Additional Areas Examined

Care Practices

The serving of the mid-day meal was observed. The menu was clearly displayed in the dining room. There was a choice available for patients to choose from, however the only alternative meal available for patients who required therapeutic diets was soup. There was only one choice of vegetable available. The desert was described as chocolate corn-flour and was observed being served from an uncovered saucepan on an unheated trolley. Condiments were not offered to patients and when questioned by the inspector, a number of staff members stated that none of the patients liked condiments. Patients were observed wearing white plastic aprons. We observed tea being served to patients in glasses. One staff member consulted with stated that tea was served in glasses for patients who could not hold cup handles. One staff member was observed actively feeding two patients at the same time. Given inspector findings, the meal-time experience must be reviewed. A requirement is made to address these matters.

Activities were observed during the inspection. Patients were observed to enjoy the activities and patients consulted stated that they attended activities outside of the home. However, the activities schedule on the notice board was not filled in therefore patients would not have been aware of what activities were planned. A recommendation is made to address this.

A bath list was observed on two linen trolleys. This was discussed with the nurse in charge, who stated that the purpose of the list was to communicate bed-changing days to the domestic staff. We informed the nurse in charge that baths/showers should not be assigned to specific days and a more person-centred approach should be provided. The nurse in charge agreed to develop a different format for communicating with domestic staff.

Care records

Seven patient care records were reviewed. Assessments and care plans were generally completed on a regular basis. However, there was one identified patient who did not have assessments and care plans completed, following a period of hospitalisation. An urgent action record was issued to Glenkeen house in this regard. Following the inspection, RQIA received confirmation that all required assessments and care plans were in place. The registered manager also confirmed that she was on annual leave and that that she would normally have provided assistance to the registered nurses in completing assessments and care plans for patients who were re-admitted to the home. Refer to section on staffing below.

One patient was identified as having bruising to their hand and lower arm. There was no body map completed and there was no care plan in place. This identified patient stated that the marks had been caused by resisting assistance with personal care. The patient stated to the inspector that they fought the staff off and resisted assistance with care, due to being in considerable pain. Following discussion with the nurse in charge, we were satisfied that the patient's behaviour was being managed appropriately, however a review of the care records identified that a pain assessment had not been completed and a care plans for managing behaviours and skin integrity were not in place. The nurse in charge provided assurances that this matter would be addressed. Given inspector findings in relation to the above, a requirement is made.

Two out of five care records reviewed did not have care plans regarding do not resuscitate decisions. This was discussed with the nurse in charge who confirmed that care plans were completed for patients who wanted to be resuscitated, but not for those patients who did not want to be resuscitated. A recommendation is made to address this.

Staffing

The staff duty rota for the two weeks preceding the inspection was reviewed. One twilight shift had not been covered during this period. This was discussed with the nurse in charge, who informed the inspector of the difficulties replacing staff who were on annual leave. Following the inspection, this was discussed with the registered manager, who provided assurances that the staffing levels were continually under review. Assurances were also provided by the registered manager that she provided support to the registered nursing staff, regarding admission documentation and updating of assessments and care plans. Considering inspection findings, a recommendation is made to ensure that planned staffing levels are maintained during periods of annual leave. The registered managers hours worked should also be included on the duty rota and identify either management duty or working as lead nurse.

There was also a number of deficits identified in the duty rotas reviewed. There was evidence that Tipp-ex had been used to make changes to the duty rota. Inspector informed the nurse in charge that this was unacceptable. Assurances were provided that this practice would cease. The registered manager's hours were also not included in the duty rota. A student nurse was identified on the duty rota by Christian name only. Discussion with the nurse in charge confirmed that the identified student was an employee of the home. However, following the inspection we confirmed that the student nurse was on placement. Following the inspection, assurances were provided by the registered manager that the duty is maintained to an acceptable standard. A recommendation is made to address this matter.

Questionnaires

As part of the inspection process we issued questionnaires to staff, patients and their representatives.

