Announced Primary Inspection

Name of Establishment:	**Drapersfield House**
Establishment ID No:	**1420**
Date of Inspection:	**27 May 2014**
Inspector's Name:	**Teresa Ryan**
Inspection No:	**17130**

The Regulation And Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544

1.0 General Information

Name of Home:	Drapersfield House
Address:	19 Drapersfield Road Cookstown BT80 8RS
Telephone Number:	028 8676 4868
E mail Address:	jillcanavan@aol.com
Registered Organisation/ Registered Provider:	Mr James and Mrs A McCrystal
Registered Manager:	Mr James McCrystal, Registered Manager Nurse Manager's position currently vacant
Person in Charge of the home at the time of Inspection:	Registered Nurse Margaret Kolbohn
Categories of Care:	NH-I, NH-LD, NH-LD(E), NH-PH, NH-PH(E), RC-I, RC-MP(E), RC-MP
Number of Registered Places:	45
Number of Patients/Residents Accommodated on Day of Inspection:	18 Nursing 7 Residential
Scale of Charges (per week):	£550 - Nursing £437 - Residential
Date and type of previous inspection:	28 May 2013 Primary announced Inspection
Date and time of inspection:	27 May 2014 08.00 hours -16.00 hours
Name of Inspector:	Teresa Ryan

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year is required.

This is a report of a primary announced inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were met.

3.0 Purpose of the Inspection

The purpose of this announced inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Residential Care Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)
- The Department of Health, Social Services and Public Safety's (DHSSPS) Residential Care Homes Minimum Standards (2011)

Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/Process

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the DHSSPS Nursing Homes Minimum Standards 2008.

The inspection process has three key parts; self-assessment (including completion of self- declaration), pre-inspection analysis and the inspection visit by the inspector.

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

- analysis of pre-inspection information
- discussion with the registered manager
- discussion with the registered nurse in charge
- discussion with the deputy manager
- discussion with staff
- examination of records
- consultation with stakeholders
- tour of the premises
- evaluation and feedback.

Any other information received by RQIA about this registered provider has also been considered by the inspector in preparing for this inspection.

5.0 Consultation Process

During the course of the inspection, the inspector spoke with:

Patients/residents	**10 individually and to others in groups**
Staff	**15**
Relatives	**-**
Visiting Professionals	**-**

Questionnaires were provided, during the inspection, to patients, their representatives and staff seeking their views regarding the service. Matters raised from the questionnaires were addressed by the inspector during the course of this inspection.

Issued To	**Number issued**	**Number returned**
Patients / Residents	**5**	**5**
Relatives / Representatives	**5**	**5**
Staff	**15**	**15**

6.0 Inspection Focus

The inspection sought to establish the level of compliance achieved regarding the selected DHSSPS Nursing Homes Minimum Standards.

The criteria from the following standards are included;

- Management of Nursing Care – Standard 5
- Management of Wounds and Pressure Ulcers – Standard 11
- Management of Nutritional Needs and Weight Loss – Standard 8 and 12
- Management of Dehydration – Standard 12

An assessment on the progress of the issues raised during and since the previous inspection was also undertaken. The inspector will also undertake an overarching view of the management of patients' human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.

The registered persons and the inspector have rated the home's compliance level against each criterion of the standard and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Guidance - Compliance statements	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Drapersfield House is situated in a quiet, rural location on the outskirts of Cookstown, Co Tyrone.

The home is owned and operated by Mr James and Mrs A McCrystal. The current registered manager is Mr James McCrystal. The nurse manager's post is currently vacant.

The home is a large detached property which was converted and developed to provide both nursing and residential care accommodation.

Accommodation is provided over three floors with access from the ground floor via a through floor passenger lift and stairs. There are 33 single and six double bedrooms.

Communal lounges and dining areas are provided over the three floors.

The home also provides for catering and laundry services on the ground floor.
A number of communal sanitary facilities are available throughout the home.

Adequate car parking facilities are provided at the front of the home.

An enclosed sensory garden is maintained in the courtyard at the rear of the home where patients and residents can pursue their horticultural interests and or relax in tranquil, secure surroundings.

The home is registered in the following categories of care:

Nursing 1 - Old age not falling within any other category.
Nursing PH, PH(E) - Physical disability other than sensory impairment under and over 65 years
Learning disability LD, LD(E) - Learning disability under and over 65 years.
Residential – one old age not falling within any other category.
Residential MP(E) - Mental disorder excluding learning disability under and over 65 years.

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (announced) to Drapersfield House. The inspection was undertaken by Teresa Ryan on Tuesday 27 May 2014 from 08.00 hours to 16.00 hours.

The inspector was welcomed into the home by Registered Nurse Margaret Kolbohn who was in charge of the home and was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Mr James McCrystal, Registered Manager, Mrs Jill Cavanagh, Deputy Manager and Margaret Kolbohn at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. This self-assessment is appended to the report at Appendix One.

During the course of the inspection, the inspector met with patients, residents and staff. The inspector observed care practices, examined a selection of records and carried out a general inspection of the home's environment as part of the inspection process.

Questionnaires were issued to patients and staff during the inspection. Subsequent to the inspection a number of relatives/representatives completed questionnaires. The inspector spent a number of extended periods observing staff and patient/resident interaction.

Discussions and questionnaires are unlikely to capture the true experiences of those patients/residents unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience. These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool is designed to help evaluate the type and quality of communication which takes place in the nursing home. A description of the coding categories of the Quality of Interaction Tool is appended to the report at Appendix One.

As a result of the previous inspection conducted on 28 May 2013 one requirement and three recommendations were issued. These were reviewed during this inspection. The inspector evidenced that the requirement and two recommendations had been fully complied with and one recommendation was assessed by the inspector as being moving towards compliance. This recommendation is restated. Details can be viewed in the section immediately following this summary.

Standards inspected:

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed. (Selected criteria)

Standard 8: Nutritional needs of patients are met. (Selected criteria)

Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)
Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria)

Inspection Findings

- **Management of Nursing Care – Standard 5**

There was evidence of comprehensive and detailed assessment of patient needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patient needs was evidenced to inform the care planning process.

Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis plus as required. However review of three patients' care records revealed a number of shortfalls in two of these care records. Two requirements are made.

There was also evidence that the referring HSC Trusts generally maintained appropriate reviews of the patient's and resident's satisfaction with the placement in the home and the quality of care delivered. There were six patients /residents care reviews overdue. The registered nurse in charge informed the inspector that she was currently making efforts to put arrangements in place for these care reviews to be undertaken as a matter of priority.

- **Management of Wounds and Pressure Ulcers – Standard 11 (selected criteria)**

There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment. There was one patient in the home who required wound management intervention for a wound. Review of this patient's care records revealed a number of shortfalls. As previously stated two requirements are made in regard to these shortfalls. A recommendation is made that the repositioning chart be reviewed to address inspection of the patient' skin at each positional change.

Management of Nutritional Needs and Weight Loss – Standard 8 and 12 (selected criteria)

The inspector reviewed the management of nutrition and weight loss within the home. Robust systems were evidenced with risk assessments and appropriate referrals to GP's, speech and language therapists and/or dieticians being made as required.

Review of care records for two patients evidenced that the patients were referred for dietetic assessments in a timely manner. Review of these two patients' care plans on eating and drinking revealed that the dietician's recommendations were not fully addressed in the care plan for the patient with the wound. This professional's recommendations were fully addressed in the other patient's care plan.

The inspector also observed the serving of the lunch meal and can confirm that the patients and residents were offered a choice of meal and that the meal service was well delivered. Patients and residents were observed to be assisted with dignity and respect throughout the meal. A requirement is made that staff as appropriate be trained in the following areas;

Management of nutrition
Dysphagia awareness
Oral hygiene
First aid
Preparation and presentation of pureed meals
Use of food and fluid thickening agents
Fortification of foods
Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes (2014).

- **Management of Dehydration – Standard 12 (selected criteria)**

The inspector also examined the management of dehydration during the inspection. The home was evidenced to identify fluid requirements for patients and residents and records were maintained of the fluid intake of those patients assessed at risk of dehydration.

Review of a sample of fluid balance charts for one identified patient revealed that these were accurately maintained and totalled for the 24 hour period**.** This patient's recommended daily fluid intake with the action to take if targets were not being achieved was not addressed in their care plan on eating and drinking. Patients and residents were observed to be able to access fluids with ease throughout the inspection.

The inspector can confirm that based on the evidence reviewed, presented and observed; that the level of compliance with this standard was assessed as substantially compliant.

Patients, their representatives and staff questionnaires

Some comments received from patients and their representatives;
"Wonderful this is a great home",
"No problems the care is first class",
"Staff treat me and my belongings with respect",
"The care is very good and the staff are excellent",
"I am very happy here, the food is excellent, you could not get better".

Some comments received from staff;
"I had induction when I commenced work",
"The quality of care in the home is very good and staff treat the patients and residents very well",
"Everybody works well as a team",
"Staff friendly everybody made welcome".

A number of additional areas were also examined;

- records required to be held in the nursing home
- guardianship
- Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)

- Patient/resident and staff quality of interactions (QUIS)
- complaints
- patient finance pre-inspection questionnaire
- NMC declaration
- staffing and staff comments
- comments from representatives/relatives *and visiting professionals*
- environment

Full details of the findings of inspection are contained in Section 11 of the report.

A recommendation is restated that details contained in reports of unannounced visits undertaken in the home under Regulation 29 be discussed with staff during staff meetings/forums.

Conclusion

The inspector can confirm that at the time of inspection the delivery of care to patients and residents was evidenced to be of a good standard. There were processes in place to ensure the effective management of the themes inspected.

The home's general environment was well maintained and patients and residents were observed to be treated with dignity and respect. However areas for improvement are identified. Three requirements and one recommendation are made and one recommendation is restated. These requirements and recommendations are addressed throughout the report and in the Quality Improvement Plan (QIP)

The inspector would like to thank the patients, the residents, registered manager, registered nurse in charge, deputy manager, registered nurses and staff for their assistance and co-operation throughout the inspection process.

The inspector would also like to thank the patients, relatives and staff who completed questionnaires.

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	20 (1) (c) (i)	Staff as appropriate should be trained in the following arrears: • The management of restraint including the safe use of bedrails • Record keeping - registered nurses • Moving and handling • Fire awareness/fire drills • Management of behaviours that challenge • Control of substances hazard to health (COSHH)	Review of the staff training records revealed staff attended training in the following areas since the previous inspection; Twenty staff were trained in the management of restraint including the safe use of bedrails. Eleven staff were trained in record keeping. Thirty four staff were trained in moving and handling. One hundred and thirteen staff were trained in fire awareness and fire drills. Fifteen staff were trained in the management of behaviours that challenge. Fourteen staff were trained in COSHH. The registered nurse in charge informed the inspector through email on the 28/05/14 that further training in these areas was planned for a number of days in June 2014.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	25.12	It is recommended that action plans to address deficits identified in reports of unannounced visits under Regulation 29 be developed and that these action plans be reviewed to ensure deficits previously identified were addressed. The following information should also be included in these reports. • Duration of visits • Grades and numbers of all staff on duty at the time of visits • Identification numbers of patients and residents consulted • Outcomes of audits undertaken on a monthly basis	Review of a sample of reports of unannounced visits undertaken in the home under Regulation 29 revealed that all elements of this recommendation were being addressed.	Compliant
2	25.12	It is recommended that reports of unannounced visits under Regulation 29 be discussed with staff during staff	Review of a sample of the minutes of staff meetings revealed that details in these reports had been discussed with staff during one staff meeting. Restated	Moving towards compliance.

		meetings/forums and ways forward agreed on how action plans contained in these reports will be addressed.		
3	5.3	It is recommended that infection control assessments be introduced into patients' and residents' care records	Review of three patients' care records revealed that infection control assessments were undertaken for these patients.	Compliant

10.0 Inspection Findings

Section A

Standard : 5.1

- **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment**

Standard 5.2

- **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission**

Standard 8.1

- **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent**

Standard 11.1

- **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.**

Inspection Findings:

Policies and procedures relating to patients'/residents' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing and Residential Care Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and Residential Care Homes Minimum Standards (2011) and NMC professional guidance.

The inspector reviewed three patients' care records which evidenced that patients' individual needs were established on the day of admission to the nursing home through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks.

Specific validated assessment tools such as moving and handling, pain, infection control, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart and continence were also completed on admission.

Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure

ulcer/wound and if required, the specific care plans regarding the management of the pressure ulcer/wound.

Review of three patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 11 days of patient's admission to the home.

In discussion with the registered nurse in charge she demonstrated a good awareness of the patient who required wound management intervention for a wound and the number and progress of patients who were assessed as being at risk of weight loss and dehydration.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section B

Standard 5.3

- **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.**

Standard 11.2

- **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.**

Standard 11.3

- **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.**

Standard 11.8

- **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration**

Standard 8.3

- **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.**

Inspection Findings:

The inspector observed that a named nurse and key worker system was operational in the home. The roles and responsibilities of named nurses and key workers were outlined in the patient's/ resident's guide.

Review of three patients' care records and discussion with patients and staff evidenced that patients as appropriate and their representatives were involved in discussions regarding the agreeing and planning of nursing interventions. Records also evedenced discussion with patients and or their representatives following changes to the plans of care.

The registered nurse in charge informed the inspector that there was one patient in the home who required wound management for a wound.

Review of this patient's care records revealed the following;

- The patient's assessment of needs did not fully address the patient's assessed needs and was not revised in accordance with the changing needs of the patient.
- A number of the patients' care plans were not reviewed following the review of the assessment of needs.
- The patient's care plan on eating and drinking did not fully address the dietician's recommendations.
- The outcome of the continence assessment was not recorded in the assessment and the care plan on promoting continence.
- The patient's care plan on personal care and dressing was not person centred.
- The patient's care plan on wound care did not specify the dressing regime or the frequency of the dressing. It is acknowledged that the dressing regime and the frequency of the dressing were recorded on the patient's open wound observation charts.
- The pressure relieving equipment in place on the patient's bed and when sitting out of bed was not recorded in the care plan. It is acknowledged that a specialist mattress and cushion was in place for this patient.
- The type of mattress in use was based on the outcome of the pressure risk assessment.
- A daily repositioning and skin inspection chart was in place for the patient. Review of a sample of these charts revealed that the patient's skin condition was inspected for evidence of change twice daily. A recommendation is made that this chart is reviewed to address the inspection of the patient's skin at each positional change. It was also revealed that the patient was repositioned in bed in accordance with the instructions detailed in their care plan on pressure area care and prevention.
- The patient's moving and handling needs were assessed and addressed in their care plan. There was evidence that manual handling aids were used to minimise risk of friction. Staff consulted confirmed there was sufficient nursing equipment available to move and handle patient's appropriately.
- The patient's weight was recorded on admission and on at least a monthly basis or more often if required.
- The patient's nutritional status was also reviewed on at least a monthly basis or more often if required.
- Daily records were maintained regarding the patient's daily food and fluid intake.

The registered nurse in charge and registered nurses informed the inspector that pressure ulcers were graded using an evidenced based classification system.

Discussion with the registered nurse in charge confirmed that where a patient was assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention plan and treatment programme. Review of two of these patients' care records revealed one patient's care records addressed their assessed needs and was completed to a good standard.
There were a number of shortfalls in the other patient's care records and these are as follows;

- This patient's assessment of needs was not reviewed following the patient being seen by a speech and language therapist.
- The patient's risk assessment did not address the risk of dehydration.
- The patient's recommended daily fluid intake with the action to take if targets were not being achieved was not addressed in their care plan on eating and drinking.
- The type of the pressure relieving mattress and cushion in place was not recorded in the patient's care plan on pressure area care and prevention. It was stated that a "pressure relieving mattress and cushion was in place"

The registered nurse in charge and registered nurses confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local healthcare Trust. Staff spoken with were knowledgeable regarding the referral process. Discussion with two registered nurses evidenced that they were knowledgeable of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient

Review of the records of incidents revealed that the incidence of pressure ulcers, grade 2 and above, were reported to the RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005**.**

Policies and procedures were in place for staff on making referrals to the dietician. These included indicators of the action to be taken and by whom. All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment.

Review of care records for two patients evidenced that the patients were referred for dietetic assessments in a timely manner. Review of these two patients' care plans on eating and drinking revealed that as previously stated the dietician's recommendations were not fully addressed in the care plan for the patient with the wound. This professional's recommendations were fully addressed in the other patient's care plan.

A tissue viability link nurse was employed in the home which is commendable. The tissue viability nurse for the home attended training provided by the NHSCT on a regular basis and this nurse cascades the knowledge and skills acquired from this training to the registered nurses in the home. The registered nurse in charge informed the inspector that this nurse also trains the care staff in pressure area care and prevention.

Discussion with the registered nurse in charge, registered nurses, care staff and review of the staff training records revealed that registered nurses and care staff were trained in wound management and pressure area care and prevention in February, May and November 2013 and February 2014. Three staff were trained in the management of nutrition since the previous inspection and a requirement is made that

additional staff be trained. Seven staff attended training in food safety in May 2014.

A requirement is made in regard to shortfalls in patients' care records inspected. A requirement is also made in regard to the reviewing of the patients' assessment of needs.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Moving towards compliance**

Section C

Standard 5.4

- **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.**

Nursing Homes Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16

Inspection Findings:

Review of three patients' care records evidenced that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care including wound care for each patient.

Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. The reviews undertaken did not fully address the outcome of assessments and the care prescribed in care plans. As previously stated a requirement is made in regard to shortfalls in care records.

Review of one patient's care records in relation to wound care indicated that these care records were reviewed each time the dressing was changed and also when the dressing regime was changed or the condition of the wound had deteriorated. The evaluation process included

the effectiveness of any prescribed treatments, for example, prescribed analgesia.

Monthly audits were also undertaken in regard to wound care and records were held on audit outcomes. Discussion with the registered nurse in charge and two registered nurses confirmed that action was taken to address any deficits or areas for improvement identified through the audit process.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

Section D

Standard 5.5

- **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.**

Standard 11.4

- **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.**

Standard 8.4

- **There are up to date nutritional guidelines that are in use by staff on a daily basis.**

Nursing Homes Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)

Inspection Findings:

The inspector examined three patients' care records which evidenced the completion of validated assessment tools such as;

- the Roper, Logan and Tierney assessment of activities of daily living
- Braden pressure risk assessment tool

- Community Nutrition Risk Scoring Tool

The inspector confirmed the following research and guidance documents were available in the home;

- DHSSPS 'Promoting Good Nutrition' A Strategy for good nutritional care in adults in all care settings in Northern Ireland 2011-16
- The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.
- The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care
- The European Pressure Ulcer Advisory Panel (EPUAP)
- RCN/NMC guidance for practitioners.

Discussion with the registered nurse in charge and registered nurses confirmed that these staff should be trained in the Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes (2014). A requirement is made in regard to this training. Discussion with the registered nurse in charge, registered nurses and review of governance documents evidenced that the quality of pressure ulcer/wound management was audited each time dressings were changed and discussed at each hand over report. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

Registered nursing staff were found to be knowledgeable regarding wound and pressure ulcer prevention, the individual dietary needs and preference of patients/residents and the principles of providing good nutritional care.

Ten staff consulted could identify patients/residents who required support with eating and drinking. Information in regard to each patient's/resident's nutritional needs including aids and equipment recommended to be used was held in the dining room for easy access by staff**.** This is commendable practice.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

Section E

Standard 5.6

- **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.**

Standard 12.11

- **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.**

Standard 12.12

- **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.**
  Where a patient is eating excessively, a similar record is kept
  All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.

Inspection Findings:

A policy and procedure relating to nursing records management was available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, The Residential Care Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008), DHSSPS Residential Care Homes Minimum Standards (2011) and NMC professional guidance.

Registered nurses spoken with were aware of their accountability and responsibility regarding record keeping.

A review of the training records confirmed that staff had received training on the importance of record keeping commensurate with their roles and responsibilities in the home.

Review of three patients' care records revealed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient. These statements reflected wound and nutritional management intervention for patients as required.

Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patients' status or to

indicate communication with other professionals/representatives concerning the patients. Entries were noted to be dated, timed and signed with the signature accompanied by the designation of the signatory.

The inspector reviewed a record of the meals provided for patients and residents. Records were maintained in sufficient detail to enable the inspector to judge that the diet for each patient and resident was satisfactory.

The inspector reviewed the care records of three patients identified of being at risk of inadequate or excessive food and fluid intake. This review confirmed that;

- daily records of food and fluid intake were being maintained
- the nurse in charge had discussed with the patient/ resident/representative their dietary needs
- where necessary a referral had been made to the relevant specialist healthcare professional
- a record was made of any discussion and action taken by the registered nurse
- care plans had been devised to manage the patient's nutritional needs and were reviewed on a monthly or more often basis.

As previously stated under Section B review of one patient's care records evidenced a deficit in recording directions from the dietician.

Review of a sample of fluid balance charts for one identified patient revealed that these were accurately maintained and totalled for the 24 hour period**.** As previously stated under Section B the patient's recommended daily fluid intake with the action to take if targets were not being achieved was not addressed in their care plan on eating and drinking. As previously stated a requirement is made in regard to shortfalls in the care records inspected.

Staff spoken with were evidenced to be knowledgeable regarding patients' and residents' nutritional needs

As previously stated three staff were trained in the management of nutrition since the previous inspection and a requirement is made that additional staff be trained. Seven staff attended training in food safety in May 2014.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

Section F

Standard 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.**
Inspection Findings:
Please refer to criterion examined in Section E. In addition the review of three patients' care records evidenced that consultation with the patient and/or their representative had taken place in relation to the planning of the patient's care. This is in-keeping with the DHSSPS Minimum Standards and the Human Rights Act 1998.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section G

Standard 5.8

- **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate**

Standard 5.9

- **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.**

Inspection Findings:

Prior to the inspection a patients'/residents' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that patients/residents with six exceptions had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014. The registered nurse in charge informed the inspector that she was currently making efforts to put arrangements in place for the care reviews which are overdue to be undertaken as a matter of priority.

The information provided in this questionnaire revealed that the minutes of care reviews provided by the referring HSC Trust for 13 patients/residents were provided to the home within a six week period. The minutes of care reviews for 8 patients/residents were provided to the home outside the six week period.

The registered nurse in charge informed the inspector that patients'/ residents' care reviews were held post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient/resident or family. A member of nursing staff, preferably the patient's named nurse, resident's key worker attends each care review. A copy of the minutes of the most recent care review was held in the patient's/resident's care record file.

The inspector viewed the minutes of three care management care reviews which evidenced that, where appropriate, patients and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended, an updated assessment of the patient's needs and a record of issues discussed. Care plans were evidenced to be updated post care review to reflect recommendations made where applicable.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section H

Standard 12.1

- **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.**
  Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.

Standard 12.3

- **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.**
  A choice is also offered to those on therapeutic or specific diets.

Inspection Findings:

A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance.

There was a four weekly menu planner in place. The registered nurse in charge informed the inspector that the menu planner had been reviewed and updated in consultation with patients, residents, their representatives and staff in the home. The current menu planner was implemented on January 2014.

The inspector discussed with the registered nurse in charge and a number of staff the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients and residents.

Staff spoken with were knowledgeable regarding the individual dietary needs of patients and residents to include their likes and dislikes. Discussion with staff and review of the record of the patients' and residents' meals confirmed that patients and residents were offered choice prior to their meals.

Staff spoken with were knowledgeable regarding the indicators for onward referrals to the relevant professionals. eg. speech and language therapists and or dieticians.

As previously stated under Sections B and E, review of two patients' care records evidenced that the patients were referred for dietetic assessments in a timely manner. Review of these two patients' care plans on eating and drinking revealed that as previously stated the dietician's recommendations were not fully addressed in the care plan for the patient with the wound. This professional's recommendations were fully addressed in the other patient's care plan.

As previously stated under Section D relevant guidance documents were in place.

Review of the menu planner and records of patients' and residents' choices and discussion with a number of patients, residents, registered nurses and care staff, it was revealed that choices were available at each meal time. A range of choices were also available for patients on therapeutic diets.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

Section I

Standard 8.6
- **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.**

Standard 12.5
- **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.**

Standard 12.10
- **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:**
  - **risks when patients are eating and drinking are managed**
  - **required assistance is provided**
  - **necessary aids and equipment are available for use.**

Standard 11.7
- **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.**

Inspection Findings:

The inspector discussed the needs of the patients and residents with the registered nurse in charge. It was determined that a number of patients had swallowing difficulties.

Review of training records revealed that six staff had attended training in dysphagia awareness and oral hygiene since the previous inspection. Staff as appropriate should be trained in the preparation and presentation of pureed meals, the use of food and fluid thickening agents, the fortification of foods, first aid and additional staff should be trained in dysphagia awareness and oral hygiene.

Review of two patients' care records revealed that these two patients were referred to a speech and language therapist. These patients' care plans had been reviewed and updated to address this professional's recommendations.

Discussion with registered nurse in charge confirmed that meals were served at appropriate intervals throughout the day and in-keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.

The registered nurse in charge also confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning, afternoon and at supper times.

The inspector observed that a choice of fluids to include fresh drinking water were available and refreshed regularly. Staff were observed offering patients and residents fluids at regular intervals throughout the day.

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and residents and the principles of providing good nutritional care. Ten staff consulted could identify patients and residents who required support with eating and drinking. Information in regard to each patient's and resident's nutritional needs including aids and equipment recommended to be used was held in the dining room for easy access by staff**.** This is commendable practice.

On the day of the inspection, the inspector observed the lunch meal. Observation confirmed that meals were served promptly and assistance required by patients and residents was delivered in a timely manner.

Staff were observed preparing and seating the patients and residents for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients and residents with their meal and patients and residents were offered a choice of fluids. The tables were well presented with condiments appropriate for the meal served. Daily pictorial menus were provided on each table and this is commendable.

A tissue viability link nurse was employed in the home.

Discussion with the registered nurses clearly evidenced their knowledge in the assessment, management and treatment of wounds. Review of the template used to undertake competency and capability assessments for the registered nurses revealed that pressure ulcer/wound care was addressed. The inspector reviewed 13 competency and capability assessments for registered nurses. These assessments were reviewed on an annual or more often basis.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

11.0 Additional Areas Examined

11.1 Records required to be held in the nursing home

Prior to the inspection a check list of records required to be held in the home under Regulation 19(2) Schedule 4 of The Nursing Homes Regulations (Northern Ireland) 2005 was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required records were maintained in the home and were available for inspection.

11.2 Patients under Guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) Order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection. During the inspection there were no patients in the home who were subject to a guardianship order.

11.3 Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspector discussed the Human Rights Act and Human Rights Legislation with the registered manager, registered nurse in charge and deputy manager. The inspector can confirm that copies of these documents were available in the home. The registered manager, registered nurse in charge and deputy manager displayed an awareness of the details outlined in these documents. The registered nurse in charge informed the inspector that these documents will be discussed with staff during staff meetings and that staff will be made aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patients/ residents' care and accompanying records.

The inspector also discussed the Deprivation of Liberty Safeguards including the recording of best interest decisions on behalf of patients and residents. A copy of DOLS was also available in the home**.**

11.4 Quality of interaction schedule (QUIS)

The inspector undertook a number of periods of observation in the home which lasted for approximately 30 minutes each. The inspector observed the lunch meal being served in the dining rooms on the ground floor. The inspector observed the activity therapist providing activities to a number of patients and residents in one of the sitting rooms in the afternoon. The inspector also observed care practices during a tour of the premises. The observation tool used to record this observation was the Quality of Interaction Schedule (QUIS). This tool uses a simple coding system to record interactions between staff, patients and visitors.

Positive interactions	All positive
Basic care interactions	-
Neutral interactions	-
Negative interactions	-

A description of the coding categories of the Quality of Interaction Tool is appended to the report at Appendix Two.

Observation of the lunch meal confirmed that meals were served promptly and assistance required by patients and residents was delivered in a timely manner.

Staff were observed preparing and seating the patients and residents for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients and residents with their meal and patients and residents were offered a choice of fluids. The staff explained to the patients and residents their meal choices and provided appropriate assistance and support to the patients and residents

Observation of care practices during the provision of activities to patients and residents revealed that the activity therapist initiated conversation with patients and residents, and listened to their views and was respectful in their interactions with them. The activity therapist was also observed encouraging and enabling the patients and residents to participate in the activities. During this period of observation the patients and residents were being entertained by a musician from outside the home
.
Observation of care practices during a tour of the premises revealed staff treated the patients and residents with dignity and respect. Overall the periods of observation were positive in regard to the care of patients and residents in the home.

11.5 Complaints

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being pro-actively managed. The inspector reviewed the complaints records during the inspection. This review revealed that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought. The registered nurse in charge informed the inspector that lessons learnt from investigations were acted upon.

11.6 Patient/ Resident Finance Questionnaire

Prior to the inspection a patient/resident financial questionnaire was forwarded by RQIA to the home for completion. The evidence provided in the returned questionnaire indicated that patients' and residents' monies were being managed in accordance with legislation and best practice guidance.

11.7 NMC declaration

Prior to the inspection the registered manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses were appropriately registered with the NMC. This was also evidenced by the inspector on the day of inspection.

11.8 Staffing/Staff Comments

Discussion with the registered nurse in charge and a number of staff, and review of a sample of staff duty rosters evidenced that the registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients and residents currently in the home for day and night duty. The ancillary staffing levels were found to be satisfactory. An activity therapist was employed for 32.5 hours per week. The registered manager informed the inspector that a nurse manager had been appointed and arrangements were in place for this manager to take up employment in the home on receipt of satisfactory pre-employment checks.

Staff were provided with a variety of relevant training including the management of enteral feeding systems, the use of the McKinley syringe driver, male catheterisation and mandatory training since the previous inspection. A recommendation is restated that details contained in reports of unannounced visits undertaken under Regulation 29 be discussed with staff during staff meetings/forums.

During the inspection the inspector spoke to15 staff. The inspector was able to speak to a number of these staff individually and in private. Fifteen staff completed questionnaires. The following are examples of staff comments during the inspection and in questionnaires;

"I had induction when I commenced work",
"The quality of care in the home is very good and staff treat the patients and residents very well",
"Everybody works well as a team",
"Staff friendly everybody made welcome",
"I get great satisfaction caring for other individuals. I feel happy at work because I know the home is providing a high standard of care and every member of staff works together as a team to ensure this",
"All the patients and residents are treated with dignity and respect",
"I feel that staff are very caring towards the patients and residents and have a good rapport with their families and friends",
"I feel the patients and residents are very well cared for and they get any food they wish to have".

11.9 Patients' Comments

During the inspection the inspector spoke to 10 patients individually and to a number in groups. Five patients completed questionnaires. The following are examples of patients' comments during the inspection and in questionnaires:

"Wonderful this is a great home",
"Staff treat me and my belongings with respect",
"The care is very good and the staff are excellent",
"I am very happy here, the food is excellent, you could not get better",
"Staff can make me a snack and a cup of tea at any time",
"I find this home very good and the staff are very good",
Staff always respect my privacy and they always knock my door before entering",
"I feel safe in this home",
"We are very well treated everything especially the activities is very good".

11.10 Relatives' Comments

Subsequent to the inspection five relatives completed questionnaires. The following are examples of relatives' comments;

"My mother has been really well looked after, the staff could not do any more for her than they have already done",
"The home is a happy and welcoming place",
"The care provided to my mother is excellent, and so is the food. The staff always have time for my mother they make her very welcome on each occasion that she arrives for respite care",
"No problems, the care is first class",
"Staff treat my relative with dignity and respect".

11.11 Environment

During the inspection the inspector undertook a tour of the premises and viewed the majority of the patients' and residents 'bedrooms, sitting areas, dining rooms, kitchen, laundry, bath/shower and toilet facilities. The home was found to be warm, clean, and comfortable. The improvements in the environment standards since the previous inspection are acknowledged. A number of areas throughout the home had been redecorated. Floor coverings had been replaced in a number of areas throughout the home. A number of new televisions had been provided for the patients and residents use. The outside of the home had been repainted and additional garden furniture had been provided. The senior management team are commended on their efforts in this regard.

The details of the Quality Improvement Plan appended to this report were discussed with Mr James McCrystal, Registered Manager, Mrs Margaret Kolbohn, Registered Nurse in Charge and Mrs Jill Cavanagh, Deputy Manager at the conclusion of the inspection.

The timescales for completion commence from the date of inspection.

The registered provider / manager is required to record comments on the Quality Improvement Plan.

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.

Enquiries relating to this report should be addressed to:

Teresa Ryan
The Regulation and Quality Improvement Authority
Hilltop
Tyrone and Fermanagh Hospital
Omagh
Co Tyrone
BT70 0NS

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Primary Announced Inspection

Drapersfield House

27 May 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Mr James McCrystal, Registered Manager, Mrs Margaret Kolbohn, Registered Nurse in charge and Mrs Jill Cavanagh, Deputy Manager at the conclusion of the inspection.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers/managers should note that failure to comply with regulations may lead to further enforcement and/or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider/manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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.

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 (NI) 2005

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	16 (2)(b)	The registered person shall ensure that the patients' care records are reviewed and updated in order to ensure that care plans fully reflect the patients' assessed needs. Regular audits should be undertaken of patients' care records. Ref. Section B, C, E and H	One	This has been addressed and all patients and residents care plans fully reflect assessed needs. Regular audits are now undertaken.	Two weeks
2	15 (2)(a)(b)	The registered person shall ensure that the assessment of the patient's needs is kept under review and revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually. Ref Section B	One	The assessment of all patients and residents and all reviewed and updated when circumstances change.	Two weeks
3	20 (1)(c)(i)	Staff as appropriate should be trained in the following areas; Management of nutrition, Dysphagia awareness, Oral hygiene, First aid, Preparation and presentation of pureed meals, Use of food and fluid thickening agents, Fortification of foods, The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes (2014). Ref. Section B, E, D and I	One	Nutrition and must held on 25.6.14. 14 staff attended. Dysphagia awareness to take place in Sept from SALT awaiting date + thickenings agents. Oral hygiene to take place on 17.9.14 from 14.00-16.00hrs. First aid 11 staff attended on 11.6.14 Trust to provide training awaiting date.	One month

Recommendations

These recommendations are based on the Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.3	It is recommended that the repositioning chart in use in the home be reviewed to address the inspection of the patient's skin at each positional change. Ref Section B	One	new repositioning daily charts implemented.	Two weeks
2	25.12	It is recommended that reports of unannounced visits undertaken under Regulation 29 be discussed with staff during staff meetings/forums. Ref. Section 11, point 11.8 (additional areas examined)	Two	Regulation 29 was discussed at staff meeting on 11.6.2014	One month

The registered provider / manager is required to detail the action taken, or to be taken, in response to the issue(s) raised in the Quality Improvement Plan. The Quality Improvement Plan is then to be signed below by the registered provider and registered manager and returned to:

The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS

Signed: _____ **Signed:** _____

Name: _____ **Name:** _____
Registered Provider **Registered Manager**

Date _____ **Date** _____

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	[signature]	17/07/14
Further information requested from provider			