Unannounced Care Inspection Report
13 June 2016

Drapersfield House

Type of Service: Nursing Home
Address: 19 Drapersfield Road, Cookstown BT80 8RS
Tel No: 02886764868
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Drapersfield House took place on 13 June 2016 from 09.45 to 16.00 hours. The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

For the purposes of this report, the term 'patients' will be used to described those living in Drapersfield House which provides both nursing and residential care.

Is care safe?

There were systems in place for the recruitment and selection of staff. New staff completed an induction programme and there were systems in place to monitor staff performance on an ongoing basis. Training had been provided in all mandatory areas and this was kept up to date. The planned daily staffing levels for the home were subject to regular review to ensure the assessed needs of the patients were met. The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. A range of risk assessments were reviewed as required and informed the care planning process. The home was clean, reasonably tidy and warm throughout. However, weaknesses were identified in the recruitment and selection process and in the safe storage arrangements of cleaning chemicals. These deficits pose potential risk to patients' safety. One requirement and one recommendation have been made to secure compliance and drive improvement.

Is care effective?

With the exception of the completion of continence assessments, the care records accurately reflected the assessed needs of patients and were kept under review, in accordance with NMC guidelines. Wounds were managed in keeping with best practice and where specialist healthcare professionals were involved, their advice was adhered to. Care plans were developed with input from patients and/or their representatives and there was evidence of regular communication with patient representatives regarding changes in the patients' condition. Patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored. Staff also confirmed that communication between all staff grades was effective. Staff, patients and relatives' meetings were held on a regular basis. All those consulted with stated that if they had any concerns, they could raise these with the management. No areas for improvement were identified during the inspection.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients confirmed that they were afforded choice, privacy, dignity and respect. The Charter of Individual Rights of Patients; the complaints procedure; and details on advocacy services were displayed prominently in the home. Mealtimes were observed to be quiet and tranquil and patients were provided with assistance as required. Planned activities were displayed and arrangements were in place to meet patients' religious and spiritual needs within the home. Social care plans were in place to provide information to staff to ensure that patients' social care needs were met individually. Examples of compassionate care were observed and have been included in the report. The views of patients and their representatives were sought and the comments recorded were analysed and areas for improvement were acted upon. A number of

positive comments were received and have been included in the report. No areas for improvement were identified during the inspection.

Is the service well led?

There was a clear organisational structure within the home. The home was operating within its registered categories of care and a certificate of public liability insurance was current and displayed. There were systems and processes in place to ensure that urgent communications, safety alerts and notices were managed appropriately the home's policies and procedures were subject to regular review. 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. There were systems in place to monitor and report on the quality of nursing and other services provided. Monthly monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. A recommendation has been made in regards to the further development that is required in the infection prevention and control auditing process to secure compliance and drive improvement.

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 DHSS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	3

* The total number of requirements and recommendations above includes one recommendation that has been stated for the second time. Details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager and the responsible person, 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 type e.g. care inspection

The most recent inspection of the home was an unannounced finance inspection undertaken on 11 March 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection. There were no areas that required to be followed up in this inspection.

2.0 Service details

Registered organisation/registered provider: Drapersfield Ltd Jill Canavan	**Registered manager:** Margaret Kolbohm
Person in charge of the home at the time of inspection: Margaret Kolbohm	**Date manager registered:** 16 June 2016
Categories of care: RC-MP, NH-MP, RC-MP(E), RC-I, NH-I, NH-LD, NH-LD(E), NH-PH, NH-PH(E) A maximum of 10 residential places. 2 identified persons in categories NH-LD/LD(E), 1 identified person in category NH-MP, 2 identified persons in category RC-MP and 1 identified person in category RC-MP(E)	**Number of registered places:** 45

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

Care delivery/care practices were observed and a review of the general environment of the home was undertaken. During the inspection the inspector spoke with five patients individually and greeted others in small groups, two care staff, three registered nurses and two relatives.

In addition questionnaires were provided for distribution by the registered manager; ten for relatives, five for patients and 10 for staff. One relative, two patients and seven staff questionnaires were returned. Refer to section 4.5 for details.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- six patient care records
- staff training records for 2015 and 2016
- accident and incident records from the previous inspection
- audits in relation to accidents and infection prevention and control
- records relating to adult safeguarding
- complaints received since the previous care inspection
- staff induction, supervision and appraisal records
- staff, patients' and relatives' meetings held since the previous care inspection
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a sample of policies and procedures
- NMC and NISCC registration records
- recruitment and selection records.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 11 January 2016

The most recent inspection of the home was an unannounced finance inspection. The completed QIP was returned and approved by the finance inspector.