Questionnaire's issued to	Number issued	Number returned
Staff	10	10
Patients	5	5
Patients representatives	2	1

All comments on the returned questionnaires were in general positive. Some comments received are detailed below:

Staff

‘I feel that end of life care in Glenkeen is very good’
‘’I can honestly say the patients are very well looked after’
‘All the staff are very good to the patients’
‘I would place any of my own family members here, something I said I would never do’
‘If I had to choose a nursing home for a family member, I would choose Glenkeen’
‘I couldn’t ask for anything better to come out of Glenkeen’
‘Patients have great relationships with the carers and are shown the respect they deserve’
‘Patients are treated with respect and dignity’
‘My only issue is not enough staffing on the floor, especially on holiday time or when staff are sick. We are really stretched when this happens’

Patients

‘I am very happy in the home’
‘I get what I need. I have no concerns’
‘I can get breakfast in bed when I want. They come quickly when I call’

Patients’ representatives

‘Staff are very friendly and approachable’
‘My one negative comment is that (my relative) sometimes has to wait for a period of time before getting help to go to the toilet’

Regulation 29 Monthly monitoring report

The regulation 29 monthly monitoring report for July 2015 was not available for inspection, however the reports from the preceding three months were reviewed. The content of the three reports reviewed did not provide sufficient detail to form an opinion of the standard of nursing provided in the home. It was concerning that the duration of the monitoring visits was only hour and ten minutes to one hour and forty minutes on each of the three reports.

The detail of the areas for improvement within the regulation 29 reports were discussed with the registered manager following the inspection. Advice was given in relation to the template for conducting provider visits which is available on the RQIA website.

In view of inspector findings, a requirement is made to ensure that the monthly monitoring report is available in the home. A recommendation is also made regarding the content of the report.

Environment

The home was found to be clean with no malodours present. Patients were observed to be comfortable in their environment. However, we observed five patients’ specialist chairs, that were is a state of disrepair. All of the identified chairs were torn and could not have been effectively cleaned. This is unacceptable. Urgent action record was issued to Glenkeen regarding this matter. A requirement is made to ensure that all seating utilised in the home is fit for purpose.

There were no airways contained in the emergency equipment boxes that were located on both floors. Discussion with the nurse in charge confirmed that records of checks were not maintained. A recommendation is made to address this.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Preschela Bagio as part of the inspection process and with the registered manager, following the inspection. The timescales commence from the date of inspection.

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

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

6.1 Statutory Requirements

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

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015 and the Residential Care Homes Minimum Standards, August 2011. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

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

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref:** Regulation 12 (4) (a) (b) **Stated:** First time **To be Completed by:** 30 September 2015	The registered person must review the serving of meals to ensure that: • meals are served at a temperature which is in accordance with the nutritional guidelines • staff provide appropriate supervision to patients during mealtimes The deployment of staff at mealtimes and issues in relation to respect and dignity, when assisting patients to eat, must be included in this review. **An audit of the mealtime experience must be submitted to RQIA with the returned QIP.**
	Response by Registered Person(s) Detailing the Actions Taken: An review of the dining experience has been reviewed and changes have been made. 1 resident who has Parkinson requests to have her tea in a glass as she cannot hold the tea in a cup and this is reflected in her care plans to continue to promote her independence. New disposable bibs are now been used instead of the disposable aprons An audit has been carried out and is as follows Choice Resident's choice is taken into account, includes the choice of where they sit and whom they sit with Given a choice of drinks and desserts, for any residents who cannot verbally choose both desserts are shown to the resident. All desserts are served from the kitchen and are kept on a low heat to ensure that they are served at the correct temperature A clear menu is recorded on the menu chart each day offering choice and a variety of meals Residents who can verbally make their needs known are informed of what the menu is and a choice of 2 meals are available if they do not like what is on the menu individual choices are catered for Any residents who are on special diets that is soft, puree a choice of 2 meals are provided Any resident who cannot verbally express their choice involves the cook working with families on their likes and dislikes A choice of 2 vegetables are available daily A variety of condiments are available on each table Physical Environment Overall the physical environment is warm and welcoming when the residents enter the dining room creating a relaxed environment that is warm and residents can enjoy their meals Tables are laid out attractively with flower displays as center pieces on each one, a selection of condiments are on each table in a presentable tray, dining room well furnished to display an environment that is

