The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
11 May 2016

Marina Care Home

Address: Shore Road, Ballyronan, BT45 6JA
Tel No: 02879418770
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Marina Care Home took place on 11 May 2016 from 09:15 to 16:15 hours.

The focus of this inspection was to assess the day to day operations of the home since registration on 5 April 2016 following a change of ownership. The inspection also sought to assess progress with the 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.

Is care safe?

Staff consulted with, were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding. Despite up to date training records not being available, consultation with staff confirmed that they had completed all mandatory training. Planned staffing levels were adhered to and staff were observed assisting patients in a timely and unhurried way. However, three recommendations have been stated in regards to record keeping of adult safeguarding incidents; induction records; and recruitment and selection processes. Recommendations made by the local Health and Social Care Trusts, in response to a serious adverse incident, which occurred in the home, had not been embedded into practice. A requirement has been stated in this regard.

Is care effective?

Staff meetings had been held on a regular basis and all staff consulted with stated that they felt they could approach management with any concerns. Requirements have been stated for the second time in relation to the completion of risk assessments and care plans. Records were not maintained in keeping with best practice guidance and a recommendation has been made in regards to the provision of training for registered nurses in this regard. One requirement has also been stated in regards to the management of patients who are at risk of dehydration.

Is care compassionate?

Staff interactions were observed to be compassionate, caring and timely and patients and relatives consulted with stated that they felt that patients' rights to choice, dignity and respect were upheld. Those consulted with knew how to raise concerns and felt that they their concerns would be listened to. There was evidence of good communication in the home between staff and patients. Patients were very praiseworthy of staff and a number of their comments are included in the report. Compliments were available regarding end of life care, where relatives found the staff to be particularly compassionate.

Is the service well led?

The responsible person was managing the home in an acting capacity due to recent management changes that had occurred in the home. Those consulted with stated the recent change of ownership of the home had not impacted upon the patients or the staff. However, we found that the previous registered providers had removed the complaints records from the home and there was no access to the staff training that had previously been provided.

The staff consulted with were aware of the new registered provider's presence in the home and were aware of the new organisational structure. The home was operating within the categories of care for which the home is currently registered.

Two requirements have been stated in relation to the unavailability of complaints records; and the notification of any serious injury in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. One recommendation has also been stated in regards to the need for the audits of patients' falls to be further developed. Weaknesses were also identified in the safe and effective domains.

Furthermore, it was concerning that four recommendations had not been met and have been stated for the third and final time. This was discussed with senior management within RQIA. Given that Burnview Healthcare Limited had only taken over management of the home on 5 April 2016; and the assurances that were given by the responsible person during and following the inspection, a decision was made to allow additional time to drive the required improvements. These matters will be followed up at a future inspection. If improvements are not identified at the next inspection, enforcement action will then be considered.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	*6	*10

The total number of requirements and recommendations above includes two requirements which have been stated for the second time; one recommendation which has been stated for the second time and four recommendations which have been stated for the third and final time. This was discussed with senior management in RQIA. Given that Burnview Healthcare Limited had only taken over management of the home on 5 April 2016; and the assurances that were given by the responsible person during and following the inspection, a decision was made to allow additional time to drive the required improvements. These matters will be followed up at a future inspection. If improvements are not identified at the next inspection, enforcement action will then be considered.

Details of the QIP within this report were discussed with Briege Kelly, acting manager and responsible person, as part of the inspection process. The timescales for completion commence from the date of inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 18 January 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. Refer to sections 4.3, 4.4 and 4.6 for further detail.

2.0 Service details

Registered organisation/registered person: Briege Agnes Kelly	**Registered manager:** Briege Agnes Kelly
Person in charge of the home at the time of inspection: Briege Agnes Kelly	**Date manager registered:** Acting – no application required
Categories of care: NH-I, NH-DE, RC-I, RC-MP(E) 22 Nursing : 11 residential. 1 identified patient in category NH-DE	**Number of registered places:** 33

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

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with five patients, three care staff, one registered nurse and one patient's representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- staff training records
- accident and incident records
- notifiable incidents
- audits
- records relating to adult safeguarding
- complaints records
- recruitment and selection records
- NMC and NISCC registration records
- staff induction, supervision and appraisal records
- staff, patients' and relatives' meetings
- staff, patients' and patients' representative questionnaires
- monthly monitoring reports in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- policies and procedures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 18 January 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. The QIP was validated at this inspection. Please refer to section 4.2 below.