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

4.2 Review of requirements and recommendations from the last care inspection dated 11 January 2016

Last care inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 12 (1) (a) (b) **Stated:** Second time	The registered manager must ensure that all patients with pressure care/ wound management have the relevant risk assessments for pressure care, a care plan for the care required for their identified needs and that all records pertaining to pressure / wound care management are up to date and reviewed as indicated.	**Met**
	Action taken as confirmed during the inspection: A review of care records confirmed that wounds were managed in keeping with best practice. Wound assessments and care plans were in place and were reviewed on a regular basis. A review of progress notes evidenced that wound dressings were changed, in line with the care plan.	

Requirement 2 **Ref**: Regulation 27 (4) (a) **Stated:** First time	The registered person shall have in place a valid fire risk assessment and fire management plan. The fire risk assessment must be reviewed annually, or whenever the fire risk has changed. The fire management plan must be reviewed and modified to ensure satisfactory fire safety controls are implemented.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed that the fire management plan had been updated following the last inspection.	
Requirement 3 **Ref**: Regulation 13 (1) (b) **Stated:** First time	The registered person must ensure that patients are repositioned as per the repositioning regime identified in the care plan and where shortfalls are identified these are actioned accordingly.	**Met**
	Action taken as confirmed during the inspection: A sampling of repositioning records confirmed that patients were repositioned in line with their care plan.	
Requirement 4 **Ref**: Regulation 13 (7) **Stated:** First time	The registered person must ensure that infection prevention and control issues identified are actioned as required. Systems and protocols must be established to ensure compliance with best practice in infection prevention and control within the home.	**Partially Met**
	Action taken as confirmed during the inspection: The areas reviewed were found to be clean and reasonably tidy. Cleaning schedules were in place and infection prevention and control audits and decontamination records had been completed on a regular basis. However, improvements were required in terms of traceability of audit. A recommendation has been made in this regard. Refer to section 4.3 and 4.6 for further detail.	

Requirement 5 **Ref**: Regulation 15 (e) **Stated:** First time	The registered person must ensure that the home only accommodates patients within the category of care for whom they are registered. An application for variation must be submitted for the two patients identified at this inspection.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. An application for variation had been submitted in respect of the two identified patients.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 36 Criteria 2 **Stated:** First time	It is recommended that a policy and procedure regarding Stoma care management is developed in accordance with best practice guidelines.	**Met**
	Action taken as confirmed during the inspection: The policy on stoma care had been developed in line with best practice guidelines.	
Recommendation 2 **Ref**: Standard 4 Criteria (1) (7) **Stated:** First time	It is recommended that the continence assessment is reviewed and developed to ensure a comprehensive assessment is completed. Assessments and care plans should include all interventions required to manage patients' continence needs and should include but not limited to; bowel patterns and type and continence products required.	**Not Met**
	Action taken as confirmed during the inspection: A review of care records identified that the continence risk assessments did not reflect the patients' individual needs. Although the assessment included the type of continence product the patients required, there was no evidence of bowel type and pattern recorded. **This recommendation was not met and has been stated for the second time.**	

Recommendation 3 **Ref**: Standard 4 Criteria 8 **Stated:** First time	It is recommended that care plans pertaining to urinary catheters contain specific steps to ensure the safe management of the urinary catheter.	**Met**
	Action taken as confirmed during the inspection: A review of care records confirmed that care plans had been developed in regards to the safe management of urinary catheters.	
Recommendation 4 **Ref**: Standard 6 Criteria 14 **Stated:** First time	It is recommended that patients personal care needs are regularly assessed and met to include (but not limited to) nails and grooming needs. Records should be completed to evidence care delivered or not delivered. Training should be provided for all care staff to further enhance the delivery of care in this regard.	**Met**
	Action taken as confirmed during the inspection: Patients were observed to be comfortable in their surroundings. There were no concerns observed in regards to the patients' personal level of hygiene. Where patients had refused assistance with personal hygiene, this was recorded in their progress notes. Discussion with the registered manger also confirmed that supervision had been undertaken with staff with regards to patients' hygiene needs. Personal care audits were also completed by the registered manager.	
Recommendation 5 **Ref**: Standard 4 **Stated:** First time	It is recommended that registered nursing staff develop care plans that are patient centred and that the content of care plans is measurable, specific and relate to the assessed needs of the patient.	**Met**
	Action taken as confirmed during the inspection: A review of patients' care records confirmed that care plans were patient centred and relevant to the assessed needs of the patients.	

4.3 Is care safe?

There were systems in place for the recruitment and selection of staff. A review of recruitment records evidenced that these were reviewed by the registered manager and checked for possible issues.

Where nurses and carers were employed, their pin numbers were checked on a regular basis with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council

(NISCC), to validate their registration status. The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI and a register was maintained which included the reference number and date received. However, there was no indication of whether or not the criminal checks had been clear. The review also evidenced that one staff member had commenced employment prior to having employment references received. These matters were discussed with the registered manager during feedback. A recommendation has been made in this regard.