	conducive to eat in Residents that can walk into dining room are encouraged to do so All residents are seated before meals are served Unwanted noise in the dining room is kept to a minimum and staff are reminded of this, background music is played Tables are laid out avoiding patterns kept plain so residents can recognise what is on the table, a selection of napkins are readily available for any residents that wish to use them Social Environment Residents that can feed themselves are served first and the residents that require assistance are only served their meals when someone is available to assist them, not left on the table, to avoid meals being served at the incorrect temperature Try to create an environment for the residents to have social chat with other residents Staff aware and care is taken to seat residents at the same table that are compatiable with each other and are comfortable to be seated together Staff to wait until all the residents at one table are finished their main meal before serving the next course Nutrition Meals offered reflect the nutritional needs of the residents, a variety of meals are provided Meals offered are varied and cater for the nutritional needs of the residents Staff are aware of any residents that are at risk of not finishing their meals and not meeting their nutritional needs, staff assist with meals when required Any residents that require special diets are catered and provided for and assistance is given to ensure this Staff are aware of any residents that require a food and fluid chart to be recorded and the importance of recording after each meal Sufficient staff are available in the dining room to assist with meals Residents who require assistance are assisted individually A choice of 2 vegetables are available daily and residents who require a special diet are given choice Individual Needs Residents are positioned correctly at the tables, situated close enough so they can reach their meal and see it Meals are presented on the plate attractively and appetising to eat Any residents who require special diets also have their meals well presented and are not mixed together before serving Any resident who requires assistance at meal times, staff to do so without interruption and sits with the resident allowing residents adequate time to take their meals, not rushed Staff to be aware of individual needs and to use appropriate language whilst in the dining room, avoiding language such as purees, softs,

	feeders to avoid the use of labels regarding types of meals After each meal is finished residents are offered second helpings if required Staff to be aware of interventions and ensure residents are provided with an explanation before carrying out any task and to support residents who require it Avoid cluster in the dining room, ensure other disciplines are not allowed in the dining room when meals are served, to keep visitors to a minimum at this time Avoid any unnecessary disruption at meal times, to create a stress free environment that residents can enjoy their meals and enhance their appetite Customer Care Any resident who requires assistance is assigned 1 staff to do so Presentation of food is to be well presented before serving, must appear appetising Check that residents are happy with their choice of meal if not an alternative is provided Any resident who has poor communication staff to be aware and try and maintain eye contact Member of catering staff to speak to the residents and check that the meals that have been served are satisfactory and there are no complaints, any dissatisfaction expressed is dealt with swiftly and professionally Check that if any meal is not being eaten that the resident is offered an alternative as the resident may not wish to express any concerns Involvement and Influence Catering staff are to update the menus regularly and are reviewed as required When a new resident is admitted to the home catering staff to be aware of any likes/dislikes and liase with family members if resident unable to express their preferences Cook meets with residents regularly to gain their opinions and any new ideas they would like introduced into the menu. Any wish expressed must be introduced. A record is kept of any meetings, views and opinions expressed by residents Any dissatisfaction expressed by any resident a written action of what has been done to solve this is kept and if the outcome was satisfactory

Requirement 2 **Ref:** Regulation 16 (1) (b) **Stated:** First time **To be Completed by:** 30 September 2015	Risk assessments and care plans must be reviewed in a timely manner. This refers specifically to patients who return to the home, following a period of hospitalisation. **Response by Registered Person(s) Detailing the Actions Taken:** A resident who had returned from the hospital and their care needs had changed their care plan was not updated immediately to reflect these changes on this occasion, as is the normal procedure in line with the policies within the home. This resident's care plan has been updated and the policy on the updating of care plans will be followed through
Requirement 3 **Ref:** Regulation 29 (5) (a) **Stated:** First time **To be Completed by:** 30 September 2015	A copy of the regulation 29 monitoring reports must be retained in the home and available for inspection. **Response by Registered Person(s) Detailing the Actions Taken:** All the regulation 29 reports are emailed directly after each visit, unfortunately July's report was missed and was not available, this has now been printed and is available for inspection
Requirement 4 **Ref:** Regulation 27 (2) (c) **Stated:** First time **To be Completed by:** 30 September 2015	Seating provided in the home for use by patients must be in good working order, properly maintained in accordance with the manufacturer's instructions and fit for purpose. **An audit of specialist seating and action plan for replacement of identified chairs must be submitted to RQIA with the returned QIP.** **Response by Registered Person(s) Detailing the Actions Taken:** 5 chairs 3 of which had been provided by OT and have been referred to urgently to be repaired we are currently waiting on OT to repair them and have been told due to a waiting list the chairs will be repaired accordingly. Meanwhile the maintenance person within the home has repaired the tears temporarily until OT are able to do so. 1 chair has been removed from the home and replaced the other chair was purchased by family and had a small tear on the arm this has been repaired by the maintenance man
Recommendations	
Recommendation 1 **Ref**: Standard 12.5 **Stated:** First time **To be Completed by:** 30 September 2015	It is recommended that the registered person must ensure that a variety of hot and cold drinks and snacks are offered to the patients/residents midmorning. **Carried forward from last inspection.** **Response by Registered Person(s) Detailing the Actions Taken:** At 11am a variety of hot and cold drinks are available for residents, tea and coffee are provided as well as a variety of cold drinks. Snacks are offered includes biscuits and yohurts are offered. This has been in place since the last inspection
Recommendation 2	All policies and procedures should be reviewed to ensure that they are