4.2 Review of requirements and recommendations from the last care inspection dated 18 January 2016

Last care inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 15 (2) (b) **Stated:** First Time	The registered persons must ensure that risk assessments are completed for all patients and that the assessment of the patient's need is kept under review and revised on a regular basis. **An urgent actions record was issued.**	**Not Met**
	Action taken as confirmed during the inspection: A review of care records evidenced continued deficits in the completion of patients' risk assessments. This requirement was not met and has been stated for the second time.	
Requirement 2 **Ref**: Regulation 16 (1) **Stated:** First Time	The registered persons must ensure that comprehensive written care plans are prepared by registered nurses, in consultation with the patient and/or their representative. **An urgent actions record was issued.**	**Not Met**
	Action taken as confirmed during the inspection: A review of care records evidenced continued deficits in the completion of patients' care plans. This requirement was not met and has been stated for the second time.	

<table>
<tr><td rowspan="2">Requirement 3

Ref: Regulation 13 (1) (a)

Stated: First time</td><td>It is required that the home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients.

It is therefore required that where nursing needs are identified, care must be delivered to ensure individual patient needs are met, in particular, focus must be made on the maintenance of repositioning records for all patients who are assessed as being at high risk of pressure sore development.

An urgent actions record was issued.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of care records confirmed that patients were repositioned in line with their care plans.</td></tr>
<tr><td rowspan="2">Requirement 4

Ref: Regulation 19 (1) (a) Schedule 3 (3) (k)

Stated: First time</td><td>The registered person must ensure that record keeping is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance including:

• wound observation charts must be completed at the time wounds are being dressed
• dressing changes and observations of wound healing must be recorded in the progress notes
• care plans must be updated to reflect changes in wound treatment</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Discussion with the manager and staff confirmed that there were systems in place for the assessment and management of wounds. There was evidence that patients had been repositioned in line with their care plans and there were no wounds present on the day of the inspection.</td></tr>
</table>

<table>
<tr><th colspan="2">Last care inspection recommendations</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Recommendation 1

Ref: Standard 5.6

Stated: Second time</td><td>The registered manager should ensure that bowel function, reflective of the Bristol Stool Chart, should be recorded on admission as a baseline measurement and thereafter in the patients' daily progress records.</td><td rowspan="2">Partially Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Although there was evidence that the Bristol Stool Chart was referenced in the daily elimination records, there was no evidence that a baseline had been determined on admission. For example, continence assessments did not have the bowel section completed.

This recommendation was not met and has been stated for the third and final time following consultation with senior management in RQIA</td></tr>
<tr><td rowspan="2">Recommendation 2

Ref: Standard 32.1

Stated: First time</td><td>End of life arrangements for patients should be discussed and documented as appropriate and include patients' wishes in relation to their religious, spiritual and cultural need.

Arrangements for breaking bad news with patients and/or their representatives should also be discussed and documented as appropriate.

Carried forward from previous inspection.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A palliative care folder was reviewed. This evidenced that end of life arrangements had been discussed with patients' representatives; and advanced care plans were in place for each patient, as appropriate.</td></tr>
</table>

<table>
<tr>
<td rowspan="2">Recommendation 3

Ref: Standard 32.1

Stated: Second time</td>
<td>The following policies and guidance documents should be developed and made readily available to staff:

• a policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) Breaking Bad News
• a policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) Palliative Care Guidelines which should include the out of hours procedure for accessing specialist equipment and medication, referral procedure for specialist palliative care nurses and the management of shared rooms
• a policy on death and dying in line with current best practice, such as DHSSPSNI (2010) Living Matters: Dying Matters which should include the procedure for dealing with patients' belongings after a death</td>
<td rowspan="2">Partially Met</td>
</tr>
<tr>
<td>Action taken as confirmed during the inspection:
Although the above policies were in place, they required to be further developed in line with this recommendation.

