Unannounced Care Inspection Report
27 October 2016

Ratheane Private Nursing Home

Type of Service: Nursing Home
Address: 58 Mountsandel Road, Coleraine BT52 1JF
Tel no: 02870344299
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Ratheane took place on 27 October 2016 from 09.15 to 17.30 hours.

The inspection sought to assess progress with any issues raised during and since the last inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. A general inspection of the home confirmed that the premises and grounds were well maintained.

Areas for improvement were identified in relation to the management of short-notice absenteeism; the completion of competency and capability assessments, for registered nurses who have the responsibility of being in charge of the home, in the absence of the registered manager; and in the supervision arrangements of the dining room. Three recommendations have been made in this domain.

Is care effective?

We examined the systems in place to promote effective communication between staff, patients and relatives and were assured that these systems were effective. Patients and staff were of the opinion that the care delivered provided positive outcomes. We examined the systems and processes in place to ensure that that the outcome of care delivery was positive for patients. A review of care records confirmed that a range of risk assessments were completed. Care plans were created to prescribe care. There were arrangements in place to monitor and review the effectiveness of care delivery.

Deficits were identified in the management of urinary catheters. Areas for improvement were also identified in relation to wound care records; care plans for infections; and patient/representative involvement in care plan development. One requirement and three recommendations have been made.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully. Staff were also observed to be taking time to reassure patients as was required from time to time. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding issues affecting them. Patients spoken with commented positively in regard to the care they received.

One area for improvement was identified in relation to the need for social care plans to be developed, to ensure that patients' social care needs are met individually. One recommendation has been made.

Is the service well led?

There was a clear organisational structure evidenced within Ratheane and staff were aware of their roles and responsibilities. A review of care observations confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide. There was evidence of good leadership in the home and effective governance arrangements. Staff spoken with were knowledgeable regarding the line management structure and who they would escalate any issues or concerns to.

Areas for improvement were identified in relation to the recording of the name of the person in charge of the home, in the absence of the registered manager; and in relation to the auditing processes of care records and personal care records. Two recommendations have been made.

The term 'patients' is used to describe those living in Ratheane which provides both nursing and residential care.

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	1	*10

* The total number of requirements and recommendations above includes one recommendation that has been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Araceli Flores, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 01 September 2016.

No requirements or recommendations were made during this inspection.

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

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Mary Macklin Brian Macklin	**Registered manager:** Araceli Flores
Person in charge of the home at the time of inspection: Araceli Flores	**Date manager registered:** 2 September 2014
Categories of care: RC-I, RC-PH, RC-PH(E), NH-I, NH-PH, NH-PH(E) Up to a maximum of 16 Residential beds.	**Number of registered places:** 79

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. Questionnaires were distributed to patients, relatives and staff. We also met with twelve patients, six care staff, two registered nurses, and six patients' representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- four patient care records
- staff training records for 2015/2016
- accident and incident records
- audits in relation to falls
- records relating to adult safeguarding
- one staff personnel record
- complaints records
- staff induction and supervision records.
- records pertaining to NMC and NISCC registration checks
- minutes of staff meetings held since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 01 September 2016

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 01 September 2016. Enforcement action did not result from the findings of this inspection. No requirements or recommendations were made during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 12 October 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 39.8 **Stated:** First time	It is recommended that staff are made aware of the regional guidance and minimum standard in relation to communicating effectively and in relation to palliative and end of life care.	**Met**
	Action taken as confirmed during the inspection: There was sufficient evidence on the day of the inspection to evidence that the staff were aware of the above guidelines or were aware of where to access this information. Staff had attended training on palliative care and the home had also participated in an electronic forum in relation to palliative care and quality improvement.	
Recommendation 2 **Ref**: Standard 4.9 **Stated:** First time	It is recommended that nursing and care staff are aware of the requirements for record keeping in relation to care charts.	**Not Met**
	Action taken as confirmed during the inspection: Given that deficits were identified during this inspection, in relation to the completion of repositioning records, this recommendation was not met and has been stated for the second time. Refer to section 4.4 for further detail.	