Ref: Standard 36.2 & 36.4 **Stated:** First time **To be Completed by:** 30 September 2015	subject to a three yearly review. • A policy on palliative and end of life care should be further developed in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines* and should include the out of hours procedure for accessing specialist equipment and medication. • A policy on death and dying should be developed in line with current best practice, such as DHSSPSNI (2010) *Living Matters: Dying Matters.* The policies and guidance documents listed above, should be made readily available to staff.
	Response by Registered Person(s) Detailing the Actions Taken: The policy within the home on palliative care and end of life reflected the guideance in accordance with NICE Quality Standard for end of life care adults and SCIE end of life care for people with dementia living in care homes, and also pain and symptom control guidelines for palliative care, the policy has been updated to include the current regional guidance GAIN and staff have access to these documents as can be downloaded from the main computer. The policy also includes out of hours procedure for accessing specialist equipment and medication. The policy on death and dying reflected guidance and breaking bad news regional guidelines national council for hospice and specialist palliative care service and RCN guidance on breaking bad news the policy has been updated to include DHS&PS living matters, dying matter a palliative and end of life care strategy for adults in NI March 2010
Recommendation 3 **Ref**: Standard 11.4 **Stated:** First time **To be Completed by:** 30 September 2015	The activities programme should be formalised in order for patients to be aware of what activities are planned.
	Response by Registered Person(s) Detailing the Actions Taken: A new activity board has been purchased and the activity therapist writes the daily activites for the morning and afternoon and she also includes the activities for the following day for residents and families to see
Recommendation 4 **Ref**: Standard 4.1 **Stated:** First time **To be Completed by:** 30 September 2015	The registered manager must ensure that patients DNR decisions are recorded in keeping with good practice guidelines and there should be evidence of effective communication of DNR decisions between staff involved in the patients care
	Response by Registered Person(s) Detailing the Actions Taken: All residents and families are consulted to see if they wish to have CPR carried out and only the residents who requested this status had a care plan in place to reflect this, all residents now have a CPR care plan including residents and families who do not wish CPR to be carried out and are updated yearly or as the need arises

Recommendation 5 **Ref**: Standard 41.4 **Stated:** First time **To be Completed by:** 30 September 2015	The staffing levels on the nursing unit should be reviewed to ensure that at all times there are sufficient numbers of staff and skill mix deployed to meet the needs of the patients in the home. This refers specifically to days when the registered manager is not on duty and to the shortfall of the twilight shift.
	Response by Registered Person(s) Detailing the Actions Taken: 2 new nurses have recently joined the company and we have presently recruited 2 care assistants for the twilight shift unfortunately when a vacancy arises due to waiting on Access NI and return of 2 references there may be a time lapse until this shift is filled
Recommendation 6 **Ref**: Standard 41 **Stated:** First time **To be Completed by:** 30 September 2015	The registered managers hours worked should be included on the duty rota and identify either management duty or working as lead nurse. The duty rota should also record the surname and first name of each member of staff.
	Response by Registered Person(s) Detailing the Actions Taken: The registered manager's hours are now identified on the off duty, off duty updated so the first names of staff employed are available
Recommendation 7 **Ref**: Standard 33.1 **Stated:** First time **To be Completed by:** 30 September 2015	It is recommended that, in addition to the emergency equipment already provided, the following equipment is readily available and records maintained of regular checks: • Emergency patient airways (both floors) • Emergency 'ambu' bag (both floors) • Suction equipment (ground floor)
	Response by Registered Person(s) Detailing the Actions Taken: An airway has been included in the emergency boxes on both floors, an ambu bag was already included in the box, the availability of suction equipment is available on both floors previously had 1 for both floors, an audit of both boxes will be carried out and recorded monthly and the audit records readily availbale

Registered Manager Completing QIP	Jacqueline Mc Shane	**Date Completed**	23rd September, 2015
Registered Person Approving QIP	Janet Montgomery	**Date Approved**	1st October, 2015
RQIA Inspector Assessing Response	Aveen Donnelly	**Date Approved**	02 October 2015

Please ensure the QIP is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address