Following the inspection, the responsible person confirmed that all new policies had been implemented in the home.

This recommendation has been stated for the third and final time following consultation with senior management in RQIA.</td>
</tr>
</table>

Recommendation 4 **Ref**: Standard 11 **Stated:** Second time	A record should be maintained to evidence the decision making process regarding the provision of activities and events for patients accommodated in the nursing home. This record should include the level of participation and enjoyment and the activities provided to patients who cannot or do not wish to partake in group activities.	**Partially Met**
	Action taken as confirmed during the inspection: Although there was evidence of a rolling programme of activities in the home, a review of records pertaining to the provision of activities did not evidence any level of participation or the activities provided to patients who were unable to participate in group activities. **This recommendation was not met and has been stated for the third and final time following consultation with senior management in RQIA.**	
Recommendation 5 **Ref**: Standard 4.1 **Stated:** Second time	The process for discussing care plans with patients and/or their representatives should be reviewed to ensure that they are facilitated to participate in all aspects of reviewing outcomes of care, on a regular basis.	**Not Met**
	Action taken as confirmed during the inspection: There was no evidence that patients and/or their representatives had been involved in the development of the care plans. **This recommendation was not met and has been stated for the third and final time following consultation with senior management in RQIA.**	

Recommendation 6 **Ref**: Standard 35.3 **Stated:** First time	The registered manager should ensure that there are robust systems in place to discharge, monitor and report on the delivery of nursing care, in particular, the auditing processes in relation to care records.	**Not Met**
	Action taken as confirmed during the inspection: A review of the care record audits confirmed that although records had been audited, no deficits were identified. Given the inspection findings in relation to record keeping we were not assured of the effectiveness of these audits. This recommendation was not met and has been stated for the second time.	

4.3 Is care safe?

Discussion with the manager confirmed that there were systems in place for the safe recruitment and selection of staff. However, a review of two personnel files evidenced that these had not been reviewed by the manager at the time of recruitment. The review evidenced that two references had been received from the applicant's most recent employers, prior to commencing employment. However, the records did not evidence that qualifications had been checked and there was no evidence that physical and mental health assessments had been completed.

Discussion with the manager and a review of the registration checks, confirmed that registered nurses' pin numbers had been checked with the Nursing and Midwifery Council (NMC) prior to commencing employment; and on a regular basis thereafter, to validate their registration status. However a review of the registration checks for care staff evidenced that seven care staff had not submitted an application to register with the Northern Ireland Social Care Council (NISCC). Following the inspection, the manager confirmed by email to RQIA, that applications for all care staff had been submitted to the Northern Ireland Social Care Council.

An enhanced criminal records check had been completed for one staff member; and although the AccessNI reference number had been recorded, there was no process for recording whether or not the AccessNI check was clear. It was also identified that one staff member, who was no longer in employment, had been employed without the AccessNI check having been completed. This was discussed with the manager, who demonstrated that a new recruitment and selection checking system was had been implemented. Following the inspection, the manager confirmed that an audit of personnel records had been completed and that AccessNI checks had been completed for all staff members. However, a recommendation has been stated to ensure that there are robust recruitment and selection processes in place, to address the deficits identified in this inspection.

One staff member consulted with confirmed that they had completed a three day induction; however the review of personnel files did not evidence that induction records had been maintained. A recommendation has been stated in this regard.

Staff consulted with stated that training had been provided in all mandatory areas. 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 safeguarding had been provided by the previous registered persons. A sampling of training records in relation to adult safeguarding evidenced that training had been completed. However, compliance in relation to other mandatory areas was difficult to ascertain as the training records had been retained by the previous registered providers. This was discussed with the manager, who stated that the training records would be sought from the previous registered providers and provided assurances that this information would be forwarded to RQIA. Assurances were also provided that all staff would be required to complete the training provided by Burnview Healthcare Limited. Dates of planned training were also submitted to RQIA. Although RQIA were satisfied on this occasion, compliance with training will be monitored during future inspections.