There was evidence that new staff completed an induction programme to ensure they developed their required knowledge to meet the patients' needs. 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.

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. Observation of the delivery of care evidenced that training had been embedded into practice. Advice was given on the development of a training matrix, that would improve the registered manager's oversight on overall compliance in this area.

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the week commencing 6 June 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. Discussion with the registered manager confirmed that there was a system in place to manage any potential safeguarding concern in accordance with the regional safeguarding protocols and the home's policies and procedures.

A range of risk assessments were completed as part of the admission process and were reviewed as required. These risk assessments informed the care planning process.
A review of the accident and incident records confirmed that the falls risk assessments and care plans were generally completed following each incident, care management and patients' representatives were notified appropriately. RQIA had been notified appropriately.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy and warm throughout. However, the sluice rooms were observed to be unlocked. Cleaning chemicals were also stored in this room in an unlocked cupboard. This posed a potential risk to patients. This was discussed with the manager, who provided assurances that a key pad lock would be installed, to ensure that the sluice rooms were secured. A requirement has been made in this regard.

One armchair in an identified patient's bedroom room was observed to be torn and in need of replacement. This meant that that the chair could not be cleaned effectively and as such, posed an infection prevention and control risk. This was discussed with the registered manager who ensured that the identified chair was replaced on the day of the inspection. All other furnishings in the home were observed to be fit for purpose. Refer to section 4.6 for further detail on auditing arrangements for infection prevention and control.

Areas for improvement

A recommendation has been made that the recruitment and selection processes are further developed, to ensure that staff members do not commence employment until two satisfactory employment references have been received. This process should also ensure that a record is maintained of whether or not the Access NI criminal record checks are clear.

A requirement has been made to ensure that the any chemicals used within the home are stored securely in accordance with COSHH regulations.

Number of requirements	**1**	**Number of recommendations**:	**1**

4.4 Is care effective?

As discussed in section 4.2, deficits were identified in the completion of continence assessments and a recommendation has been stated for the second time in this regard. A review of six patient care records evidenced that all other relevant risk assessments and care plans had been completed and were reviewed on a regular basis, in accordance with NMC guidelines. For example, records in relation to the management of wounds/pressure ulcers indicated that when a patient was identified as being at risk of developing a pressure ulcer a care plan was in place to direct staff on the management of this risk. Where applicable, specialist healthcare professionals were involved in prescribing care in relation to the management of wounds.

Patients who were identified as requiring a modified diet, had the relevant choke risk assessment in place and patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans. Patients who exhibited behaviours which challenge, had care plans in place which identified potential triggers and included strategies the staff should take to manage the behaviour. Care plans for patients' mobility reflected the moving and handling assessment, any contractures the patient may have had and the likelihood of the patient sustain an a fall.

The care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.
There was evidence that the care planning process included input from patients and/or their representatives, if appropriate, and there was evidence of regular communication with patient representatives within the care records.

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 food and fluid intake charts confirmed that patients' fluid intake had been monitored.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to discussing patients' details in front of other relatives.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective. Staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager.

Discussion with the registered manager and review of records evidenced that patients and/or relatives meetings were held on a regular basis and records were maintained. Patients and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and their feedback had been listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

The Charter of Individual Rights of Patients was displayed at the front entrance to the building along with the complaints procedure. Contact details for advocacy services were also displayed on a notice board in the home. Advocates can represent the views for patients/patients' representatives who are unable or not confident in expressing their wishes. Menus were displayed clearly throughout the building and were correct on the day of inspection. We observed the lunch time meal being served in two dining rooms.
The atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set with tablecloths and specialist cutlery and plate guards were available to help patients who were able to maintain some level of independence as they ate their meal.

The hairdresser visited on a regular basis and discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. There was a list of planned activities displayed on the ground and first floors in order to assist patients to choose which to participate in. Social care plans were in place to provide information to staff to ensure that patients' social care needs were met individually. One

patient consulted with described how one of the registered nurses arranged to have a photograph of her favourite singer, framed for her bedroom.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. Staff were also observed offering to bring a patient a cup of coffee, when they returned from their breaks.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. A review of records also evidenced that the registered manager also made contact with patients/patients' representatives, following a period of respite care to elicit their views on the service. Views and comments recorded were analysed and areas for improvement were acted upon.

The care plan detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for the patient. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met. The registered manager also confirmed that she personally made telephone contact with family members a few weeks after a patient had died, to check on their wellbeing and to invite them to visit the home at any point.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included expression of gratitude for 'providing kind and loving care to (the named patient)'.

