Unannounced Care Inspection Report
13 June 2017

Moneymore

Type of Service: Nursing Home
Address: Cookstown Road, Moneymore, BT45 7QF
Tel No: 028 86748118
Inspector: Aveen Donnelly

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 41 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare Claire Maureen Royston	**Registered Manager:** Ailish Devlin (acting)
Person in charge at the time of inspection: Ailish Devlin	**Date manager registered:** Not applicable
Categories of care: Nursing Home (NH) I – Old age not falling within any other category PH – Physical disability other than sensory impairment Residential Care (RC) I – Old age not falling within any other category PH(E) - Physical disability other than sensory impairment – over 65 years MP(E) - Mental disorder excluding learning disability or dementia – over 65 years	**Number of registered places:** 41 comprising: 37 – NH-I (including 1 patient in category NH-PH) 4 - RC-I, PH(E) and MP(E)

4.0 Inspection summary

An unannounced inspection took place on 13 June 2017 from 09.15 to 16.30 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 ‘patients’ is used to describe those living in the home 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.

There were examples of good practice found throughout the inspection in relation to staff induction, training, supervision and appraisal, adult safeguarding, risk management processes; the completion of risk assessments and care plans; wound care management and the management of diabetes; repositioning and fluid intake monitoring; and communication between residents, staff and other key stakeholders. The culture and ethos of the home promoted treating patient with dignity and respect. There was also evidence of good practice identified in relation to the governance and management arrangements; management of complaints and incidents; quality improvement processes and maintaining good relationships within the home.

Areas for improvement were identified in relation to the decontamination and storage of commodes; the accuracy of the bowel records and the oversight the registered nurses had of these records; and the recruitment practices.

Patients said that they were satisfied with the care and services provided and described living in the home, in positive terms.

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	2	1

Details of the Quality Improvement Plan (QIP) were discussed with Ailish Devlin, 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 10 January 2017

The most recent inspection of the home was an unannounced care inspection undertaken on 10 January 2017. 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 inspection we analysed the following information:

- notifiable events submitted 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 quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

During the inspection the inspector met with eight patients, three care staff, one registered nurse, one kitchen staff, one laundry staff and five patients' representative. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection.

Ten questionnaires for staff and relatives and eight for patients were left for distribution.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- staffing arrangements in the home
- one staff recruitment and selection record
- staff induction, supervision and appraisal records
- staff training records for 2016/2017
- accident and incident records
- records relating to adult safeguarding
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- emergency evacuation register
- seven patient care records
- two patient care charts including food and fluid intake charts and repositioning charts
- patient register
- annual quality report
- compliments records
- RQIA registration certificate
- certificate of public liability
- audits in relation to care records and falls
- complaints received since the previous care inspection
- minutes of staff' and relatives' meetings held since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as 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 10 January 2017

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

6.2 Review of areas for improvement from the last care inspection dated 10 January 2017

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 (8) (a) **Stated:** First time	The registered persons must ensure that the home is conducted in a manner which respects the dignity of patients. This refers specifically to the review of working practices in the morning, which must be reviewed and monitored, to ensure that patients' personal care needs are delivered in a respectful manner.	
	Action taken as confirmed during the inspection: Discussion with the manager and a review of records confirmed that supervision had been undertaken with staff in relation to personal care needs. This had also been discussed at the recent staff' meeting. A review of the complaints records confirmed that no complaints had been received in relation to patients' personal care needs. Patients were observed to be well presented; and there were no concerns raised by relatives spoken with.	**Met**
Area for improvement 2 **Ref**: Regulation 13 (1) (a) **Stated:** First time	The registered persons must ensure that patients who require a modified diet receive the appropriate consistency of food and fluids, as recommended by the Speech and Language Therapist. Where a patient does not consent to an intervention records must be maintained to guide staff in managing the identified risk.	
	Action taken as confirmed during the inspection: A review of patient care records confirmed that patients who were identified as requiring a modified diet, had the relevant risk assessments completed. Care plans in place were reflective of the recommendations of speech and language therapist; and care plans were kept under review. The prescribed consistency of diet was clearly recorded on the front of the supplementary care booklets; records were maintained.	**Met**

Area for improvement 3 **Ref**: Regulation 12 (1) (a) (b) **Stated:** First time	The registered persons must ensure that the seating arrangements within the home are reviewed and monitored, to ensure that the staff have the knowledge and skills to position patients in line with good practice. Instruction must be given to all staff in relation to adjustable footplates on chairs. Evidence of timely referral to or advice sought from appropriate health and social care professionals must be documented in patient records.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and a review of records confirmed that all patients' seating requirements had been reassessed, following the last care inspection; and referrals had been made, as appropriate to the occupational therapists. Proper seating had been addressed with the staff, in the staff meeting; all patients were observed to be seated appropriately.	
Action required to ensure compliance with The DHSSPS Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 23 **Stated:** First time	The registered persons must ensure that the settings of pressure relieving mattresses are monitored and recorded, to ensure their effective use.	**Met**
	Action taken as confirmed during the inspection: There was a system in place to ensure that mattress settings were correct.	

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 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 5 June 2017 evidenced that the planned staffing levels were consistently adhered to. Observation of the delivery of care evidenced that

patients' needs were met by the number and skill mix of staff on duty. Discussion with staff, patients and their representatives evidenced that there were no concerns regarding staffing levels.

The manager explained there was currently only one registered nurse vacancy; this vacancy was being filled by agency staff. There were no care staff vacancies.

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 the manager and a review of one personnel file evidenced that recruitment processes were generally in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Where nurses and carers were employed, their registrations were checked with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC), to ensure that their registrations were valid. The review of recruitment records evidenced that enhanced criminal records checks were completed with AccessNI prior to the staff member starting their employment. For agency staff, their profile was maintained, which included information on the AccessNI check and verification of their NMC registration.

Although the manager had obtained most of the information required, to demonstrate that prospective employees were suitable to work with vulnerable adults, further action was required, to ensure that all the required information was received, prior to staff starting in post. For example, one staff member only had one reference received, prior to commencing employment. Following the inspection, the manager confirmed to RQIA, by email on 15 June 2017, that this reference had been received. This has been identified as an area for improvement.

A record of staff including their name, address, contact number, position held, contracted hours, date of receipt of AccessNI certificate, date commenced and date position was terminated (where applicable) was maintained and provided an overview of all staff employed in the home. This additional detail supplemented the information contained in the staff recruitment files as required in accordance with regulation 19(2), schedule 4(6) of The Nursing Homes Regulations (Northern Ireland) 2005.

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. The manager also explained that they signed the induction record after the staffs' probationary period had been completed, to ensure that all areas of the induction process had been satisfactorily completed. A review of records confirmed that agency staff also received an induction to the home.

Discussion with the 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.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and records were kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. The records reviewed confirmed that 90% of staff had, so far this year, completed their mandatory training. For agency staff, the manager also received a profile which included information on their compliance with mandatory training requirements.

Observation of the delivery of care evidenced that training had been embedded into practice. Overall compliance with training was monitored by the manager and this information informed the responsible persons' monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff were appropriately managed in accordance with the NMC. Similar arrangements were in place to ensure that care staff were registered with the NISCC.

Staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The staff understood what abuse was and how they should report any concerns that they had. The relevant contact details were available in a folder for all staff to access; and the staff spoken with, were aware of the home's whistleblowing policy.

Discussion with the manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified. Discussion also evidenced that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures.

Review of patient care records evidenced that validated 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 consistently completed following each incident and that care management and patients' representatives were notified appropriately.

Where patients required bedrails, to maintain their safety whilst in bed, there was evidence that risk assessments had been completed; and that regular safety checks had been carried out, when the patients were in bed. The care plans reflected the assessment outcome and included the reasons why less restrictive measures were not suitable for the patients. Where bedrails were not suitable for use, there was evidence that staff had completed a bedrails balance tool, to support their decision making.

There were processes in place to check that emergency equipment, such as the suction machines, were regularly checked as being in good order and fit for use. This meant that in the event of an emergency the equipment was ready for use.

A review of the home's environment was undertaken which included a number of bedrooms, bathrooms, shower and toilet facilities, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. However, the sluice rooms were observed to have a large amount of commodes stored there, which meant that the staff could not access the clinical waste bins or the sink, where the bed pans would be washed. Although the staff consulted with were able to describe how they cleaned commodes after use; the commodes in both sluice rooms were not all clean. Commode cleaning schedules were also not available for inspection. This was discussed with the manager; and has been identified as an area for improvement.

Fire exits and corridors were observed to be clear of clutter and obstruction. The emergency evacuation register was up to date and included the details of the last patient admitted to the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff induction, training, supervision and appraisal, adult safeguarding, and risk management processes.

Areas for improvement

Areas for improvement were identified in relation to the decontamination and storage of commodes; and the recruitment practices.

	Regulations	Standards
Total number of areas for improvement	1	1

6.5 Is care effective?

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

Review of seven patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

There were a number of examples of good practice found throughout the inspection in this domain. For example, registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), Speech and language therapist (SALT), dietician and Tissue Viability Nurse specialists (TVN). A review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patients' records.

A review of wound care records evidenced that wound care was managed in line with best practice. A review of the records of one patient evidenced that the dressing had been changed according to the care plan. 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. Advice was given in relation to dating the photographs.

There was also good practice identified in relation to the management of diabetes. The signs and symptoms of hypoglycaemia and hyperglycaemia were included in the care plan; there was evidence that blood glucose monitoring was undertaken, in keeping with the prescribed insulin regimen.

Where patients were prescribed antibiotic therapy for the treatment of acute infections, care plans had been developed in relation to this; and patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

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, as appropriate. The supplementary care booklets had the relevant repositioning regimes and consistency of recommended diet recorded on the front; this ensured that care staff, were aware of this information.

Despite the areas of good practice identified, there were some areas identified for improvement. For example, a review of the bowel records evidenced gaps of up to seven days in many of the records. The records of colostomy activity were also confusing in the way they were being recorded; and there was no evidence that the registered nurses had oversight of the bowel records. This was discussed with the manager and has been identified as an area for improvement.

Patients who required urinary catheters had care plans in place, to ensure that they were managed in keeping with best practice guidance. The care plan included detail on hygiene care of the catheter; the frequency of tube change; and monitoring of fluid intake and output. However, there was no evidence that the care staff recorded when the catheter leg bags were changed. Despite this, discussion with care staff confirmed that catheter leg bags were routinely changed, on the patients' shower day. Advice was given to the manager, in relation to the recording of this information.

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

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a patient register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

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 meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The most recent registered nurses' meeting was held in 21 March 2017; and a general staff meeting was held on 22 March 2017. A health and safety/clinical governance meeting was also held on 17 May 2017, which included information arising from the audits of accidents, undertaken by the manager. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities.

All those consulted with confirmed that if they had any concerns, they could raise these with the staff and/or the manager. A patients' and relatives' meeting had been held on 13 April 2017 and records were available. The manager also obtained feedback from two relatives every month, to ascertain their views on the home environment and the safety of the care provided. A review of the feedback provided on this system; identified that one relative had recently queried whether the staff had participated in fire drills. The manager was aware of this and outlined to the inspector how this would be addressed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the completion of risk assessments and care plans; wound care management and the management of diabetes; repositioning and fluid intake monitoring; and communication between residents, staff and other key stakeholders.

Areas for improvement

An area for improvement was identified in relation to the accuracy of the bowel records and the oversight the registered nurses had of these records.

	Regulations	Standards
Total number of areas for improvement	1	0

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.

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with eight 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 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.

Patients stated that they were involved in decision making about their own care; and staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. One patient was identified as being unable to verbalise their feelings; staff had developed a communication tool, to assist them in identifying the patient's needs. A referral had also been made to the speech and language therapist for specialist advice in this area. The manager also explained that the home had become involved

with associations such as 'Deaf and Blind NI' and that training had recently been delivered in the home. They explained that they were looking at ways to enhance the quality of life for patients living in the home; and that plans were in place to purchase larger remote controls and talking clocks etcetera.

Patients were offered a choice of meals, snacks and drinks throughout the day. We observed the lunch time meal in two dining rooms. The lunch served appeared appetising and patients spoken with stated that they were satisfied with the meals provided. The atmosphere was quiet and tranquil and patients were encouraged to eat their food; assistance was provided by staff, as required. Menus were displayed in pictorial format to assist in making choices and to provide an awareness of the meal to be served.

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. Two staff members were designated to provide activities in the home. Patients consulted with stated that there were different activities they could participate in. On the day of the inspection, the activities coordinator involved the patients in making pancakes, which they evidently enjoyed. Relatives consulted with stated that there was a variety of activities in the home and discussion with patients confirmed that they were given a choice with regards to what they wanted to participate in. There were various photographs displayed around the home of patients' participation in recent activities; for example, the staff celebrated significant birthdays for patients; and the home had arranged for a local country music star to sing for the patients. Advice was given in relation to displaying the planned activities, so that patients and relatives could be aware of what activities were planned.

There was evidence of regular church services to suit different denominations.

The care plans detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for the patients, as appropriate. 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. At the time of the inspection no one was receiving end of life care.

Discussion with the 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. An annual quality audit had been undertaken on 31 March 2017.

An electronic feedback system was also situated in the reception area. This was available to relatives and other visitors to give general feedback on an ongoing basis or answer specific questions on the theme of the month. The feedback was summarised automatically by the system and the results were available to the registered manager and the regional manager.

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 manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and their relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included praise for the 'unstinting and unwavering attention' given to a patient who had been receiving end of life care.

Consultation

During the inspection, we met with eight patients, three care staff, one registered nurse, one kitchen staff, one laundry staff and five patients' representative. Some comments received are detailed below:

Staff

"The (nursing and care staff) are very good".
"I have no problems".
"In general, the care is very good".
"I have no concerns".
"There are no issues here".

Patients

"It is all very good, I don't ask for much".
"I have no complaints".
"I have no problems, but they could hurry up a bit".
"It is surprising how quickly they come when you need them".
"I have not had any need to complain, but there is no place like your own home".
"I am happy enough".
"Everything is grand".

One patient commented further, in relation to the attitude of some of the staff; and stated that they did not like to complain. This comment was relayed to the manager during feedback, to address with staff.

Patients' representatives

"'It is very nice, I visit a lot of nursing homes and this is the best of them".
"There are very good reports about this home locally, we have no concerns at all".
"I am not 99% happy, but actually 100% happy with everything here".
"We have no concerns".

We also issued ten questionnaires to staff and relatives respectively and eight questionnaires to patients. No patients' questionnaires were returned within the timeframe for inclusion in this report. However, ten staff and six relatives had returned their questionnaires. Comments and outcomes were as follows:

Relatives: respondents indicated that they were either 'very satisfied' or 'satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. One respondent provided written comment in relation to the staffing levels, stating that some patients had to wait up to 30 minutes to be brought to the toilet and that more activities should be provided for mental stimulation. The respondent also indicated that their relative's hearing aid was not always inserted. Other written comments included 'very good working staff and management', 'we are provided with love and care' and 'the care is of a very high standard'. Following the inspection, this comment was relayed to the manager to address.

Staff: the majority of respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led.

However, one respondent indicated that they were unsatisfied that there were sufficient staff to meet the needs of the patients. Written comments received included 'staff appear stressed and unable to (carry out) all residents' needs due to heavy workload and filling in charts etc.', 'the skill mix sometimes poor and dependency levels not taken into account' and 'would benefit from better care if more staff were on duty, although staff are able to meet the residents' needs'. Two respondents provided written comment in relation to the patients having a say in how their care is delivered. Comments included 'due to demands in the nursing home, we need a routine on a daily basis, so it's not always possible to deliver care to everyone's likings' and 'residents (are) expected to fit in with daily routine of the home'. Given that no such concerns were identified during the inspection, these comments were relayed to the manager, who provided assurances that these matters would be addressed.

Any comments from patient representatives and staff in returned questionnaires received after the return date will be shared with the registered 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 and taking account of the views of patients. Mealtimes and activities were well managed.

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.

Observation of patients and consultation with staff 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 staff spoken with confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. All those consulted with described the manager in positive terms; comments included 'she is very approachable' and 'she's very good'. Staff described how they felt confident that the manager would respond positively to any concerns/suggestions raised.

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. There was a system in place to identify the person in charge of the home, in the absence of the manager. Advice was given in relation to ensuring that this was recorded on the duty rota.

A 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 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 confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the manager was.

Discussion with the 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. As discussed in section 6.4, the two sluice rooms were observed to have too many commodes stored there; and a number of commodes had not been cleaned. A review of the infection prevention and control audits confirmed that this had not been identified through this process. This was discussed with the manager who advised that the checking of the sluice rooms would be included in the manager's daily environmental audits. This has already been identified as an area for improvement in the domain of safe care.

A review of the patient falls audit evidenced that this was analysed to identify patterns and trends, on a monthly basis. Through discussion, it was evident that the manager had identified patients who had most frequently fallen; and appropriate measures had been put in place, to further reduce the rate of falls. Advice was given in relation to recording this information. The accidents which occurred in the home also informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

As a further element of its Quality of Life Programme, Four Seasons Healthcare operate a Thematic Resident Care Audit ("TRaCA") which home managers can complete electronically. Information such as home governance, information governance, housekeeping, resident care and health and safety checks are recorded on various TRaCAs on a regular basis. This information was subject to checks by the regional manager once a month. A review of the "resident care TRaCA" confirmed that when shortfalls had been identified, these were followed up in a timely manner by the registered nurses.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection, confirmed that these were appropriately managed.

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 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. An action plan was generated to address any areas for improvement; discussion with the manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships within the home.

Areas for improvement

No areas for improvement were identified during the inspection; however, consideration should be given to the areas for improvement identified in the domains of safe and effective care.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ailish Devlin, manager, 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 DHSSPS 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.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

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:** First time **To be completed by:** immediate from the day of the inspection	The registered persons shall review the arrangements for the decontamination and storage of commodes within the home. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: Supervisions have been carried out with staff in relation to the decontamination and storage of commodes. This has also been discussed at the staff meetings on the 29th and 30th of June. The Manager is montioring compliance during the daily walkaround to ensure a high standard is maintained. Cleaning and decontamination records are now in place and will be closely montiored.
Area for improvement 2 **Ref:** Regulation 13 (1) (a) and (b) **Stated:** First time **To be completed by:** immediate from the day of the inspection	The registered persons shall ensure that bowel records are accurately maintained; and that the registered nurses have oversight of these records, to ensure that deficits are identified and appropriate action is taken, as appropriate. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: A Bowel audit chart has been implemented to ensure that the registered nurses have an oversight of bowel recording and actioned taken where applicable. The Manager has conducted supervisions with staff on recording accurately in bowel charts.
Action required to ensure compliance with The DHSSPS Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref**: Standard 38.3 **Stated:** First time **To be completed by:** 11 August 2017	The registered persons shall ensure that two written references linked to the requirements of the job are obtained for all staff, one of which must be from the applicant's present or most recent employer. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: The identifed missing reference had been obtained following inspection and going forward all new staff to have 2 satisfactory references before commencing employment. This will be monitored through the internal audit system and during Regulation 29 visits.

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

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