Recommendation 3 **Ref**: Standard 5.8 **Stated:** First time	It is recommended that all patient information is held in a confidential manner to safeguard the privacy and dignity of patients.	**Met**
	Action taken as confirmed during the inspection: Supplementary care records were maintained in each patients' individual bedroom.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. The registered manager stated that there were some staff members who were on long term sick leave. Although the registered manager stated that absenteeism was not problematic, a review of the staffing rota for the week commencing October 2016 evidenced that the planned staffing levels had not been consistently adhered to, due to short notice sick calls.

Staff shortages had occurred on two day-shifts and on one night-shift, in the seven day period reviewed. The registered manager confirmed that there had not been any adverse effects on patients' care needs on the identified days and records were maintained of the efforts made to cover the shifts. Although the patients and their representatives spoken with, did not raise any concerns regarding staffing levels or having their needs met in a timely manner, two written comments were provided on the returned questionnaires in relation to the staffing levels.

Staff spoken with described that they would forfeit their breaks to make sure the patients' needs were met and one registered nurse stated that they had to come to the home on their day off, to ensure that their care records were updated. Further comment, in relation to the staffing arrangements of the home are detailed in section 4.6. A recommendation has been made in this regard.

Staff spoken with confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

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

Consultation with the registered manager and staff confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision and a matrix had been developed to enable the registered manager to have oversight of when annual appraisals were due to be held.

Although, the registered manager explained that competency and capability assessments were completed with all registered nurses who were given the responsibility of being in charge of the home, the review of records confirmed that these had not been consistently completed for all registered nurses. A recommendation has been made in this regard.

A review of the staff training records and discussion with staff, confirmed that training had been provided in all mandatory areas and this was kept up to date. A training matrix had been developed which provided clear information to enable the registered manager to review staff training and see when updates/refresher training were due. A review of staff training records confirmed that the majority of staff had completed 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. Observation of the delivery of care evidenced that training had been embedded into practice.

There were safe systems in place for the recruitment and selection of staff. A review of one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Where nurses and carers were employed, their PIN numbers were checked, on a regular basis, with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), to ensure that their registrations were valid. Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI and a record was maintained which included the reference number and date received.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adults safeguarding. There had been three safeguarding investigations reported since the last care inspection; two of which were ongoing and will be followed up during future inspection. A review of documentation confirmed that the safeguarding concerns had been managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

Validated risk assessments were completed as part of the admission process and were reviewed as required. Although the risk assessments generally informed the care planning process, weaknesses were identified in the completion of care records. Refer to section 4.4 for further detail.

The inspector observed there was no staff presence in the dining room for approximately ten minutes, whilst the patients were eating their meals. When this was raised to staff, they explained that one care staff would normally be assigned to supervise the dining room. A recommendation has been made to ensure that there are adequate numbers of staff present when meals are served to ensure that required assistance is provided; and that risks are managed appropriately.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were consistently completed following each incident, care management and patients' representatives were notified appropriately. RQIA had been notified appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

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. The majority of patients' bedrooms were personalised with photographs, pictures and personal items.

Infection prevention and control measures were adhered to and equipment was stored appropriately. The armrest of one specialist armchair was torn, exposing the foam inside. The registered manager explained that this armchair was owned by the local health and social care trust and that it was waiting to be repaired. Advice was given in relation to temporarily covering the tear, to ensure that the chair could be effectively cleaned. No other concerns were identified in relation to the other furnishings in the home.

Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

A recommendation has been made that the short-notice absenteeism is proactively addressed, to ensure that the staff are supported to deliver safe and effective care.

A recommendation has been made that competency and capability assessments are completed on an annual basis, for registered nurses who have the responsibility of being in charge of the home, in the absence of the registered manager.

A recommendation has been made to ensure that there are adequate numbers of staff present when meals are served to ensure that required assistance is provided; and that risks are managed appropriately.

Number of requirements	0	**Number of recommendations**	3

4.4 Is care effective?

A review of four patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. Although there was evidence that the risk assessments and care plans were generally updated on a regular basis, the risk assessments did not consistently inform the care planning process. For example, where a patient had a wound, there was evidence that a wound assessment had been updated every time the wound dressing had been changed. Although there was evidence that recommendations made by the tissue viability nurse specialist (TVN), had been adhered to, the care plan for the management of the wound did not specify the prescribed care in relation to the management of the wound, until three weeks after the patient's admission.

There was also no evidence that wound care records were supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines. A recommendation has been made in this regard.

One identified patient had an indwelling urinary catheter in place. The review of this patient's record identified that although there was a care plan in place, this was not sufficiently detailed to direct nursing care in the management of the catheter. For example, the care plan did not specify the actions to be taken, in the event that the catheter was to bypass or the daily catheter care of the urethral site. The care record also did not accurately reflect when the patient's catheter had last been changed because the form which was used to record the dates the catheter was last changed had not been completed every time the catheter had been changed. Although, the registered nurse explained that the unit diary was utilised to communicate when scheduled catheter changes were due, a review of the unit diary did not evidence this. This meant that there was evidence that the urinary catheter had not been changed in over four and a half months, when it should have been changed every three months. A requirement has been made in this regard.

The review of care records also identified that care plans were not developed in response to patients receiving antibiotic treatment for acute infections. A recommendation has been made in this regard.

Although there was a system in place to ascertain input from patients and/or their representatives, if appropriate, in the care planning process, the review of the care records evidenced that this was not consistently sought. A recommendation has been made in this regard.

As discussed in section 4.2, a review of the personal care records evidenced that records were not consistently maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that the staff did not consistently complete the skin section. One patient, who was observed to have changed position throughout the inspection, did not have any repositioning changes recorded for the whole day. Deficits were also identified in the recording of weekly showers or baths, which meant that we were not assured of the accuracy of the records. A recommendation that was previously made in this regard has been stated for the second time during this inspection.

There was some evidence of good practice in relation to the care records. Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day. Referrals were made to relevant health care professionals, such as GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of the patient's poor nutritional intake.

Patients who were identified as requiring a modified diet had the relevant choke risk and malnutrition risk assessments completed and patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective.

Discussion with the registered 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. The most recent staff meeting was held on 25 October 2016. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities.

Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager. Information on advocacy services was not available to patients. Advocates can represent the views for patients/patients' representatives who are unable or not confident in expressing their wishes. However, registered nursing staff confirmed that advocacy services could be accessed via the patients' care management process, if required.

Discussion with the registered manager and review of records evidenced that patients' and/or relatives' meetings had not been held formally, due to poor attendance historically. The registered manager and regional manager explained that they were endeavouring to make the planned meetings more of a social occasion, to encourage attendance.

The annual quality assurance report evidenced that patients' and relatives' views had been sought and comments cards were also available in the foyer. The complaints procedure was provided to all patients in the service user guide. All patients and patients' representatives consulted with expressed their confidence in raising concerns with the home's staff/ management.

Areas for improvement

A recommendation has been made that the care records include the prescribed regimen for dressing changes. Care records should also be supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines

A requirement has been made that the care and treatment provided meets the patients' individual assessed needs. This relates particularly to the care of patients with indwelling urinary catheters.

A recommendation has been made that care plans are developed, in response to acute infections, whereby patients have been prescribed antibiotics

A recommendation has been made that care plans are developed in partnership with the patients and/or their representatives.

Number of requirements	1	**Number of recommendations**	3

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect.

Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care.

Patients were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

We observed the lunch time meal in the dining room. The atmosphere was quiet and tranquil. Tables were set with in advance of the patients entering the room and discussion with the staff confirmed that there was sufficient adaptive cutlery and plates, if required. Although the menu was not displayed in the dining room, discussion with the registered manager and head cook evidenced that new menus were in the process of being developed. The lunch served in both units appeared very appetising and patients spoken with stated that it was always very nice.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Although staff supported patients to maintain friendships and socialise within the home, social care plans were not in place to provide information to staff to ensure that patients' social care needs were met individually. A recommendation has been made in this regard.

