Unannounced Care Inspection Report
7 and 8 November 2018

Massereene Manor

Type of Service: Nursing Home (NH)
Address: 6 Steeple Road, Antrim, BT41 1AF
Tel No: 028 9448 7779
Inspector: Lyn Buckley

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care and residential care for up to 74 persons.

3.0 Service details

Organisation/Registered Provider: Massereene Manor **Responsible Individuals:** Mrs Janet Montgomery Mrs Naomi Carey	**Registered Manager:** See below
Person in charge at the time of inspection: Mrs Anne McCracken - Manager	**Date manager registered:** Mrs Anne McCracken – application not yet submitted.
Categories of care: Nursing Home (NH) DE – Dementia. MP – Mental disorder excluding learning disability or dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. LD – Learning disability. LD(E) – Learning disability – over 65 years. Residential Care (RC) DE – Dementia.	**Number of registered places:** 75 comprising: 61 – NH - DE, MP and MP(E) 10 – RC – DE 3 – NH - LD and LD(E) The home is also approved to provide care on a day basis to four persons.

4.0 Inspection summary

An unannounced inspection took place on 7 November 2018 from 06:25 to 15:30 hours and on 8 November 2018 from 09:40 to 16:00 hours.

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.

The term 'patient' is used to describe those living in Massereene Manor which provides both nursing and residential care.

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to day to day management of care delivery and effective communication between staff and management; the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives.

Areas requiring improvement were identified in relation to infection prevention and control practices, management and training regarding COSHH, post falls reviews and audits, the

completion of induction records for agency staff, nurse in charge competency and capability assessments and review of the current governance system.

Patients spoken with described that living in the home was a positive experience. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	*4	*8

*The total number of areas for improvement includes two regulations which have been stated for a second time, two standards stated for a second time; and one standard which has been carried forward for review at the next care inspection.

Details of the Quality Improvement Plan (QIP) were discussed with Naomi Carey, Responsible Individual, and Anne McCracken, 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.

4.2 Action/enforcement taken following the most recent inspection dated 1 November 2018

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 1 November 2018. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection we spoke with 12 patients individually and with others in small groups, three patients' relatives and 21 staff. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. Ten patients' questionnaires and ten patients' relatives/representatives questionnaires were left for distribution. A poster was provided for staff

inviting them to provide feedback to RQIA on-line. The registered manager was also provided with 'Have we missed you' cards which were then placed in a prominent position to allow patients and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision.

A poster informing visitors to the home that an inspection was being conducted was displayed in the foyer of each building.

The following records were examined during the inspection:

- duty rota for all staff from 7 October to 3 November 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records for 2018
- incident and accident records from 6 August 2018
- six patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits
- complaints record
- compliments received
- RQIA registration certificate.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 1 November 2018

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 1 November 2018. The completed QIP, when it is returned, will be reviewed and approved by the pharmacist inspector. This QIP will then be validated by the pharmacist inspector at the next medicines management inspection.

6.2 Review of areas for improvement from the last care inspection dated 4 August 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 (4) **Stated:** First time	The registered person shall ensure that the responsibility of being the nurse in charge of the home, in the absence of the registered manager, is delegated appropriately on night duty to ensure the delivery of safe and effective care.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and staff and review of duty rotas evidenced that this area for improvement, as stated, had been met.	
Area for improvement 2 **Ref:** Regulation 13 (1) **Stated:** First time .	The registered person shall ensure that the nurse in charge of the nursing home, in the absence of the registered manager, can make contact with the registered persons and/or senior managers as required. For example, outside normal working hours to communicated serious concerns or in an emergency.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and nursing staff and review of records evidenced that this area for improvement had been met.	
Area for improvement 3 **Ref:** Regulation 13 (7) **Stated:** First time .	The registered person shall ensure that staff adhere to good practice in relation to the use of personal protective equipment (PPE) such as aprons and gloves, the storage in areas where there is a toilet and the cleaning of contaminated toilets outside usual housekeeping hours.	**Partially met**
	Action taken as confirmed during the inspection: Discussion with staff confirmed that training in the use of PPE had been delivered as part of infection prevention and control training. Staff were also aware that outside the usual	

