Unannounced Care Inspection Report
12 September 2016

Hamilton Private Nursing Home

Type of Service: Nursing Home
Address: The Plantain, 168 Ballycorr Road, Ballyclare BT39 9DF
Tel no: 02893341396
Inspector: Karen Scarlett

1.0 Summary

An unannounced inspection of Hamilton Private Nursing Home took place on 12 September 2016 from 09.10 to 15.00 hours.

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

Is care safe?

The home was found to be well presented, warm and clean. Discussion with staff, observation and review of the duty rota evidenced that planned staffing levels were adhered to and no concerns were raised in relation to staffing. Weaknesses were identified in the delivery of safe care, specifically in relation to staff training in adult safeguarding and a recommendation has been made.

Is care effective?

A review of care records evidenced that risk assessments had been completed and reviewed in order to inform the care planning process. There was evidence of team work and systems were in place to ensure effective communication among the staff team. Staff spoken with confirmed that there were regular staff meetings although minutes of the latest meeting were not available for review. These were forwarded to RQIA by the registered manager following the inspection. No requirements or recommendations were made as a result of the findings of this inspection. In relation to the delivery of effective care, a recommendation made at a previous inspection in regards to the management of end of life care planning has now been stated as a requirement. In addition, a review of fluid balance and repositioning charts identified ongoing concerns with the completion of these. Two requirements made in this regard have been stated for a third and final time in consultation with senior management in RQIA.

Is care compassionate?

There was evidence of good relationships in the home between staff and patients. Patients were very praiseworthy of staff and a number of their comments are included in the report. An activity therapist had been employed since the previous care inspection and was making a positive impact on patients' experience.

Is the service well led?

There was a clear organisational structure in the home. Complaints and notifications regarding incidents and accidents were managed appropriately. Two recommendations have been made, one in relation to the nurse in charge of the home in the absence of the manager and another in relation to the management of restrictive practices. Two recommendations made previously in relation to infection control audits and care record audits have not been met and have been stated for a second time in order to secure compliance and drive improvement.

The term 'patients' is used to describe those living in Hamilton Private Nursing Home as it provides both nursing and residential care.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**3***	**7***

***The total number of requirements and recommendations above include two requirements which have been stated for a third and final time, three recommendations stated for a second time and one recommendation stated for a third and final time.

In the absence of the registered manager, details of the Quality Improvement Plan (QIP) within this report were discussed with Janice Todd, registered nurse, and Patrick Hamilton, manager, as part of the inspection process. The findings were discussed with Lucy Hamilton, registered manager, by phone on 15 September 2016. 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 medicines management inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 7 April 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

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

2.0 Service details

Registered organisation/registered person: Mrs Heather Hamilton	**Registered manager:** Ms Lucinda Dawn Hamilton
Person in charge of the home at the time of inspection: Janice Todd, registered nurse	**Date manager registered:** 05 June 2008

Categories of care: NH-I, NH-PH, RC-I, RC-MP(E), RC-PH(E) A maximum of 3 residents in categories RC-I, RC-MP(E) or RC-PH(E) with 1 additional identified resident in category RC-I. Category NH-PH for 1 identified patient only.	**Number of registered places:** 36

3.0 Methods/processes

Prior to inspection we analysed the following records:

- 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 plan (QIP) from the previous care inspection
- the previous care inspection report
- pre-inspection audit.

During the inspection we met with six patients, three care staff, two registered nurses and two patient's visitors/representatives. Questionnaires were also left with the nurse in charge to distribute; 10 for staff not on duty at the time of the inspection, 10 for relatives and five for patients.

The following information was examined during the inspection:

- three patient care records and a selection of daily charts
- staff duty rotas from 5 September until 18 September 2016
- staff training records
- a random sample of incident and accident records from the previous three months
- complaints records from the previous care inspection
- a sample of audits
- monthly quality monitoring reports for the previous three months
- minutes of staff meetings
- one recent recruitment file.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 7 April 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 8 March 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 12 (1) (a) & (b) **Stated:** Second time	The registered person shall provide treatment to patients which meets their individual needs and reflects current best practice. This is particularly in relation to: • ensuring that the repositioning schedule is adhered to and records of same are up to date • individualised time frames for repositioning are recorded on the chart and care plan	**Partially Met**
	Action taken as confirmed during the inspection: Since the previous care inspection new repositioning charts had been introduced to allow staff to complete the condition of the skin using best practice guidelines and to indicate the position of the patient. The charts also indicated the individualised time frames for repositioning as stated in the care plan. This represented an improvement since the previous inspection. It was disappointing that these were not being consistently completed, particularly at night, and long gaps were noted, of up to 22 hours between entries in one record reviewed. This requirement has been partially met. In consultation with senior management in RQIA it was decided that as some progress had been made that the requirement would be stated for a third and final time.	
Requirement 2 **Ref:** Regulation 15 (2) **Stated:** Second time	The registered person must ensure that the assessment of patient's needs is kept under review, particularly in relation to: • ensuring that fluid balance charts are recorded and totalled accurately and appropriate actions taken as required	**Not Met**
	Action taken as confirmed during the inspection: Since the previous care inspection new food and fluid charts had been introduced and these were an improvement. A review of three patient fluid intake charts evidenced that although some	

	improvements had been made in the standard of recording, charts were inconsistently completed and in one chart there were several occasions when no entries had been made after 16.00 hours until the next morning. There was no indication of the fluid target for two of the three patients reviewed. There was insufficient evidence that registered nursing staff had responded to poor oral intake. Despite the charts indicating a poor oral intake the registered nurses indicated in the progress notes comments such as, 'eating and drinking well' and 'eating and drinking as charted'. In one case a patient with poor oral intake over several days had developed a urinary tract infection and was commenced on antibiotics, which may have been preventable. The charts were generally totalled correctly at the end of each 24 hour period and entered into the progress notes by the night staff but it was concerning that no apparent action had been taken to address deficits. This was discussed with the registered nurses on duty who accepted that improvements could be made. The findings were discussed with senior management in RQIA and given that some progress had been made in the quality of recording and the assurances given by two registered nurses, it was decided to state the requirement for a third and final time.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 46, criterion 2 and 3 **Stated:** First time	Regular infection prevention and control audits should be carried out and documented and any deficits actioned appropriately.	**Partially Met**
	Action taken as confirmed during the inspection: Since the previous inspection monthly infection control audits had been carried out. However, an issue had been identified for two consecutive months and there was no evidence that action had been taken to address this. The recommendation has been partially met but the audits require development to ensure that actions have been taken to address the identified deficits and this appropriately documented. This has been stated for a second time.	

Recommendation 2 **Ref**: Standard 12, criterion 20 **Stated:** First time	Dining arrangements should be reviewed as patient numbers increase to ensure that patients are enabled to have their meals in the dining room should they so choose.	**Met**
	Action taken as confirmed during the inspection: The breakfast and lunch time meal service was observed in the dining room. An extra table had been placed in the dining room to facilitate patients to eat their meal there should they so choose. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 47 **Stated:** Second time	Oxygen cylinders should be securely stored at all times.	**Met**
	Action taken as confirmed during the inspection: Oxygen cylinders were observed to be securely stored. This recommendation has been met.	
Recommendation 4 **Ref:** Standard 25.11 **Stated:** Second time	Care records should be regularly audited to ensure they are consistent with the home's policies and procedures and appropriate actions taken to enhance the quality of care.	**Not Met**
	Action taken as confirmed during the inspection: There was evidence that seven audits had been carried out between April and June. There was no audit schedule in evidence to guide staff in the numbers and frequency of audits required. It was further noted that where deficits had been identified there was no evidence that these had been addressed and the action documented. The audits require further development and the recommendation has not been met.	
Recommendation 5 **Ref**: Standard 19 **Stated:** First time	The regional guidelines for breaking bad news should be made available for staff to reference as required	**Not Met**
	Action taken as confirmed during the inspection: These guidelines had not been made available to staff. This recommendation has not been met and has been stated for a second time.	

Recommendation 6 **Ref**: Standard 20, criterion 2 **Stated:** First time	End of life care and death arrangements should be discussed with patients and a personalised care plan drawn up, as appropriate.	**Not Met**
	Action taken as confirmed during the inspection: One relevant patient care record was reviewed and it could not be evidenced that a personalised end of life care plan had been drawn up. A care plan was in place regarding the patient's resuscitation status and this referenced pain management but did not include the patient's wishes in terms of end of life care or death arrangements. From a review of the care plan it was not apparent that the patient's condition had deteriorated. Deterioration was noted in the progress notes and daily diary but the care plan was not reflective of the current condition of the patient in terms of their mobility, eating and drinking, pain management, mouth care or medication needs. This recommendation has not been met and has been subsumed into a requirement.	
Recommendation 7 **Ref**: Standard 12 **Stated:** First time	The mealtime experience of patients should be reviewed to ensure that hot food is served hot.	**Not Met**
	Action taken as confirmed during the inspection: The lunchtime meal was taken to the lounge uncovered with the potential for the food to be served cold. This recommendation has not been met and has been stated for the second time.	
Recommendation 8 **Ref**: Standard 12, criterion 27 **Stated:** First time	An accurate record should be kept of the food consumed or refused by patients who are identified as being at risk of malnutrition or overweight. Where necessary, a referral should be made to the relevant professional.	**Met**
	Action taken as confirmed during the inspection: Food charts were in place for those identified to be at nutritional risk. The food charts reviewed were consistently well kept and indicated the amount taken at each meal. This recommendation has been met.	