Planned activities were displayed on a TV screen near the front entrance and included hairdressing and barbering services; church services and Sunday singing; a Halloween fancy dress party; and games and quizzes. The Spring/Summer newsletter for the home was reviewed which included many photographs of the patients, seeming to enjoy the various activities they had been involved in.

Care plans detailed the 'do not attempt resuscitation' (DNAR) directive were in place for patients, as required. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner.

During the inspection, we met with twelve patients, six care staff, two registered nurses, and six patients' representatives. Some comments received are detailed below:

Staff

"I was highly surprised at the standard of care, when I came here".
"The care here is second to none, there is nothing I would not do for the patients here".
"The care is very good, they are all well looked after".
"I would have no hesitation putting my own mother in here".
"It is alright here. The patients' needs are met to the best of our ability".
"I am quite happy".

Patients

"You couldn't get better, it is excellent and they do a marvellous job".
"It is all very good, I would never need to complain".
"I get everything I need, wouldn't have a bad word against them".
"The staff are number one, in my book".
"They are absolutely marvellous".
"They are very good to me".
"They treat me alright; I get a choice of a male carer, because that is what I want".
A1, number I am getting on very well".

One patient stated to the inspector that the home could be short staffed at times.

Patients' representatives

"'On occasion, we have thought that (our relative) was perhaps not turned as often as they should have been, but it is generally not a problem".
"It's ok here".
"We are very pleased, they are very good to her here".
"Can't fault it".
"It is great, they are all very good, kind and considerate".

One patients' representative stated to the inspector that the staff are sometimes under pressure.

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. Eight staff, five patients and four relatives had returned their questionnaires, within the timeframe for inclusion in this report. Comments and outcomes were as follows:

Patients: respondents indicated that they were either 'satisfied' or 'very satisfied' that the home was delivering safe, effective, compassionate and well led care. In response to the question on whether or not patients' felt that their needs were met promptly, one written comment received indicated 'no' and stated that 'there (wasn't) enough equipment for the staff'.

Relatives: respondents indicated that they were either 'satisfied' or 'very satisfied' that the home was delivering safe, effective, compassionate and well led care. In response to the question on whether or not relatives' were satisfied that staff had enough time to care for their loved one, two respondents indicated 'no'.

Written comments included 'Staff do not always have enough time to provide care needed, whilst the care given is very good, perhaps more staff are required, therefore things won't be rushed'. Another comment related to the 'lack of cover' when staff were short staffed. Refer to section 4.3 for further detail.

One patient's representative provided written comment in relation to the manner in which their complaint had been dealt with. Although the patient's representative indicated that they were satisfied that the registered manager had addressed their concerns, they provided negative written comment in relation to senior management involvement in the complaint. Following the inspection this matter was communicated to the responsible person to address.

Staff respondents indicated that they were either 'satisfied' or 'very satisfied' that the home was delivering safe, effective, compassionate and well led care In response to the question on whether or not there was sufficient staff to meet the needs of the patients, four staff indicated 'no'. Comments recorded included, "only when somebody rings in sick and we can't get cover' 'need more staff', 'not enough staff'.

Areas for improvement

A recommendation has been made that social care plans are developed, to ensure that patients' social care needs were met individually.

Number of requirements	0	Number of recommendations	1

4.6 Is the service well led?

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

The registered manager explained that the deputy manager's post was currently vacant and that the post had been advertised. There was a system in place to record the name of the person in charge of the home, in the absence of the registered manager; however, a review of the records evidenced that this had not been consistently completed. A recommendation has been made in this regard.

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

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

Patients were aware of who the registered manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. All those consulted with during the inspection, described the manager's leadership style in positive terms and described her as being 'approachable'.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails.

An audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous inspection, confirmed that these were appropriately managed.

Given that deficits were identified in the care records, we were not assured about the effectiveness of the audits. A recommendation has been made in this regard.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

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

Areas for improvement

A recommendation has been made that a record is maintained of the name of the person in charge of the home, in the absence of the registered manager

A recommendation has been made that the system of auditing care records is evidentially reviewed to ensure that the deficits identified in this inspection are continually monitored. This refers specifically to the auditing of patients' risk assessments and care plans; and the auditing of personal care records.

Number of requirements	0	**Number of recommendations**	2

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Araceli Flores, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

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

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

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 12 (1) (a) **Stated:** First time **To be completed by:** 24 December 2016	The registered persons must ensure that the care and treatment provided meets the patients' individual assessed needs. This relates particularly to the care of patients with indwelling urinary catheters. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Care plans have been updated and clear instructions on catheter care have been identified including date for cathether change
Recommendations	
Recommendation 1 **Ref**: Standard 4.9 **Stated:** Second time **To be completed by:** 24 December 2016	It is recommended that nursing and care staff are aware of the requirements for record keeping in relation to care charts. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Meeting with care staff has been held and sheet with all documentation they need to fill has been provided to them. Checks are carried out daily by Staff nurse and senior care assistants.
Recommendation 2 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 24 December 2016	The registered persons should ensure that short-notice absenteeism is proactively addressed, to ensure that the staff are supported to deliver safe and effective care. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Record sheet is in place for staff who have been contacted to cover shifts if staff ring in at short notice. Relief staff have been appointed to assist in covering shifts.
Recommendation 3 **Ref**: Standard 39 **Stated:** First time **To be completed by:** 24 December 2016	The registered persons should ensure that competency and capability assessments are completed on an annual basis, for registered nurses who have the responsibility of being in charge of the home, in the absence of the registered manager. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The competency and capability assessment for nurse incharge has been completed and will be reviewed annually.

Recommendation 4 **Ref**: Standard 12.11 **Stated:** First time **To be completed by:** 24 December 2016	The registered persons should ensure that there are adequate numbers of staff present when meals are served to ensure that required assistance is provided; and that risks are managed appropriately. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Staff members is allocated to dining room for all meals to ensure adequate supervision and assistance is provided.
Recommendation 5 **Ref**: Standard 23 **Stated:** First time **To be completed by:** 24 December 2016	The registered persons should ensure that the care plans include the prescribed regimen for dressing changes. Care records should also be supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Care plans have been reviewed and prescribed regimen for dressings are included in careplans - photographs have been taken where patients were able to consent.
Recommendation 6 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 24 December 2016	The registered persons should ensure that care plans are developed, in response to acute infections, whereby patients have been prescribed antibiotics **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Care plans have been put in place for patients with infection and whereby antibiotics have been prescribed.
Recommendation 7 **Ref**: Standard 4.5 **Stated:** First time **To be completed by:** 24 December 2016	A recommendation has been made that care plans are developed in partnership with the patients and/or their representatives. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: A Patient/Family consultation form is in place for all patients to sign to evidence that they have been involved in the planning of their relatives care.

Recommendation 8 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 24 December 2016	The registered persons should ensure that social care plans are developed, to ensure that patients' social care needs were met individually. **Ref: Section 4.5**
	Response by registered provider detailing the actions taken: Social care plans are in place. Life story books are now in placefor all patients who wished to complete them.
Recommendation 9 **Ref**: Standard 41.7 **Stated:** First time **To be completed by:** 24 December 2016	The registered persons should ensure that a record is maintained of the name of the person in charge of the home, in the absence of the registered manager **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: Registered manager highlights in the nurses rota the person incharge of the home on every shift.
Recommendation 10 **Ref**: Standard 35.4 **Stated:** First time **To be completed by:** 24 December 2016	The registered persons should ensure that the system for auditing care records is evidentially reviewed to ensure that the deficits identified in this inspection are continually monitored. This refers specifically to the auditing of patients' risk assessments and care plans; and the auditing of personal care records. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: A robust audit of all files is now underway for all patients care plans and risk assessments. Action plans will be drafted and actioned by relevant staff to ensure compliance.

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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