	housekeeping hours that nursing and care staff were responsible for cleaning contaminated patient areas and equipment. However, we observed that some staff continued to wear PPE inappropriately and hoists, slings, patient chairs and other items continued to be stored in bathrooms where there was a toilet. Refer to section 6.4 for details. This area for improvement is stated for a second time	
Area for improvement 4 **Ref:** Regulation 14 (2) **Stated:** First time	The registered person shall ensure that cleaning chemicals are securely stored in accordance with COSHH requirements.	**Not met**
	Action taken as confirmed during the inspection: Observations evidenced that this area for improvement had not been met. Refer to section 6.4 for details. This area for improvement is stated for a second time.	
Area for improvement 5 **Ref:** Regulation 13 (1) **Stated:** First time	The registered person shall ensure that any medicine which is kept in the nursing home is stored in a secure place.	**Met**
	Action taken as confirmed during the inspection: Observations evidenced that this area for improvement had been met.	
Area for improvement 6 **Ref:** Regulation 27 (4) (c) **Stated:** First time	The registered person shall ensure that fire escape routes and fire exit doors are maintained free from obstruction at all times in accordance with fire safety regulations.	**Met**
	Action taken as confirmed during the inspection: Observations evidenced that this area for improvement had been met.	

Area for improvement 7 **Ref:** Regulation 27 (4) (e) and (f) **Stated:** First time	The registered person shall ensure that all staff can demonstrate the action to be taken in the event of a fire alarm sounding.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff evidenced that this area for improvement had been met.	
Area for improvement 8 **Ref:** Regulation 14 2 (c) **Stated:** First time .	The registered person shall ensure that the nursing home is secured, particularly after the usual working hours, to avoid unwanted intruders and to maintain the safety of patients and staff.	**Met**
	Action taken as confirmed during the inspection: Observations and discussion with staff evidenced that this area for improvement had been met.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 22 **Stated:** First time .	The registered person shall ensure that patients' care plans and risk assessments are updated post falls.	**Not met**
	Action taken as confirmed during the inspection: Review of four patients care records evidenced that two patients' falls risk assessment and associated care plans had not been reviewed following a fall. Nursing staff spoken with were aware that this should be completed. Refer to Section 6.4 for details. This area for improvement has not been met and is stated for a second time.	
Area for improvement 2 **Ref**: Standard 46 **Stated:** First time	The registered person shall ensure infection prevention and control training is provided for all housekeeping staff and that the use of PPE is monitored and poor practice challenged in keeping with best practice guidance.	**Not met**
	Action taken as confirmed during the inspection: Observations evidenced that housekeeping staff and care staff did not use PPE appropriately despite evidence of the delivery of IPC training in its' use. Refer to section 6.4 for	

	details. This area for improvement has not been met and is subsumed in to an area for improvement under regulation.	
Area for improvement 3 **Ref**: Standard 44 **Stated:** First time	The registered person shall ensure that the covering of the internal extractor fans and the identified handrail are reviewed and replaced/repaired as required.	**Met**
	Action taken as confirmed during the inspection: Observations evidenced that this area for improvement had been met.	
Area for improvement 4 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that patients' care plans regarding wound care and the management of behaviours that challenge accurately reflect the prescribed care and treatment and/or recommendations made by other healthcare professionals.	**Partially Met**
	Action taken as confirmed during the inspection: Review of patient care plans evidenced that the management of behaviours that challenged accurately reflected patients assessed needs. However, care plans relating to wound care did not. Refer to section 6.5 for details. This area for improvement is partially met and the element relating to wound care is stated for a second time.	
Area for improvement 5 **Ref**: Standard 6 **Stated:** First time	The registered provider shall ensure that 'net pants' are not used communally but individually labelled for any patient requiring their use.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and staff and observations evidenced that this area for improvement had been met.	

Area for improvement 6 **Ref**: Standard 35.7 **Stated:** First time	The registered provider shall ensure that reports of visits undertaken on behalf of the responsible individual provide evidence of a review of previous action plan and that areas of concern raised by relatives/visitors are reported to the manager/nurse in charge of the home.	**Carried forward to the next care inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.	
Area for improvement 7 **Ref**: Standard 28.1 **Stated:** First time	The registered person shall ensure that patients' receive their medication in a timely manner.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and staff and observation confirmed that this area for improvement had been met.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The nurse in charge at the commencement of the inspection and the manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. Nursing and care staff spoken with and a review of the staffing rota from 7 October to 3 November 2018 evidenced that the planned staffing levels were generally adhered to. Staff confirmed that if a shift was not covered, contingency plans were put into place to by the management team, or nurse in charge of the home at the time; to ensure patients' needs were met. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff.

The duty rotas reviewed were very difficult to read due to the number of alterations, the use of correction fluid which did not allow the original entry to be viewed and the number of names 'fitted' into the limited space available. In addition it was difficult to ascertain if these handwritten names were staff from the home or an agency, and where in the home they had worked. For example, agency staff were not always identified with their full name or as agency staff or which of the six units they worked in. Details were discussed with the manager and deputy manager who both confirmed that the layout of the rotas was to be reviewed soon. An area for improvement was made.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner.

Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients; and stated that staffing arrangements had improved since the last care inspection in respect of the management of short notice sick leave. Nursing staff demonstrated their knowledge of how to escalate concerns to the management team especially outside of the normal office hours. We also sought staff opinion on staffing via the online survey. However, no responses were received before the issuing of this report.

Patients spoken with, who were able to express their views or feelings, indicated that they were well looked after by the staff and felt safe and happy living in Massereene Manor. We observed patients to be relaxed, conformable in their surroundings and with staff.

We had the opportunity to meet with three patients' relatives during the inspection. Two of the three patients' relatives spoken with were complimentary regarding the care their loved one received, the attitude of staff and the provision of meals. One of the relatives said they had had concerns in the past regarding staffing but had seen that this was improving. One patient's relatives raised specific concerns regarding the care of their loved one and how this was affected by staffing levels. Details were discussed with the manager and responsible individual during feedback. Both were aware of the specific concerns raised and confirmed that the patient's care manager was also aware of the concerns raised and that the complaints process had been followed.

As stated previously, observation of the delivery of care and discussion with staff evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner.

A review of records confirmed that a process was in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC. However, while we were able to confirm that all registered nurses employed by the home were on the live NMC register we were unable to confirm that care assistants were on the live NISCC register as the record had not been updated to reflect new staff. It was agreed that the manager would email confirmation of NISCC registration status for all care assistants employed by the nursing home to RQIA. The updated information and assurance was received by email on 20 November 2018.

We discussed the provision of mandatory training with staff and reviewed staff training records for 2018. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. However, the overview for training was not up to date. It was agreed that the manager would provide RQIA with an updated overview of staff training. The updated information was received by email on 20 November 2018.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the manager and staff confirmed that the regional operational safeguarding policy and procedures were embedded into practice.

We reviewed accidents/incidents records from 6 August 2018 in comparison to the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were maintained and notifications were submitted in accordance with regulation.

Nursing and care staff spoken with demonstrated their knowledge on how to prevent falls and the action to be taken when a fall occurred, including basic first aid, the recording of clinical observations, referral to other healthcare professionals as required and the post fall review process. However, review of four patients care records evidenced that a post falls review of risk assessments and care plans was not undertaken in two of the four records reviewed. As stated in section 6.2 an area for improvement was not met and was stated for a second time.

Discussion with the manager and deputy manager; and review of records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. However, the audit documents and the evaluation recorded did not evidence that any action had been taken to address identified patterns, trends or deficits. For example, a log of the falls occurring each month was recorded alongside a check list for the post falls review of the patients' falls risk assessment and care plans. The audit identified those care records that had not been reviewed in accordance with best practice; but there was no evidence that any action had been taken to address these deficits. Also the evaluation recorded did not always make use of the previous months' data on falls to compare or contrast outcomes and trends. Further details regarding auditing processes and governance can be viewed in section 6.7 and an area for improvement was made.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, sluice rooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients, two patient's relatives and staff spoken with were complimentary in respect of the home's environment. It was evident that painting and redecorating of communal areas had been completed in Holyhill Unit with work ongoing to improve two shower rooms and flooring in other units. The maintenance person confirmed that refurbishment work was "ongoing" as well as day to day maintenance issues such as small repairs and regulatory checks of water and room temperatures and safety equipment.

Observations evidenced that cleaning chemicals such as Difficile -S were not managed or stored in accordance with COSHH regulations. For example, two bottles of Difficile –S were observed in an unlocked cupboard within the unlocked sluice room in Holyhill Unit. Staff stated that the sluice room could not be locked as there was no key available and that the chemical cupboard was always "closed over". In Edenhill Unit a bottle of Difficile -S was observed on top of the clinical bin in the unlocked treatment room and bottles of shampoo and shower gels were observed under the sink in the kitchenette. The nursing staff in both units agreed to dispose of the bottles of Difficle –S as the date on each bottle indicated the solutions had expired. As stated in section 6.2 the area for improvement in relation to COSHH requirements was not met and was stated for a second time.

In addition from a review of the staff training matrix submitted to RQIA on 20 November 2018 it was evident that a significant number of staff, across all departments in the home, had still to receive COSHH training. Given the inspections findings detailed above an area for improvement was made.

Fire exits and corridors were observed to be clear of clutter and obstruction. All staff spoken with were aware of the procedures to be followed in the event of the fire alarm sounding.

Discussion with staff confirmed that staff were aware of how personal protective equipment (PPE) such as aprons and gloves were to be used. However observations evidenced that knowledge had still to be embedded into practice. For example, three staff were observed

moving between units wearing PPE and one staff member was observed wearing PPE to transfer a patient form their bedroom to a lounge in a wheelchair. In addition, the storage in bathrooms where there was a toilet was still an issue throughout the home as detailed in section 6.2 and an area for improvement was stated for a second time.

We also observed care staff wearing jewellery including multiple rings and necklaces and one staff member wearing gel nail varnish. Each staff member confirmed, to the inspector, that they were aware that they should not wear jewellery/nail varnish as part of the home's uniform policy and infection prevention and control measures/practice. Details were discussed during feedback and an area for improvement was made.

In Edenhill Unit we observed that a hairdressing trolley was stored under a bench in the kitchenette. Staff confirmed that the kitchenette was used by the hairdresser. Discussion with the manager confirmed that this issue had already been identified and a new room had been allocated and hairdressing was moving to the new room soon. This issue will be reviewed during subsequent inspections.

A system was in place to monitor the incidents of healthcare acquired infection and the use of antibiotics.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, the home's environment, staff knowledge of adult safeguarding and fire procedures and the delivery of care.

Areas for improvement

The following areas were identified for improvement in relation to, layout of staff rotas, auditing and governance, COSHH training and infection prevention and control practices.

	Regulations	Standards
Total number of areas for improvement	1	4

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

We reviewed six patients care records in relation to the management of falls, pressure area care and wound care. Details regarding the management of falls can be found in section 6.4. We evidenced that, generally, following an assessment of need/risk, care plans were put in place to manage nursing care needs and that these assessments and care plans were kept under regular review. In relation to pressure area care and wound care patients' daily notes and repositioning charts confirmed the delivery of care on a day to day basis and staff demonstrated their knowledge of patients' pressure area care needs. This was reassuring, however the records evidenced that nursing staff did not consistently develop a care plan to manage repositioning/pressure area care when the Braden risk assessment tool identified a risk; or when the patient required wound care. Details were discussed with the nursing staff concerned and all agreed to address this record keeping deficit. As stated previously in section 6.2 an area for improvement was made for a second time.

Discussion with staff and review of care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), speech and language therapists (SALT) and dieticians.

Observation evidenced that communication between staff at handover needed improved. For example, in one unit we observed the handover from the night care assistant to the day care assistants. The handover was very brief and lacked any detail regarding the patients' care needs or any changes overnight nor did they refer to or use any notes or records. Staff explained that nursing staff and care staff attended separate handovers and that the nurse in charge of the shift/unit gave a further handover to their care assistant team before they commenced their shift. Discussion with the manager informed us that concerns regarding communication in general and in particular the 'handover' process between shifts had been identified, discussed with the regional manager and that changes had already introduced. For example, 'flash meetings' with heads of departments/units daily at 11:00 hours were conducted by the manager or deputy manager daily to improve communication. The manager also confirmed she conducted regular 'walk arounds' to observe practice and to meet with staff, relatives and patients. We did observe part of the flash meeting held on day one of the inspection, 7 November 2018 at 11:00 hours. Staff involved from each department or unit gave a brief overview of how the morning had progressed and raised any concerns. Staff spoke positively regarding the benefits of these meetings. While we acknowledge the improvement made, we will continue to monitor communication through subsequent inspections.

We also spoke with agency staff working in the home. All but one of the agency staff spoken with confirmed that before they worked their first shift in the home they received an induction. This induction, while brief, covered the layout of the home/unit, what action to take in the event of a fire, how to call for assistance and help in an emergency and a handover of patients' care needs. Record keeping and access to care records was also explained and was commensurate with the agency staff member's role and function in the home. We reviewed induction records for agency staff. Deficits were identified regarding the completion of the records. For example, dates, times and signatures of the inductor were missing. An area for improvement was made.

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 the manager or the nurse in charge.

Relatives spoken with confirmed that they knew how to raise concerns regarding the loved one's care. Relatives were aware of the home's new manager and some had already met her. The manager confirmed that since she had taken up post a relatives' meeting had been held and 20 relatives attended. The regional manager facilitated this meeting and a follow up meeting would be planned for early in 2019.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care delivery, communication with other healthcare professionals and improvements made regarding communication between staff and management.

Areas for improvement

The following areas were identified for improvement in relation to agency staff induction records.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We arrived in the home at 06:25 hours on 7 November 2018 and were greeted by staff who were helpful and attentive. In each of the units staff confirmed that patients who were already up; this was their usual routine. Any patient awake and up has been offered a hot drink and a snack but the majority of patients remained in bed. One patient was assisted back to bed after they had finished their cup of tea and snack. Nursing and care staff were observed undertaking their usual care delivery at this time of the morning.

Later we observed patients enjoying breakfast and a morning cup of tea/coffee in the dining area, in one of the lounges or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice and staff were observed assisting patients to enjoy their chosen activity and to eat and drink as required. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes. Staff were aware of the changes to modified food and fluid descriptors and posters were displayed indicating the old and new descriptors.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff were also aware of the requirements regarding patient information and patient confidentiality.

Discussion with patients and staff and review of the activity programme displayed in the foyer evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. The manager confirmed that a second activity person was to be recruited.

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences. A variety of methods were used to promote orientation, for example appropriate signage and photographs.

There were systems in place to obtain the views of patients and their representatives on the running of the home. As stated previously a relatives meeting had been held recently with 20 relatives attending. We also spoke with three patients relatives and two of the three commented positively regarding their loved one's care and staff attitude. One patient's relative said that they were "very impressed" with the caring attitude of staff and with the quality of the meals provided. Concerns raised by relatives regarding staff numbers are detailed in section 6.2.

Ten relative questionnaires were provided; none were returned within the timescale or before the issuing of this report.

We spoke with eight patients individually who by their comments and demeanour confirmed that they were relaxed and comfortable. We observed that staff paid attention to personal hygiene and dressing. For example, patients clothing was clean, matching and suitable for the time of year. Patients who were known to 'feel the cold', despite the warm environment, wore additional layers of clothing which could easy be removed and others were provided with lap blankets depending on which they preferred. One patient said that they enjoyed their food and that the staff were good to them. 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 also spoke with 21 staff as part of the inspection process and their comments are included throughout the report. The majority of staff spoken with confirmed improvements in staffing and communication and staff morale. Others were advised to discuss queries and /or concerns they had with the manager, regional manager or the registered persons/owners.