Recommendation 9 **Ref**: Standard 37 **Stated:** First time	Clear, documented systems should be put in place for the management of records in accordance with legislative requirements and best practice guidance.	**Met**
	Action taken as confirmed during the inspection: Records were found to be well archived and managed to protect confidentiality. This recommendation has been met.	

4.3 Is care safe?

The nurse in charge 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.

A review of duty rotas for nursing and care staff confirmed that planned staffing levels were adhered to. No concerns were raised by patients, their representatives or staff in regards to the staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

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.

The staff training file for the home was reviewed. This contained a number of staff training certificates filed per subject. There was evidence that mandatory training was being undertaken but it was difficult to ascertain the total numbers of staff trained in each topic for the 2015-16 year. The system for ensuring staff attendance at training was insufficiently robust and the nurse in charge was given advice to consider a training matrix/schedule for 2016/17 to assist with this process. Staff confirmed in discussion that they had undertaken recent training in manual handling and first aid/defibrillation. From a review of the file there were eight staff who had undertaken recent training in adult safeguarding. Two registered nurses stated that they had not had recent safeguarding training. In discussion, RQIA were not assured that they were clear regarding their roles and responsibilities in relation to adult safeguarding. Two care assistants spoken with had recently undergone their induction and had received this training and were able to demonstrate knowledge of different forms of abuse and the process to follow upon witnessing any abuse. There are currently no ongoing safeguarding concerns in the home. A recommendation has been made that all staff receive training in adult safeguarding.

A review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

Review of three 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.

Incident and accident records were kept in relation to falls. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. RQIA had been appropriately notified of relevant incidents and accidents.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining room and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients, their representatives and staff spoken with were complimentary in respect of the home's environment which had recently undergone extensive refurbishment. Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

A recommendation has been made that the registered persons ensure that all staff receive training in adult safeguarding.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

Review of three 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.

Two of the three care records reviewed 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. One care plan was reviewed in relation to end of life care which failed to reflect the current needs of the patient. A previous recommendation made in this regard has now been stated as a requirement. Please refer to section 4.2 for further information.

A review of supplementary care charts including food and fluid and repositioning charts could not evidence that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Two requirements made previously in this regard have now been stated for a third and final time in consultation with senior management in RQIA. Two registered nurses spoken with were of the opinion that, with the employment of new care staff in recent months, they may require more supervision in regards to the completion of daily charts. Assurances were given that this would be prioritised. Staff spoken with demonstrated an awareness of the importance of contemporaneous record keeping.

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.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

Discussion with staff confirmed that staff meetings were held on a regular basis, however, the last minutes on file dated from April 2016. Following a telephone conversation with the registered manager on 15 September 2016 a copy of the minutes of the July staff meeting were forwarded to RQIA. A copy of the minutes should be made available to staff in the staff meeting file.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and/or the registered manager.

All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. In addition, daily diaries were in use as a tool for staff to exchange up to date information in relation to patients. Staff were also observed to be having regular, informal meetings around the nurses' station in relation to patient care.

Patients and representatives spoken with expressed their confidence in raising concerns with the home's staff/management. Patients and representatives were aware of who their named nurse was and knew the registered manager.

Areas for improvement

One previous recommendation in relation to end of life care planning has now been stated as a requirement. Two requirements made previously in relation to the completion of fluid and repositioning charts have been stated for a third and final time.

No further areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. One domestic assistant was noted to stop her cleaning work to assist a patient across the wet floor and safely into the lounge. The activities therapist was now in post three days per week and maintained individual folders of each patient's art work and activities. Patients had recently been involved in arranging flowers and the activities therapist explained that patients had made an arrangement and a card to place in the room of a recently deceased patient in remembrance. Patients were observed to be playing a ball game in the lounge, conversing with one another and enjoying themselves.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

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.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Discussion with the manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. Questionnaires had recently been distributed to patients and relatives and the management were awaiting the returns in order to produce a report to be shared with all service users. The report for November 2014 was reviewed which demonstrated that concerns raised in relation to the meal service had been addressed in response.