The 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 commencing 2 May 2016 to 8 May 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. However, five staff commented that they did not feel that there was sufficient staff on duty to meet the patients' needs. Staff were observed assisting patients in a timely and unhurried way and there was no impact on patient care observed, on the day of the inspection. Staff also commented that communication was not well maintained in the home and that care staff did not receive appropriate information regarding patients' needs, as they did not receive a shift handover report. Care staff commented that this meant they were 'working blind' and consistently had to ask the registered nurses for guidance when delivering care. This was discussed with the manager, who provided assurances that all care staff would be provided with a shift handover and that this would commence from the day of inspection.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The safeguarding records were reviewed and although there was evidence that incidents had been logged appropriately and reported in accordance with the regional safeguarding protocols and the home's policies and procedures, there was no evidence that these had been updated, to provide information on any investigation and/or outcome. For example, where a decision had been made in regards to a staff member, whose practice required to be supervised, there was no evidence regarding what the supervision entailed or a specified period in which this would be undertaken. This was discussed with the manager, who provided an update in regards to the status of the identified staff member. A recommendation has been stated in this regard.

A review of the accident and incident records confirmed that records were not maintained in sufficient detail. For example, the location of an accident was entered as 'Marina Care Home', rather than the location within the home, that the accident had occurred. Care management were not consistently informed of incidents/accidents. This was evident in one accident report, where 'bank holiday' was entered on the form. The care manager should have been informed on their next working day. The review of accident and incident records also identified that recommendations made by the Northern Health and Social Care Trust, in regards to a falls related serious adverse incident that occurred in August 2014, had not been embedded into practice. For example, the incident reports did not include detail regarding how patients were transferred from the floor, following a fall; and there was also no evidence that patients had a lying/standing blood pressure check completed on admission to the home. A requirement has been stated in this regard. Refer to section 4.6 for further detail.

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, well decorated and warm throughout. Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

The recruitment and selection processes should be reviewed to ensure that there are robust systems in place, to address the deficits identified in this inspection. A recommendation has been stated in this regard.

Records should be retained, to evidence that staff have completed an induction programme. A recommendation has been stated in this regard.

Records in relation to adult safeguarding must be maintained, to ensure that evidence of any investigation and/or outcome is recorded appropriately. A recommendation has been stated in this regard.

The management of patients' falls must be addressed, to ensure that recommendations made by local Health and Social Care Trusts, in response to serious adverse incidents, are disseminated to staff and the learning embedded into practice. A requirement has been stated in this regard.

Number of requirements	1	Number of recommendations:	3

4.4 Is care effective?

As discussed in section 4.2, two requirements have previously been stated regarding the completion of patients' risk assessments and care plans. The admission process should ensure that risk assessments are completed on the patients' admission to the home; and are then reviewed as required. Examples would include assessments in moving and handling, falls, wounds/pressure ulcers, nutrition, bed rails and choking.

However, a review of four patients' care records evidenced that patients' risk assessments were not consistently completed and had not been used to inform the care planning process. For example, one patient did not have any assessments completed until nine days after admission and only had one care plan developed on the day of inspection. Although consent had been obtained for the use of bedrails, a risk assessment and care plan had not been completed in this regard. The information included in the care plan regarding the patient's moving and handling requirements differed from that on the moving and handling assessment and staff consulted with stated they were not clear regarding the patient's moving and handling requirements. One patient had been prescribed nutritional supplements and a nutritional risk assessment had been completed; however the prescribed supplement had been out of stock for five days and there was no evidence that the registered nurses had followed up on this, to ensure that this was available to the patient. Following the inspection, the manager confirmed that the supplements that had been out of stock were available in the home. There was also no evidence that a Malnutrition Universal Screening Tool (MUST) have been completed or that the patients weight had been ascertained on admission. Although there was evidence that patients' weights had been monitored on a regular basis, this information was recorded in a weights book and had not been transcribed into the individual patients care records.

Another patient's care plan for mobility stated that the patient could mobilise with a zimmer frame, despite the patient being confined to bed. This patient had been prescribed transdermal opioid patch to manage their pain and this treatment was included in the patient's care plan. There was no evidence that a validated pain assessment tool was in use to assess the effectiveness of the prescribed treatment.

Supplementary care records, which detail personal care delivery, were reviewed and there was evidence that patients were repositioned in line with their care plan. A sampling of food and fluid intake charts confirmed that patients' fluid intake had been recorded. However, the 24 hour fluid intake received was not consistently totalled. There was also no evidence in the daily progress records reviewed that registered nursing staff had any oversight into the fluid intake of patients over a 24 hour period or had been taken to address any deficits. The review evidenced that where patients had not met their fluid target for the day, entries in the patients daily progress notes included 'fluids encouraged' or 'supplements taken'. A requirement has been made in this regard.

The inspection findings identified a need for the registered nurses to attend training and gain competency in the nursing process. A recommendation has been stated in this regard.

Discussion with the manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. Staff also confirmed that if they had any concerns, they could raise these with their line manager and/or the manager.

Discussion with the 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

Risk assessments must be completed for all patients, kept under review and revised on a regular basis. A requirement has been stated for the second time in this regard.

Written care plans must be prepared by registered nurses, in consultation with the patient and/or their representative. A requirement has been stated for the second time in this regard.

Patients' total fluid intake over a 24 hour period must be validated by registered nursing staff and recorded appropriately in the daily progress notes. A requirement has been stated in this regard.

Registered nurses should be provided with training in the nursing process, to ensure that competency is attained and that deficits identified in this inspection are addressed. A recommendation has been stated in this regard.

Number of requirements	3	Number of recommendations:	1

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with patients individually and with others in smaller groups, confirmed that they 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.

Menus were displayed clearly throughout the building and were correct on the day of inspection. We observed the lunch time meal in the dining room. We saw that 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 to maintain some level of independence as they ate their meal.

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. There was evidence of a variety of activities in the home and discussion with patients confirmed that they were given a choice with regards to what they wanted to participate in. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Discussion with the manager confirmed that plans were in place to formally obtain the views of patients and their representatives. Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. However, records in regards to complaints management were not available on the day of inspection. Refer to section 4.6 for further detail. From discussion with the 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 expressed gratitude for the 'kindness and empathy' displayed by staff, when their loved one was receiving end of life care. Another thank you card commented on how 'thoughtful and compassionate' the staff were, in delivering end of life care.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. Some comments received are detailed below:

Staff

'The change of ownership has not affected the care. I like it here'
'I am happy enough here. The changeover went very smoothly'
'The care is relatively good, I have no concerns'

Patients

'I am treated fairly well. The staff are very good really'
'It's very good here. I am well cared for'
'The staff know me very well'
'I am treated very well'
'The staff are pleasant enough'

Patients' representatives

'Everything is grand. We are kept well informed'

We also received written feedback from one relative who commented that their relative did not receive their night-time medication until late. This was communicated to the manager to address.

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?

The responsible person was managing the home in an acting capacity, following recent management changes to the home. RQIA had been notified appropriately and advice was given regarding the need to inform RQIA of any proposed management changes in the absence of a registered manager.

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. Staff consulted were able to describe their roles and responsibilities and there was a system in place to identify the person in charge of the home, in the absence of the manager.

Discussion with the 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. Staff were able to access the home's current policies and procedures. The manager confirmed that the majority of policies and procedures for the home were in the process of being reviewed, following the change in ownership.

Discussion with the manager confirmed that the complaints records were not available at the time of inspection. Therefore, we were unable to evidence 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. A requirement has been stated in this regard.

Discussion with the manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. However, as there had been a recent change in management, the manager was unable to identify all the audits that would have ordinarily been completed. The audits of accidents and incidents; and the audits of care records were reviewed.

There was no evidence that an audit of patients' falls had been completed since 30 September 2015 and there was no evidence that the auditing process identified patterns or trends, in order to reduce the risk of further falls. A recommendation has been stated in this regard. It was also concerning that recommendations made by the Northern Health and Social Care Trust, in regards to a serious adverse incident that occurred in August 2014, had not been embedded into practice. Refer to section 4.3 for further detail.