Staff were asked to complete an on line survey, we had no responses within the timescale or before the issuing of this report.

Any comments from patients, patient representatives and staff in returned questionnaires or online responses received after the issue of this report will be shared with the manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been a change in management arrangements and RQIA were notified appropriately. We await an application from the new manager to register with RQIA. A

review of the duty rota evidenced that the manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff and relatives evidenced that the manager's working patterns supported effective engagement with patients, their representatives, staff and the multi-professional team. It was reassuring that the manager had identified areas for improvement as detailed throughout the report. Addressing the quality improvement plan (QIP) issued as a result of this inspection will further enhance the quality of the care and services provided.

Staff were able to identify the person in charge of each unit within the home and the nurse in charge of the 'whole' home in the absence of the manager. However, from discussion with the manager and deputy manager and review of records it was evident that not all nursing staff delegated to be the nurse in charge of the nursing home, in the absence of the manager, had completed a competency and capability assessment. Details were discussed and it was agreed that the assessments would be completed immediately for any nurse delegated this role; and before they undertook this role again. An area for improvement was made. In addition it was found that while the day duty rota identified the nurse in charge of the home, in the absence of the manager, the nurse in charge of the home on night duty was not always identified. The manager agreed to address this immediately.

Review of the home's complaints records evidenced that systems were in place to ensure 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. RQIA were aware of a complaint that had been raised by a relative and from discussion with the manager and deputy manager they were managing the complaint appropriately. However, the complaint was not recorded in the complaints record. An area for improvement was made.

Discussion with the manager and deputy manager and review of governance records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, IPC practices and care records. However, it was evident that the while the current governance system required the completion of a number of audits; these audits did not identify areas of concern as detailed within this report; or the details of the actions taken to address any identified deficits. An area for improvement has been made regarding audit processes as stated previously in section 6.4.

We acknowledged that this inspection was conducted five weeks after the new manager came into post and that the senior management team had had to prioritise certain areas of work. We will continue to monitor the quality and standards of care and services provided by the home during subsequent inspections.

Discussion with the manager and review of records, in comparison with notifications received by RQIA, evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. As a result of the care inspection conducted on 8 February 2018, RQIA had required the nursing home to notify us of any staffing deficits which were not 'covered' in accordance with The Nursing Homes Regulations (Northern Ireland) 2005, Regulation 30. Following our review of staffing during this inspection we no longer require this level of notification.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to quality improvements and improving and maintaining good working relationships.

Areas for improvement

The following areas were identified for improvement in relation to the nurse in charge competency and capability assessments and the record of complaints.

	Regulations	Standards
Total number of areas for improvement	1	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Anne McCracken, Manager and Naomi Carey, Responsible Person, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref:** Regulation 13 (7) **Stated:** Second time **To be completed by:** Immediate action required.	The registered person shall ensure that staff adhere to good practice in relation to the use of personal protective equipment (PPE) such as aprons and gloves, the storage in areas where there is a toilet and the cleaning of contaminated toilets outside usual housekeeping hours. Ref: 6.2 and 6.4
	Response by registered person detailing the actions taken: Practices for the use of PPE will be audited throughout the month by the staff and management. Items and equipment are no longer stored inappropriately in bathrooms. The schedule is in place and inspections will be done of toilets outside of housekeeping hours.
Area for improvement 2 **Ref:** Regulation 14 (2) **Stated:** Second time **To be completed by:** Immediate action required.	The registered person shall ensure that cleaning chemicals are securely stored in accordance with COSHH requirements. Ref: 6.2 and 6.4
	Response by registered person detailing the actions taken: The door of the sluice has been fitted with a lock to ensure that cleaning chemicals are stored appropriately. Regular checks will be done by the Nurse in charge of the Unit to enusre that the door is kept closed.
Area for improvement 3 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** Immediate action required.	The registered person shall ensure that monitoring is in place to ensure staff adhere to the homes' and regional policies in relation to infection prevention and control measures and practices. This includes but is not limited to adherence to the removal of jewellery and nail varnish before commencing duty in the nursing home. Ref: 6.4
	Response by registered person detailing the actions taken: A schedule of quality audits has been written. The audits will include infection prevention and control measures and practices and uniform audit.Where there are shortfalls, action will be identified and an action plan implemented to address same.
Area for improvement 4 **Ref:** Regulation 20 (3)	The registered person shall ensure that any nurse given the responsibility of being the nurse in charge of the home in the absence of the manager is deemed competent and capable to do so; and that records of the assessment of this are maintained.