Those patients and their representatives spoken with stated that they had not had an occasion to complain but confirmed that when they would feel confident in raising a concern or query with the management or staff.

Six patients spoke with RQIA at the inspection. One patient confirmed that they had no complaints and were very happy with their decision to come to Hamilton. Another patient had recently been admitted and commented positively on their bedroom and the ensuite facilities. Another patient stated that they were very well looked after. Five questionnaires were left with the nurse in charge to distribute to patients and five were returned. All respondents expressed a high level of satisfaction with the care provided and no concerns were raised.

Two patient's representatives spoke with RQIA and commented positively on the care and the staff. They were particularly appreciative of the new café area which enabled them to visit with their relative and make a cup of coffee to enjoy. They were of the opinion that this also protected their relative's privacy as they did not have to entertain guests in their bedroom. Ten questionnaires were left with the nurse in charge to distribute to relatives/representatives and ten were returned. The respondents indicated a high level of satisfaction with the care provided.

Staff spoken with were very positive about working in Hamilton and commented on the good team working and the support of the registered manager. No concerns were raised with RQIA. Ten questionnaires were left with the nurse in charge for distribution to staff not on duty on the day of inspection. Eight were returned and seven expressed high levels of satisfaction with the care provided. One respondent was of the opinion that care was 'good' but stated that "service users do not get repositioned at 3-4 hourly as frequent as they should as can be seen on charts." They also answered 'no' when asked if they could express their opinions or suggestions, stating that nurses, senior carers and managers make decisions. This was discussed with the registered manager following the inspection. The registered manager assured RQIA that if staff members have concerns or suggestions that they can discuss these with her at any time. She further stated that she carefully monitors the completion of repositioning charts and assured RQIA that these are being completed accurately.

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 staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

On entering the nursing home the inspector was greeted by a registered nurse. When asked who was in charge, the nurse stated that the registered manager was on leave and there were two of them in charge today. A recommendation has been made that in the absence of the registered manager that one registered nurse is allocated as the nurse in charge.

The registration certificate and a certificate of public liability insurance were up to date and displayed appropriately. Discussion with the manager, registered nurses and observations evidenced that the home was operating within its registered categories of care.

A policies and procedures manual was available for the home and these were systematically reviewed on a three yearly basis or as required.

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 DHSSPS Care Standards for Nursing Homes 2015. A recent complaint by a relative was reviewed. As the result of a patient's fall an alarm mat and tab alarm had been introduced which the patient concerned objected too as they believed this to be restrictive. The registered manager confirmed, in a follow up telephone conversation, that the patient lacked capacity and they had made the decision to use equipment in their best interest. A review of the care record could not evidence that there had been any consent or discussion with family or the multi-disciplinary team around the use of these alarms. A recommendation has been made that where potentially restrictive devices or practices are considered for use that this is considered in accordance with standard 18 of the Care Standards for Nursing Homes, 2015.

Patients and their 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.

A review of records evidenced that systems were in place to ensure that notifiable events were reported to RQIA or other relevant bodies appropriately.

In the absence of the registered manager it was difficult to ascertain the systems in place to monitor and report on the quality of nursing and other services provided. This will continue to be monitored as part of the ongoing programme of inspection. There was evidence that audits were completed in relation to care records, infection prevention and control and the environment. Recommendations made previously in relation to the completion of infection control and care record audits have been stated for a second and third time respectively, as a result of the findings of this inspection. Further development is required to ensure that appropriate actions have been taken to address any shortfalls identified and these documented. Please refer to section 4.2 for further information.

Discussion with the registered manager and review of records evidenced that monthly quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. There was evidence that issues identified at the previous

month had been reviewed and actioned. Copies of the reports were available for patients, their representatives, staff and Trust representatives.

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Areas for improvement

A recommendation has been made that in the absence of the registered manager a capable and competent registered nurse is allocated as the nurse in charge.

A recommendation has been made that where potentially restrictive devices or practices are considered for use that this is considered in accordance with standard 18 of the Care Standards for Nursing Homes, 2015.

Number of requirements	0	Number of recommendations	2

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Janice Todd, registered nurse, and Patrick Hamilton, manager, as part of the inspection process. The findings were discussed with Lucy Hamilton, registered manager, by phone on 15 September 2016. The timescales commence from the date of inspection.

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

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

5.1 Statutory requirements

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

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

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

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

Quality Improvement Plan

Statutory requirements

Requirement 1 **Ref**: Regulation 12 (1) (a) & (b) **Stated:** Third and final time **To be completed by:** 31 October 2016	The registered person shall provide treatment to patients which meets their individual needs and reflects current best practice. This is particularly in relation to: • ensuring that the repositioning schedule is adhered to and records of same are up to date **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: All residents in HPNH with a Braden score of 18 or below are on a repositioning schedules - currently 13 residents are on repositioning schedules and charts. Care assistants now have 3 short staff meetings a day and at these meetings the documentation is checked and signed off by the nurse in charge. The nurse has a a new supervision of care assistants' documentation book and this is completed 3 times a day. All nurses and care assistants have been made aware of the importance of accurate documentation. The registered nurse manager checks the documentation twice weekly.
Requirement 2 **Ref:** Regulation 15 (2) **Stated:** Third and final time **To be completed by:** 31 October 2016	The registered person must ensure that the assessment of patient's needs is kept under review, particularly in relation to: • ensuring that fluid balance charts are recorded and totalled accurately and appropriate actions taken as required **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Care assistants now have 3 short staff meetings a day and at these meetings the documentation is checked and signed off by the nurse in charge. The nurse has a a new supervision of care assistants' documentation book and this is completed 3 times a day. All nurses and care assistants have been made aware of the importance of accurate documentation. The registered nurse manager checks the documentation twice weekly. All nurses have been made aware of the importance of totalling the fluid balance charts and taking appropriate action.
Requirement 3 **Ref:** Regulation 16 (1) and (2) (b) **Stated:** First time **To be completed by:**	The registered provider must ensure that a written nursing plan is prepared by a nurse in consultation with the patient or patient's representative as to how the patient's needs in respect of his health and welfare are to be met. This patient's plan must be kept under review. This is particularly in relation to patients' palliative and end of life care needs. **Ref: Section 4.2**

14 November 2016	**Response by registered provider detailing the actions taken:** In future, any palliative or end of life care patient will have a written care plan to meet their specific needs at end of life. This will be prepared by the nurse in consultation with the patient or patient's representative.
Recommendations	
Recommendation 1 **Ref**: Standard 46, criteria 2 and 3 **Stated:** Second time **To be completed by:** 14 December 2016	Regular infection prevention and control audits should be carried out and documented and any deficits actioned appropriately. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Infection prevention and control audits are carried out monthly. I have added a page to detail any actions required and the relevant dates.
Recommendation 2 **Ref**: Standard 25, 11 **Stated:** Third and final time **To be completed by:** 14 December 2016	Care records should be regularly audited to ensure they are consistent with the home's policies and procedures and appropriate actions taken to enhance the quality of care. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Care plan audits are now carried out monthly by the nurse manager. Any actions required are communicated to the named nurses and when changes are made they are signed off in the Care Plan Audit File.
Recommendation 3 **Ref**: Standard 19 **Stated:** Second time **To be completed by:** 14 October 2016	The regional guidelines for breaking bad news should be made available for staff to reference as required. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: The regional guidelines for breaking bad news have been emailed to all nurses and care assistants at HPNH. 4 copies are printed and are available for staff to access at the nurses' station.
Recommendation 4 **Ref**: Standard 12 **Stated:** Second time **To be completed by:** 14 October 2016	The mealtime experience of patients should be reviewed to ensure that hot food is served hot. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: All meals going to bedrooms and to the lounge areas are covered by metal covers which help to keep the food warm.
Recommendation 5 **Ref**: Standard 13, criterion 11	The registered provider should ensure that all staff have adult safeguarding training appropriate to their role. **Ref: Section 4.3**

Stated: First time **To be completed by:** 14 December 2016	**Response by registered provider detailing the actions taken:** All staff at HPNH have now received safeguarding training appropriate to their role.
Recommendation 6 **Ref**: Standard 41, criterion 7 **Stated:** First time **To be completed by:** 14 December 2016	The registered persons should ensure that, in the absence of the registered manager, a capable and competent registered nurse is allocated as the nurse in charge. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: The nurse in charge is highlighted on the duty rota in a darker colour of blue.
Recommendation 7 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 14 December 2016	The registered persons should ensure that where potentially restrictive devices or practices are considered for use that this is considered in accordance with standard 18 of the Care Standards for Nursing Homes, 2015. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: A form has been drawn up and the NOK of any resident currently using an alarm mat either beside their bed or on their arm chair have been asked to sign. This will be kept in the resident's care notes.

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews