The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
7 July 2016

Rylands

Type of Service: Nursing Home
Address: 11 Doagh Road, Kells, Ballymena, BT42 3LZ
Tel No: 02825892411
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Rylands took place on 7 July 2016 from 09.30 to 16.15 hours.

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

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

Is care safe?

There were safe systems in place for the recruitment and selection of staff and regular checks were undertaken to ensure that all staff were registered with the relevant professional bodies. New staff completed an induction programme. There were systems in place to support staff through one to one supervision; mandatory training; the completion of competency and capability assessments; and annual appraisals. The staffing levels for the home were subject to regular review to ensure the assessed needs of the patients were met. The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding and a review of documentation confirmed that any potential safeguarding concern was managed appropriately. A range of risk assessments were completed as part of the admission process and were reviewed as required. These risk assessments informed the care planning process. Falls risk assessments and care plans were generally completed following each incident, care management and patients' representatives were notified appropriately. The home was found to be clean, reasonably tidy, well decorated and warm throughout. Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction. No areas for improvement were identified during the inspection.

Is care effective?

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. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. A range of planned activities was displayed on the ground in order to assist patients to choose which to participate in. Arrangements were in place to meet patients' religious and spiritual needs within the home.

Is care compassionate?

A review of patient care records confirmed information about patient's background and social care plans were also in place to provide information to staff to ensure that patients' social care needs were met individually. There were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Patients and their representatives' expressed confidence in raising concerns to the home's management. There was evidence within the compliments record that the staff cared for the patients and the relatives in a kindly manner. The comments received were generally positive, a number of which have been included in the report. No areas for improvement were identified during the inspection.

Is the service well led?

There was a clear organisational structure within the home. Staff and patients' representatives provided positive comments regarding the responsiveness of the registered manager and a number of these comments are included in the report. The home was operating within its registered categories of care. The homes policies and procedures were subject to regular review and there were systems and processes in place to ensure that urgent communications, safety alerts and notices were managed appropriately. 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 had been notified appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. Monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. Systems were in place to monitor and report on the quality of nursing and other services provided. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

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	0	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with the 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 care inspection undertaken on 16 December 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection. RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection. There were no areas that required to be followed up in this inspection.

2.0 Service details

Registered organisation/registered provider: Rylands/ Trevor Duncan and Karen Duncan	**Registered manager:** Valerie Rutherford
Person in charge of the home at the time of inspection: Valerie Rutherford	**Date manager registered:** 24 March 2014
Categories of care: NH-DE, NH-I, RC-I, RC-MP(E), RC-PH(E), NH-PH, NH-PH(E), NH-LD 45 Nursing: 14 Residential. A maximum of 2 patients in category NH-LD. Category NH-DE for 1 identified patient only.	**Number of registered places:** 59

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

Care delivery/care practices were observed and a review of the general environment of the home was undertaken. During the inspection the inspector spoke with 5 patients, three care staff, two registered nurses and six relatives. In addition questionnaires were provided for distribution by the registered manager.

The following information was examined during the inspection:

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 16 December 2015

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the nursing inspector and has been validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 16 December 2015

Last care inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 13 (1) (a) (b) **Stated:** First time	The registered person must ensure that the identified patient's needs are assessed and that a treatment plan is developed and implemented accordingly and recorded to evidence all care provided, with particular reference to wound and/or pressure care management. An urgent actions record was issued.	**Met**
	Action taken as confirmed during the inspection: A review of care records confirmed that wound care was managed in line with best practice.	

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

Ref: Regulation 14 (3)

Stated: First time</td><td>The registered person must ensure that suitable arrangements are in place to provide a safe system for moving and handling patients.

An urgent actions record was issued.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of staff training records evidenced that all staff had received training in moving and handling practices. The registered manager also monitored moving and handling as part of the daily auditing process. There were no concerns identified during the inspection.</td></tr>
<tr><td rowspan="2">Requirement 3

Ref: Regulation 12 (4) (a) (b)

Stated: First time</td><td>The registered person must review the serving of meals to ensure that:

• meals are served in a timely manner to meet patients' needs
• meals are served at a temperature which is in accordance with the nutritional guidelines
• staff provide appropriate supervision to patients during mealtimes