The review of the accident and incident reports also identified that an incident, where a patient had sustained a serious injury, had not been reported to RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. This was discussed with the manager and a requirement has been stated in this regard.

The audits of care records identified that patients' care records had been audited on a regular basis. However, there was little evidence that deficits had been identified. Given that two requirements have been stated for the second time, in regards to patients risk assessments and care planning, we were not assured about the effectiveness of the audits. As discussed in section 4.2, a recommendation has been stated for the second time in this regard.

Discussion with the manager and review of records evidenced that Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, monitoring visits were completed in accordance with the regulations and/or care standards and copies of the reports were available for patients, their representatives, staff and trust representatives.

Areas for improvement

The registered manager must ensure that complaints records are available for inspection at all times. A requirement has been stated in this regard.

Falls should be reviewed and analysed on a monthly basis to identify any patterns or trends and appropriate action taken. A recommendation has been stated in this regard.

RQIA must be notified of the occurrence of any serious injury sustained in the home. A requirement has been stated in this regard.

Given that two requirements have been stated for the second time; one recommendation has been stated for the second time and four recommendations for the third and final time, this would indicate the need for more robust management and leadership in the home

Number of requirements	**2**	**Number of recommendations**:	**1**

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Briege Kelly, Acting 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 person/manager to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

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

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s 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 manager/registered person

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

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and 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 person/manager 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 person/manager 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 15 (2) (b) **Stated:** Second time **To be completed by:** 08 July 2016	The registered persons must ensure that risk assessments are completed for all patients and that the assessment of the patient's need is kept under review and revised on a regular basis. **Ref: Sections 4.2 and 4.4**
	Response by registered person detailing the actions taken: All risk assessments are completed for all patients and reviewed monthly or move often if necessary.
Requirement 2 **Ref:** Regulation 16 (1) **Stated:** Second time **To be completed by:** 08 July 2016	The registered persons must ensure that comprehensive written care plans are prepared by registered nurses, in consultation with the patient and/or their representative. **Ref: Sections 4.2 and 4.4**
	Response by registered person detailing the actions taken: All written careplans are now prepared in consulation with the resident/representative.
Requirement 3 **Ref**: Regulation 12 (1) (a)(b) **Stated:** First time **To be completed by:** 08 July 2016	The registered persons must ensure that the treatment provided to each patient meets their individual needs and reflects current best practice. This relates specifically to the arrangements for managing accidents and incidents that occur in the home. **Ref: Section 4.3**
	Response by registered person detailing the actions taken: As per the new operators policies/procedures all incidents/accidents are recorded and audited monthly.

Requirement 4 **Ref**: Regulation 13 (1)(a) **Stated:** First time **To be completed by:** 08 July 2016	The registered persons must ensure that the home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. It is therefore required that where nursing needs are identified care must be delivered to ensure individual patient needs are met. This refers particularly to the management arrangements of patients who are at risk of dehydration and require their total fluid intake to be monitored. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: As per the new operators policy/procedures all daily fluid intake is recorded and totalled every 24 hours.

Requirement 5 **Ref**: Regulation 19 (3)(b) **Stated:** First time **To be completed by:** 08 July 2016	The registered persons must ensure that complaints records are available for inspection at all times. **Ref: Section 4.6**
	Response by registered person detailing the actions taken: As per the new operators a new complaints register has been implemented to include a monthly audit of accidents.
Requirement 6 **Ref**: Regulation 30 (1) (c) **Stated:** First time **To be completed by:** 08 July 2016	The registered persons must ensure that RQIA are notified appropriately, in regards to any serious injury that occurs in the home. **Ref: Section 4.6**
	Response by registered person detailing the actions taken: All nurses have been made aware of our policy of reporting all incidents/injurys to the Home Manager who will notify RQIA.
Recommendations	
Recommendation 1 **Ref**: Standard 5.6 **Stated: <u>Third and final</u> time** **To be completed by:** 08 July 2016	The registered manager should ensure that bowel function, reflective of the Bristol Stool Chart, should be recorded on admission as a baseline measurement and thereafter in the patients' daily progress records.
	Response by registered person detailing the actions taken: As per the new operators the Activities of Living has an area to be completed on admission on what Bristol Type and recorded thereafter in daily progress notes in BO column.

Recommendation 2 **Ref**: Standard 32.1 **Stated: Third and final time** **To be completed by:** 08 July 2016	The following policies and guidance documents should be developed and made readily available to staff: • a policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.* • a policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines which* should include the out of hours procedure for accessing specialist equipment and medication, referral procedure for specialist palliative care nurses and the management of shared rooms. a policy on death and dying in line with current best practice, such as DHSSPSNI (2010) *Living Matters: Dying Matters* which should include the procedure for dealing with patients' belongings after a death.
	Response by registered person detailing the actions taken: As per new operators the above policies are in place.

Recommendation 3 **Ref**: Standard 11 **Stated: Third and final time** **To be completed by:** 08 July 2016	A record should be maintained to evidence the decision making process regarding the provision of activities and events for patients accommodated in the nursing home. This record should include the level of participation and enjoyment and the activities provided to patients who cannot or do not wish to partake in group activities.
	Response by registered person detailing the actions taken: All residents that participate in activities either one to one or in group sessions have individual records in thier daily records.
Recommendation 4 **Ref**: Standard 4.1 **Stated: Third and final time** **To be completed by:** 08 July 2016	The process for discussing care plans with patients and/or their representatives should be reviewed to ensure that they are facilitated to participate in all aspects of reviewing outcomes of care, on a regular basis.
	Response by registered person detailing the actions taken: All our care plans are devised in partnership with the patient and their representative and are person centred.
Recommendation 5 **Ref**: Standard 35.3 **Stated:** Second time **To be completed by:** 08 July 2016	The registered manager should ensure that there are robust systems in place to discharge, monitor and report on the delivery of nursing care, in particular, the auditing processes in relation to care records.
	Response by registered person detailing the actions taken: A monthly audit is completed of all care records.

Recommendation 6 **Ref**: Standard 19.4 **Stated:** First time **To be completed by:** 08 July 2016	The registered persons should ensure that the recruitment and selection processes are reviewed to ensure that there are robust systems in place, to address the deficits identified in this inspection.
	Response by registered person detailing the actions taken: As per the new operators all recruitment is in line with our recruitment policies which are fully robust.
Recommendation 7 **Ref**: Standard 19.4 **Stated:** First time **To be completed by:** 08 July 2016	The registered persons should ensure that records are retained, to evidence that staff have completed an induction programme.
	Response by registered person detailing the actions taken: As per new operators our induction programme is completed on 1st day of commencing employment and again 6 weeks after start date.

Recommendation 8 **Ref**: Standard 19.4 **Stated:** First time **To be completed by:** 08 July 2016	The registered persons should ensure that records in relation to adult safeguarding are maintained, to ensure that evidence of any investigation and/or outcome is recorded appropriately.
	Response by registered person detailing the actions taken: As per new operators records relating to safeguarding are maintained within a file in Home Managers office.
Recommendation 9 **Ref**: Standard 19.4 **Stated:** First time **To be completed by:** 08 July 2016	The registered persons should ensure that registered nurses, are provided with training, as appropriate, on the nursing process. Evidence of the training provided, in whatever format, should be retained in the home. **Ref: Section 4.6**
	Response by registered person detailing the actions taken: All nurses have had training on the nursing process on Monday 27th June 2016.

Recommendation 10 **Ref**: Standard 22.10 **Stated:** First time	The registered persons should ensure that falls are reviewed and analysed on a monthly basis to identify any patterns or trends and appropriate action taken. **Ref: Section 4.6**
To be completed by: 08 July 2016	**Response by registered person detailing the actions taken:** As per the new operators a fall analysed file is set up to include recording of date and area of the home where the fall took place and a monthly audit completed.

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

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