Stated: First time **To be completed by:** Immediate action required.	Ref: 6.7
	Response by registered person detailing the actions taken: All Registered Nurses including Nurses booked through an Agency who take charge of the Home in the absence of the Manager have completed a competency and capabilty assessment.Records have been kept.

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 22 **Stated:** Second time **To be completed by:** 30 November 2018	The registered person shall ensure that patients' care plans and risk assessments are updated post falls. Ref: 6.2 and 6.4
	Response by registered person detailing the actions taken: A monthly quality assurance report/ audit is undertaken and where there is a shortfall ,action is identified and a corresponding action plan is implemented to address same.This docmentation will evidence that any deficits have been addressed.
Area for improvement 2 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** 30 November 2018	The registered person shall ensure that care plans in place to manage pressure area care and wound care. Ref: 6.2 and 6.4
	Response by registered person detailing the actions taken: Staff have been reminded that care plans should be in place to manage pressure care and wound care.Review of the documentation and discussion with the Nurses confirmed that wound care management must be in line with good practice. The auditing of the care records is now a robust and comprehensive process.
Area for improvement 3 **Ref**: Standard 35.7 **Stated:** First time **To be completed by:** 31 March 2018	The registered person shall ensure that reports of visits undertaken on behalf of the responsible individual provide evidence of a review of the previous action plan and that areas of concern raised by relatives/visitors are reported to the manager/nurse in charge. Ref 6.2
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 4 **Ref**: Standard 41 **Stated:** First time **To be completed by:** Immediate action required.	The registered person shall ensure that the staff duty rotas clearly records: • the full name of each staff member, including any agency staff employed • the capacity in which they worked; that is as a nurse/care assistant/agency nurse/agency care assistant • the hours they worked. Ref: 6.4
	Response by registered person detailing the actions taken: Staff duty rotas clearly record the name of the staff member which includes agency staff, the capacity in which they are working and the hours they have worked.

Area for improvement 5 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 28 February 2019.	The registered person shall review the home's audit processes/governance system to ensure it is robust and effective in identifying deficits in the delivery of care and services. Where deficits are identified there is clear evidence of the action taken to address them. Ref: 6.4 and 6.7
Area for improvement 6 **Ref:** Standard 47.3 **Stated:** First time **To be completed by:** 31 January 2019.	The registered person shall ensure that staff receive training in COSHH. Ref: 6.4
	Response by registered person detailing the actions taken: RESPONSE TO AREA IMPROVEMENT 5 All monthly audits are completed throughout the month. The documentation will provide evidence that any deficits have been addressed. When the required amendments are made the Deputy Manager/ Nurse signs the audit. RESPONSE TO AREA IMPROVEMENT 6 4 sessions for COSHH training have been arranged for January and all staff will attend.
Area for improvement 7 **Ref**: Standard 39.1 **Stated:** First time **To be completed by:** Immediate action required.	The registered person shall ensure that records pertaining to the induction of agency staff are completed in full. Ref: 6.5
	Response by registered person detailing the actions taken: All Nurses have been reminded that any records pertaining to the induction of agency staff must be completed in full.
Area for improvement 8 **Ref:** Standard 16.11 **Stated:** First time **To be completed by:** 30 November 2018.	The registered person shall ensure that all complaints/expressions of dissatisfaction about the nursing home are recorded. Ref: 6.7
	Response by registered person detailing the actions taken: The Home can provide assurance that the Complaints policy is being adhered to in accordance with legislation and DHSSPS guidance on complaints.

Please ensure this document is completed in full and returned via Web Portal

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