The deployment of staff at mealtimes and issues in relation to respect and dignity, when assisting patients to eat, must be included in this review. An audit of the mealtime experience should also be used to assist in identifying deficits and improvements in this area.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Discussion with the registered manager confirmed that all available staff were deployed to the dining room to provide assistance where required. A dining audit was also undertaken on a regular basis. The meal time experience was observed to be quiet and assistance was provided in a discreet and timely manner.</td></tr>
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<table>
<tr><th colspan="2">Last care inspection recommendations</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Recommendation 1

Ref: Standard 37.1

Stated: Second time</td><td>Consideration should be given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A storage cabinet had been provided to ensure that personal care records were stored securely.</td></tr>
<tr><td rowspan="2">Recommendation 2

Ref: Standard 35.3

Stated: First time</td><td>The registered manager should audit the patients' personal care records, to ensure that deficits identified during this inspection are addressed.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of the registered manager's daily auditing record confirmed that personal care records were checked on a regular basis. There was also evidence that this information informed the responsible persons' monthly monitoring visit in accordance with regulation 29.</td></tr>
<tr><td rowspan="2">Recommendation 3

Ref: Standard 4.1

Stated: First time</td><td>The progression of care plan development in the five day period following patient admission to the home should be monitored to ensure that prioritisation is given to the assessments and care plans that need to be completed within this timeframe.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of the care record of one patient who had recently been admitted to the home confirmed that risk assessments and care plans had been developed within the recommended timeframe. This was also being monitored by the registered manager.</td></tr>
</table>

Recommendation 4 **Ref**: Standard 39.4 **Stated:** First time	The format of the falls risk assessment and bowel assessment forms should be further developed to provide a clear breakdown of the scores ascertained each time the assessments are updated. Training should be provided as relevant to staff's roles and responsibilities.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of care records confirmed that the above documents had been developed for clarity and ease of completion.	
Recommendation 5 **Ref**: Standard 17.4 **Stated:** First time	The appropriateness of patients' placements within the home should be kept under regular review, in particular, patients who have a confirmed diagnosis of dementia. The review process should also include consideration of the support and/or alternative arrangements when it becomes apparent that the existing placement is no longer able to meet the patient's increased or increasing dementia care needs. This review should also address the training needs of staff, as deemed appropriate.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. There was evidence within the care records that staff referred patients appropriately to behavioural specialists, as required. A review of staff training records also confirmed that training in managing behaviours which challenge, had been provided.	
Recommendation 6 **Ref**: Standard 39.1 **Stated:** First time	An induction programme should be completed for all newly employed staff.	**Met**
	Action taken as confirmed during the inspection: A review of personnel records confirmed that all staff had completed an induction programme.	

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. A review of the staffing rota for the week commencing 27 June 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. A number of staff commented on the high dependency levels of the patients. Refer to section 4.5 for further detail. Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

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.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records confirmed that staff, as appropriate, completed training 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. Training had also been provided in the management of behaviours which challenge. Observation of the delivery of care evidenced that training had been embedded into practice. 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.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, undertook competency and capability assessments and completed annual appraisals. A matrix was in place to ensure that the registered manager had oversight of when the assessments were due to be updated.

There were safe systems in place for the recruitment and selection of staff. A review of three personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. 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 their registrations were current. The review of recruitment records evidenced that enhanced criminal records checks were completed with AccessNI and a register 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 adult safeguarding. A review of the records identified that concerns had been logged appropriately. A review of documentation confirmed that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

A range of risk assessments were completed as part of the admission process and were reviewed as required. These risk assessments informed the care planning process.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were generally completed following each incident, care management and patients' representatives were notified appropriately. A falls safety calendar was in place, to reduce the incidence of further falls and was displayed in the nurses' station.

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

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.4 Is care effective?

A review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process. For example, records in relation to the management of wounds/pressure ulcers indicated that when a patient was identified as being at risk of developing a pressure ulcer a care plan was in place to direct staff on the management of this risk. Where applicable, specialist healthcare professionals were involved in prescribing care in relation to the management of wounds. A recommendation is made that wound care records should 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.

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 assessments 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.

The care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist

(SALT) or dieticians. Registered nurses consulted with were aware of the local arrangements and referral process to access other multidisciplinary professionals.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate, and there was evidence of regular communication with patient representatives within the care records.

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.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored. Totals of food and fluid received were recorded at the end of each day and this was recorded in the patients' daily progress notes

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

Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager. Discussion with the registered manager 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 meetings were held on 9 May 2016 and 6 June. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities.

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. Discussion with the registered manager and review of records evidenced that patients and/or relatives meetings were held on a regular basis and records were maintained. The most recent patients' meeting was held on 21 April 2016 and the most recent relatives' meeting was held on 4 May 2016. Minutes of the meetings held were reviewed and confirmed attendance and the detail of the issues discussed. Information is also displayed in the front foyer area of the home on how to make a complaint.

Areas for improvement

A recommendation has been made that wound care records are supported by the use of photography in keeping with the NICE guidelines.

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

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care. Patients were 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.

Menus were displayed clearly on each table in the dining room and were correct on the day of inspection. We observed the lunch time meal in the dining room. We saw that the atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set and specialist cutlery and plate guards were available to help patients who were able to maintain some level of independence as they ate their meal. The 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. Staff supported patients to maintain friendships and socialise within the home. A list of planned activities was displayed in order to assist patients to choose which to participate in. The activities included chair exercises, bingo, crafts, bowling, jigsaws, reminiscence, games, singalongs, walks and a movie night. Hairdressing services were available three times per week and discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

A review of patient care records confirmed information about patient's background. Social profiles had been completed which included information on the patients' background and what things were important to them as individuals. Information was also included on how the patients liked to stay healthy. Social care plans were also in place to provide information to staff to ensure that patients' social care needs were met individually.

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

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. The last annual quality survey was undertaken in September 2015. Views and comments recorded were analysed and areas for improvement were acted upon.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included: 'the quality of care provided by your staff was exceptional. Their professionalism and compassion shown towards our family during the last days of (our relative's) life was very much appreciated".

Consultation

During the inspection the inspector spoke with 5 patients, three care staff, two registered nurses and six relatives. In addition to speaking with patients, relatives and staff RQIA provided questionnaires. At the time of writing this report four relatives, five patients and six staff had retuned their questionnaires. All comments received were positive. Some comments are detailed below:

Staff

"This is a good care home, but a lot of hard work."
"The care is phenomenal. It is a heavy home though."
"I have no concerns. The patients are getting the best care here."
"The care is excellent here."

Comments in relation to the staffing levels varied between staff. One staff member described the staffing levels as "brilliant." However, two staff members commented on the heavy workload and stated that the dependency levels were very high. All those consulted with stated that the patients' needs were always met and there was no impact on patient care observed during the inspection. These comments were discussed with the registered manager, who agreed to review the dependency levels of the patients and follow up with staff.

Patients

Discussions were held with five patients individually and with others in groups. Patients spoken with were positive regarding the care they were receiving all were complementary of the staff and the food served in the home. There were no issues raised during the inspection by patients.

"I am very satisfied with the place."
"They are civil enough. One or two would be sharp, but I say nothing."
"Everything is ok here."
"I am happy enough."
"I am very satisfied. You get what you want."

One identified patient stated that they would like to attend external activities more often and another patient was dissatisfied with a new wheelchair that had been provided. These matters were raised with the registered manager to address.

Patients' representatives

During the inspection six relatives were spoken with and were very positive regarding all aspects of care. Some comments were made by relatives as follows;

"I have no concerns."
"I cannot complain."
"I couldn't say a thing wrong about the place."
"I have no concerns."
"(My relative) is as happy as he would be anywhere."
One patient's representative discussed an ongoing complaint which the local health and social care trust were investigating. This was discussed with the registered manager and will be followed up at future inspection.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0

4.6 Is the service well led?

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

Consultation with staff evidenced that they were confident in raising concerns to the registered manager. Staff commented that the registered manager "liked to run a tight ship and that it was very important to her that things would be done right." One patients' representative stated that the registered manager was "easy to talk to."

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

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

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

Discussion with the registered manager and review of records evidenced that monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. The monthly monitoring report provided a comprehensive overview of areas that were meeting standards and areas where improvements were required. An action plan was generated to address any areas for improvement. Discussion with the registered manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

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

- accidents and adverse incidents
- notifications
- infections
- complaints
- hospital admissions
- dining experience audits
- deaths
- wound management
- medicines management
- care records

The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

An audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. An action plan was in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. 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.

Areas for improvement

No areas for improvement were identified during the inspection.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager 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 may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

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

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

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref**: Standard 21 **Stated:** First time	The registered persons should ensure that wound care records are supported by the use of photography in keeping with the home's policies and procedures and the NICE guidelines. **Ref: Section 4.4**
To be completed by: 30 July 2016	**Response by registered person detailing the actions taken:** All woundcare records are now supported with a photograph. This is in keeping with the Home's policies, procedures and NICE guidelines.

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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