In addition to speaking with patients, relatives and staff RQIA provided questionnaires. At the time of writing this report one relative, two patients and eight staff had retuned their questionnaires. All comments received were positive. Some comments received are detailed below:

Staff: respondents indicated a high level of satisfaction with the care under the four domains. Comments recorded included:

"I am happy enough, we provide really good care".
"The care is very good and the patients' care is our number one priority".
"We are very attentive to the patients and only ever get positive reports back".
"We all work well together and there is a good feeling about the home".
"The staff are very dedicated and there is good teamwork here".
Patients: respondents indicated a high level of satisfaction with the care under the four domains. Comments recorded included:

"It's all very good".
"It is excellent, unbelievable care and I get everything I need".
"Sometimes they say they'll come back, but they don't. I don't complain, because it's good here".
"They are good to me".

Relatives respondents indicated a high level of satisfaction with the care in all four domains. Comments recorded included:

"It is great, just lovely. I would book myself in".
"It's very good so far. The staff communicate everything I need to know".

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 staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

Discussion with the registered manager and observation of patients evidenced 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 current and displayed.

The registered manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis. Staff confirmed that they had access to the home's policies and procedures.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the registered manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

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. These included medication and equipment alerts and alerts regarding staff that were had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. A review of records evidenced that monthly 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 registered manager also outlined how the following audits were completed in accordance with best practice guidance:

- falls
- wound management
- care records
- infection prevention and control
- cleanliness audit
- personal care of patients
- laundry and kitchen
- staff training
- complaints
- repositioning records
- referrals to multidisciplinary specialists
- patients' food and fluid intake
- meals
- absenteeism.

Discussion with the registered manager confirmed that a range of audits were conducted on a regular basis. An audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. An action plan was in place to address any deficits identified. Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous inspection, confirmed that these were appropriately managed, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

However, as discussed in section 4.3, one armchair was observed to be torn and as such could not have been cleaned effectively. Although the identified patient's chair was replaced on the day of the inspection, a review of the audits in relation to infection prevention and control, did not evidence any traceability in terms of regular checks. This meant that the audit had not been effective in identifying issues. A recommendation has also been made in this regard.

Areas for improvement

A recommendation has been made to ensure that the infection prevention and control audits are further developed to ensure there is traceability in terms of the equipment and furnishings inspected. This refers specifically to the integrity of patients' seating in the home.

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

5.0 Quality improvement plan

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

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered 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 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 person may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to RQIA's offices for review 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 14 (2) (c) **Stated:** First time **To be completed by:** 11 August 2016	The registered persons must ensure that the any chemicals used within the home are stored securely in accordance with COSHH regulations. **Ref: Section 4.3**
	Response by registered person detailing the actions taken: All sluice rooms have been fitted with a locked cupboard and to provide extra assurances, all sluice room doors have also been fitted with key pad locks, to ensure that the chemicals are stored securely.
Recommendations	
Recommendation 1 **Ref**: Standard 4 Criteria (1) (7) **Stated:** Second time **To be completed by:** 11 August 2016	It is recommended that the continence assessment is reviewed and developed to ensure a comprehensive assessment is completed. Assessments and care plans should include all interventions required to manage patients' continence needs and should include but not limited to; bowel patterns and type and continence products required. **Ref: Section 4.2**
	Response by registered person detailing the actions taken: The continence link nurse and nurse manger have updated the continence assessment to include continence products, bowel management and assessment of patients bowel habits from admission.
Recommendation 2 **Ref**: Standard 38 **Stated:** First time **To be completed by:** 11 August 2016	The registered persons should ensure that the recruitment and selection processes are further developed, to ensure that staff members do not commence employment until two satisfactory employment references have been received. This process should also ensure that a record is maintained of whether or not the AccessNI criminal record checks are clear. **Ref: Section 4.3**
	Response by registered person detailing the actions taken: A Checklist is now in place to ensure that all new staff members do not commence employment until two satisfactory employment references have been received. Management, HR and administration staff have all been reminded to ensure that all documentation is in place prior to commencement of employment. Documentation regarding the AccessNI criminal record checks have been updated to include information as to whether or not the criminal checks have been clear.
Recommendation 3 **Ref**: Standard 46.2	The registered persons should ensure that the infection prevention and control audits are further developed to ensure there is traceability in terms of the equipment and furnishings inspected. This refers specifically to the integrity of patients' seating in the home.

Stated: First time **To be completed by:** 11 August 2016	**Ref: Section 4.6**
	Response by registered person detailing the actions taken: Cleaning schedules and audits have been updated to include room number and all patient's chairs are now included in the cleaning schedule and audit. This will now provide greater traceability. Terminal cleaning of all bedrooms continues monthly this includes chairs, mattresses, cushions, beds etc

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews