Unannounced Care Inspection Report
1 and 3 November 2017

Fairfields Care Centre

Type of Service: Nursing Home (NH)
Address: 80a Fair Hill Road, Cookstown, BT80 8DE
Tel no: 028 8676 6294
Inspector: Heather Sleator

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 70 persons.

3.0 Service details

Organisation/Registered Provider: Care Facilities and Management Ltd **Responsible Individual:** Mrs Barbara Haughey	**Registered Manager:** Mr Phillip McGowan
Person in charge at the time of inspection: Mr Phillip McGowan	**Date manager registered:** 18 April 2016
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. MP (E) - Mental disorder excluding learning disability or dementia – over 65 years. LD (E) – Learning disability – over 65 years. PH – Physical disability other than sensory impairment.	**Number of registered places:** 70 comprising: 28 – NH- DE 1 - NH-MP(E) 1 - NH-LD (E) The home is also approved to provide care on a day basis for 5 persons. There shall be a maximum of 4 named residents receiving residential care in category RC-I.

4.0 Inspection summary

An unannounced inspection took place on 1 November 2017 from 09:35 to 17:00 and 3 November 2017 from 11:00 to 15:15.

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 Fairfields which provides both nursing and residential care.

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

Evidence of good practice was found in relation to staff recruitment practices; staff induction, the provision of activities and effective communication systems. There was evidence of good practice in maintaining good relationships within the home. The environment of the home was generally conducive to the needs of the patients and was attractive and comfortable.

Areas identified for improvement under regulation were in relation to; adherence to the infection prevention and control regional guidance and procedures, fire safety procedures, adult safeguarding, ensuring the delivery of care promotes and makes proper provision for the nursing, health and welfare of patients and implementing an effective quality monitoring, and governance systems.

As a consequence of the concerns identified in respect of fire safety, contact was made with the registered person post inspection. Written confirmation was requested and subsequently submitted by the registered manager that the required actions identified by the fire risk assessor had been appropriately actioned.

Areas requiring improvement were identified under the care standards and included; supplementary care records including repositioning records are maintained accurately, staff training and awareness, the auditing of care records and the monthly analysis of falls and accidents, dementia awareness and the establishment of a system that identifies the person in charge of the home in the absence of the registered manager.

Three standards previously identified were either partially met or not met and have been subsumed into regulations. Refer to section 6.2 for further information regarding this.

Patients said they were happy living in the home. Comments included, “I’m quite happy and have no complaints about the home.” Further comments can be viewed in section 6.6 of the report.

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	*8	*5

*The total number of areas for improvement includes one regulation and one standard which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Phillip McGowan, 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.

4.2 Action/enforcement taken following the most recent inspection dated 19 September 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 19 September 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 the inspection a range of information relevant to the service was reviewed. This included the following records:

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

During the inspection the inspector met with 16 patients individually and others in small groups, eight staff and two patients' visitors/representatives. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster informing staff of how to submit their comments electronically, if so wished, was given to the manager to display in the staff room.

The following records were examined during the inspection:

- duty rota for all staff from 16 to 29 October 2017
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- six patient care records
- four patient care charts including food and fluid intake charts and reposition charts
- staff supervision and appraisal planners
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

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.

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

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

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 19 September 2017

The most recent inspection of the home was an unannounced medicines management inspection.

The completed QIP was returned and approved by the pharmacist inspector.

This QIP will be validated by the pharmacist inspector at the next medicines management inspection

6.2 Review of areas for improvement from the last care inspection dated 23 March 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 16 (1) and (2) **Stated:** First time	The registered provider must ensure that registered nurses assess, plan, evaluate and review care in accordance with legislative and professional standards.	**Not met**
	Action taken as confirmed during the inspection: The review of six patient care records did not evidence a consistent approach to and adherence to the nursing process. Deficits were evident in the six care records selected for review. This area for improvement has not been met and has been stated for a second time.	

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 **Ref:** Standard 46.2 **Stated:** First time	The registered provider should ensure that infection prevention and control procedures regarding the equipment in the home are reviewed and identified deficiencies in the equipment addressed.	**Not met**
	Action taken as confirmed during the inspection: Observation of the infection prevention and control measures in the home did not evidence that staff were adhering to regional guidance. Deficits were in evidence regarding decontamination of equipment, the laundering of hoist slings and toileting slings and of the inappropriate storage and cleanliness of the sluice rooms in the home. This area for improvement has not been met and has been subsumed into a regulation in the quality improvement plan of this report.	
Area for improvement 2 **Ref:** Standard 38.3 **Stated:** First time	The registered provider should ensure that staff personnel records should identify the date clearance information in respect of Access NI was received.	**Met**
	Action taken as confirmed during the inspection: The review of two staff selection and recruitment files evidenced that the date the Access NI check was sent for and received, along with the date the staff member commenced in the home were present. The starting date of employment was after receipt of the Access NI clearance check.	
Area for improvement 3 **Ref:** Standard 39.1 **Stated:** First time	The registered provider should ensure that confirmation is present that all staff have completed a structured induction training programme when commencing employment in the home.	**Met**
	Action taken as confirmed during the inspection: The review of two staff induction training records retained within their staff personnel file evidenced that a structured induction training programme had been completed.	

Area for improvement 4 **Ref:** Standard 40 **Stated:** First time	The registered provider should ensure that a more structured and systematic approach to staff appraisal and supervision is established.	**Partially met**
	Action taken as confirmed during the inspection: The review of staff appraisal and supervision records evidenced that the majority of staff had been in receipt of an annual appraisal. Supervision records did not evidence a systematic approach to staff supervision. Refer to sections 6.4 This area for improvement has not been met and has been stated for a second time.	
Area for improvement 5 **Ref:** Standard 35.6 **Stated:** First time	The registered provider should ensure that the quality auditing processes in place accurately reflect the day to day services provided by the home in accordance with legislative requirements and the Care Standards for Nursing Homes, 2015.	**Not met**
	Action taken as confirmed during the inspection: The review of the quality auditing process in the home did not evidence these were robust and a systematic approach was in place. Refer to sections 6.4, 6.5 and 6.7. This area for improvement has not been met and has been subsumed into a regulation in the quality improvement plan of this report.	

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 registered manager confirmed the planned daily staffing levels for the home and that staffing was subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 16 October 2017 to 29 October 2017 evidenced that the planned staffing levels were adhered to. The review of the staffing rosters evidenced that there were ancillary staff on duty throughout the seven day period. Observation of the delivery of care and discussion with staff evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We also sought the opinion of staff, patients and patients representatives on staffing via questionnaires; none were returned prior to the issue of this report.

A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the manager. However, the review of the competency assessments did not evidence that they were reviewed and signed by the registered manager, at least annually, to affirm that the registered manager was satisfied that the registered nurse was capable and competent to be left in charge of the home. This has been identified as an area for improvement, refer to section 6.7.

Discussion with the registered manager and a review of two staff personnel files evidenced that recruitment processes were generally in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. The review of two staff recruitment and selection files evidenced that one staff member had commenced employment prior to a reference from their most recent employer had been received. This was discussed with the registered manager who stated that the staff member had transferred from another home within the organisation (the home, Fairfields, has subsequently come under new ownership). 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 they were suitable for employment. The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI and satisfactory references had been sought and received, prior to the staff member starting their employment.

The registered manager confirmed that newly appointed staff commenced a structured orientation and induction programme at the beginning of their employment. A review of two completed induction programmes evidenced that these were completed within a meaningful timeframe.

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the registered manager and reviewed. The review of the records did not evidence that a robust system was in place to monitor the registration status of care staff. The review of the monitoring of care staff registered with NISCC was unclear. Clarity was not present as to whether staff who were outside of, or nearing the six month time period afforded for registration by NISCC for social care workers new to the role, had commenced the registration process. This was discussed with the registered manager and identified as an area for improvement. Refer to section 6.7.

Discussion with staff and a review of the staff training records confirmed that online 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 training modules on for example; COSHH (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 training records did not confirm if staff had completed face to face training in fire safety fire drills/practice) and safe moving and handling. The records reviewed confirmed that the registered manager had a system in place to monitor staff compliance with training requirements. The registered manager stated face to face training in the identified areas had not been arranged. This has been identified as an area for improvement under regulation.

A review of the supervision and appraisal schedule confirmed that there were systems in place to ensure that staff received supervision and appraisal. The review of the records did not clearly identify that all staff had been in receipt of an annual appraisal and individual supervision. On the second day of the inspection, the registered manager produced an updated record to confirm all staff had been in receipt of an annual appraisal. Records pertaining to planned supervision remained unclear. Evidence should be maintained to demonstrate that staff had participated in the planned supervision processes. Robust systems should be in evidence regarding the mechanisms that are in place to support staff. This has been identified as an area for improvement in the previous inspection report of March 2017 and has been stated for a second time in this report. In discussion with staff they confirmed they were in receipt of supervision and an annual staff appraisal.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. The registered manager could not confirm that they had attended training which included the role of the safeguarding champion and that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. This has been identified as an area for improvement under regulation. The adult safeguarding policy reflected the new regional operational procedures.

Review of six patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. Care records are further discussed in section 6.5.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since March 2017 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients and staff spoken with were complimentary in respect of the home's environment.

The observation of the environment did not evidence infection prevention and control measures in the home were being adhered to. Concerns were identified in relation to; inappropriate storage in sluice rooms and bathrooms, sluice rooms either did not have drying racks for commodes or urinals or these were not being used appropriately by staff, not all sluice rooms were locked in keeping with COSHH legislation, and there was ineffective management of the risks of cross infection between patients in respect of the use, laundering and storage of hoist slings. This has been identified as an area for improvement in the previous inspection report of March 2017 and has been subsumed into a regulation of this report. Refer to section 7.2.

Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately with the exception of one unit in Adelaide Street, this was brought to the attention of the registered manager.

Fire exits and corridors were not observed to be clear of clutter and obstruction. A specialised chair was observed blocking a fire exit in Adelaide Street. There were no personal emergency evacuation plans (PEEP's) for patients in the home. This was brought to the attention of the registered manager who was unaware of the need to have personal evacuation plans and agreed to address the issue.

The annual fire risk assessment of the home was undertaken on 20 September 2017. Nine of the recommendations of the report had been identified as requiring immediate action. The registered manager stated that there had been no action taken, as yet, to address the recommendations of the report. This was concerning and the registered manager was informed that a status report of the progress made regarding the recommendations of the report was to be forwarded to RQIA by 14 November 2017. The information was received and was forwarded to the senior estates inspector in RQIA for review and follow up. Written confirmation was subsequently submitted by the registered manager that the required actions identified by the fire risk assessor had been appropriately actioned.

There were deficits identified in relation to fire safety in the home including; lack of personal emergency evacuation plans for patients, not all staff had undertaken face to face fire safety training/participated in fire drills and the recommendations of the most recent fire risk assessor's report of September 2017 had not been actioned. Improvement under regulation is identified regarding fire safety in the home and the governance arrangements in the home. Refer to section 6.7 and 7.2 for information regarding governance arrangements.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing arrangements.

Areas for improvement

The following areas were identified for improvement under regulation; adult safeguarding, mandatory staff training, fire safety arrangements and infection prevention and control procedures. An area for improvement in respect of planned staff supervision and annual appraisal was partially met and has been stated for a second time in this report. Governance arrangements in the home have also been identified for improvement and are detailed in section 6.7

	Regulations	Standards
Total number of areas for improvement	5	0

6.5 Is care effective?

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

Review of six 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 some risk assessments informed the care planning process.

However, the review of patient care records did not validate that safe and effective care was being delivered to patients in the home.

Care records examined did not evidence a systematic approach to assessing, planning and evaluating care. Risk assessments and care plans were either not in place or not sufficiently or regularly updated in response to the changing needs of patients.

Shortfalls were identified in wound care management. A review of care records for an identified patient evidenced that a wound assessment chart and care plan were incomplete. The registered manager stated that the patient no longer had a wound however the care documentation did not evidence this. Wound care management should be in accordance with NICE clinical guidance for the management and treatment of wounds.

Shortfalls were also identified in the management of behaviours that challenge. Two care records pertaining to behaviour management were reviewed. One care record did not evidence a care plan for behavioural management/support and the other care record had a care plan for the behaviour but this did not identify best practice and include the potential triggers for the behaviour and subsequent support to be afforded to the patient. Specific information should be present as to how the behaviours presented, the triggers for the behaviour or how the patient was to be supported. Patients' progress records made reference to behaviours when they presented however, the records were general and did not state how the patient was supported or the patient's response.

Shortfalls were also identified in the management of patients' receiving nutrition via a percutaneous endoscopic gastrostomy tube (PEG). One care record reviewed did not have a care plan for enteral feeding. The directions were in the multidisciplinary care notes which staff were following. A plan of care should have been written, reviewed and evaluated.

The management of patients' weight loss was reviewed. A review of weight monitoring records for identified patients for October 2017 did not verify what action, if any, had been taken regarding weight loss. Information was present for the patients on one floor but the information for patients on the remaining floor was not as robust. The registered manager clarified with the registered nurses, on the second day of inspection that the deficits previously identified had been actioned but had not been recorded by the registered nurses.

Registered nurses are required to promote and ensure the proper provision for the nursing, health and welfare of patients. This must be evidenced by accurate care planning and recording processes and in the delivery of care. Patient care records must reflect both the planned care and actual care delivered. The shortfalls identified on inspection regarding wound care management, behaviour management and support, enteral feeding and the management of weight loss must be addressed. The planning and delivery of care was identified as an area for improvement at the previous inspection of 23 March 2017 and has been stated for a second time in the quality improvement plan of this report.

Due to the shortfalls identified in the planning and delivery of care an area for improvement under regulation has been identified. Training should be provided for staff in relation to the management of behaviours that challenge, the care planning process (for registered nurses) and percutaneous endoscopic gastrostomy tube (PEG) feeding.

A number of care records are audited on a monthly basis as part of the home's governance procedures. It was concerning that the issues identified on inspection had either not previously been identified or had not been actioned as a result of the auditing process. A more robust system for the auditing of patient care records should be established by the registered manager. This was identified as an area for improvement under the care standards. Refer to section 6.7 for further information in respect of governance arrangements.

Personal or supplementary care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements in respect of patients' daily food and fluid intake. The review of repositioning records did not evidence the frequency of repositioning or information relating to the monitoring of mattress settings based on the weight of the patient. This has been identified as an area for improvement under the care standards.

Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005; the registered manager confirmed that the patient register was checked on a regular basis.

Discussion with staff confirmed that nursing and senior care assistants were required to attend a handover meeting at the beginning of each shift and discussions. Senior care assistants then inform the care assistants of the pertinent information gained at the handover report. No issues were raised by staff and staff stated that the handover provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective.

Meetings were held on a regular basis with different grades of staff and records were maintained and made available to those who were unable to attend. The most recent 'trained' staff meeting was 18 October 2017 and day and night care staff was 25 May 2017. Meetings were also held with catering staff and housekeeping staff. Staff did not raise any issues regarding communication in the home.

The serving of the midday meal was observed. Tables were attractively set with cutlery, condiments and napkins. Those patients who had their lunch in the lounge or their own bedroom were served their meal on a tray which was set with cutlery and condiments and the food was covered prior to leaving the dining room. The meals were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch. The day's menu was displayed in the dining rooms. Registered nurses were observed supervising and assisting patients with their meals and monitoring patients' nutritional intake.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication between residents, staff and relatives and the patients' dining experience.

Areas for improvement

The following areas identified for improvement under the regulations was in relation to the delivery of safe and effective care. Care records must evidence a systematic approach to assessing, planning and evaluating care. This area for improvement has not been met and has been stated for a second time. Staff training needs have also been identified as an area for improvement under regulation.

The following areas were identified for improvement under the care standards in relation to ensuring that repositioning records are maintained in accordance with professional standards and establishing a robust auditing system of patient care records.

	Regulations	Standards
Total number of areas for improvement	1	2

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.

Fairfields Care Centre provides nursing care and nursing care for persons living with dementia. Staff interactions with patients were observed to be caring and timely. Consultation with 16 patients individually and with others in smaller groups, confirmed that patients were afforded privacy and respect. The observation of care in the dementia unit evidenced that staff were assisting patients in a sensitive manner and actively engaging with patients when assisting with everyday tasks. However, it was observed that in one of the dementia units' bedroom doors are locked during the day. This was discussed with the registered manager who stated that was the preference of relatives as a small number of patients went into other patients' bedrooms. The registered manager was advised to consider if staff were managing the needs of all patients appropriately as the locking of bedroom doors removed the right and ability of some patients of going to their bedroom and accessing their personal space, without having to ask staff. The locking of all bedroom doors would not be considered a best practice approach in dementia care. The registered manager should ensure staff have sufficient and up to date knowledge and skills in dementia care practice. This has been identified as an area for improvement under the regulations. Refer to section 7.2.

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. Activity coordinators plan and provide activities in the home. There was evidence of 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. There was evidence of regular church services.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Patients and relatives stated they would either take their concerns to 'the nurse' or 'the manager'.

There were numerous thank you cards in the home. Comments included, "The nurses were exceptional, professional and caring," and, "We appreciated your kindness and consideration which was shown to us as a family as well as permitting us the opportunity to be involved in our (relatives) care."

During the inspection, we met with 16 patients, five care staff, three registered nurses and two patients' representatives. Some comments received are detailed below:

Staff

"I like it here."
"The care is very good."
"Good teamwork, we all help each other out."

Patients

"Staff are good to me."
"Lovely home."
"Staff work very hard."
"Not enough staff on duty, they've cut down."
"There's always something going on."
"Go to (manager) if anything's wrong."
"Good place, I love it."
"Need more staff."

Patients' representative

"Very good home, staff are good too."
"Home is 100 percent."
"Staff are very good."

We also issued ten questionnaires to staff and relatives respectively and eight questionnaires to patients. There were no questionnaires returned within the timeframe for inclusion in this report.

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 dignity and privacy afforded to patients, listening to and valuing patients and their representatives and taking account of the views of patients. Activities were plentiful and well managed.

Areas for improvement

An area for improvement was identified regarding the deprivation of liberty and dementia care. Refer to section 7.2

	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.

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.

Discussions with the staff confirmed that there were generally good working relationships and that management were responsive to any suggestions or concerns raised. Staff and patients consulted with described the registered manager in positive terms and that they felt confident that the registered manager would respond positively to any concerns/suggestions raised.

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. The review of the staff duty rota did not evidence that there was a system in place to identify the person in charge of the home, in the absence of the registered manager. This has been identified as an area for improvement under the care standards.

Discussion with the registered manager and 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.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed for example; in relation to falls, wound management, infection prevention and control, environment, complaints, incidents/accidents and bed rails. However, as discussed in the previous sections of the report there have been a number of areas identified for improvement in relation to the governance arrangements in the home including; fire safety, supervision and appraisal system, the registration of staff with their professional bodies and the competency and capability assessments of registered nurses. Whilst systems were in place to monitor the quality of the services provided by the home the efficacy of the systems requires review as has been demonstration by the areas identified for improvement under regulation and the care standards. Therefore a further area for improvement has been identified under regulation regarding the governance arrangements for the home. Refer to sections 6.4, 6.5 and 6.6 for further detail.

A review of the patient falls audit did not evidence that this was analysed to identify patterns and trends, on a monthly basis. The audit did not identify for example; if the same patient was involved in the accident, the time of day or the area of the home where the accident occurred. This information should be included to provide a more comprehensive review. This has been identified as an area for improvement under the care standards.

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 registered manager and the responsible individual and the 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 maintaining good working relationships within the home.

Areas for improvement

The following area was identified for improvement under regulation: the governance arrangements of the home.

The following areas were identified for improvement under the care standards: the establishment of a system to identify the person in charge of the home in the absence of the registered manager and the analysis of any falls/accidents on a monthly basis.

	Regulations	Standards
Total number of areas for improvement	1	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Phillip McGowan, Registered 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 to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

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

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 16 (1) and (2) **Stated:** Second time **To be completed by:** 31 December 2017	The registered provider must ensure that registered nurses assess, plan, evaluate and review care in accordance with legislative and professional standards. Ref: Sections 6.2 and 6.5
	Response by registered person detailing the actions taken: Care plan audits will continue and action plans discussed. In addition care plan training will be arranged to be disseminated in qtr 1 of 2018
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** 31 December 2017	The registered person shall ensure the infection prevention and control procedures are in accordance with regional guidance and are monitored as part of the homes quality auditing systems. Ref: Sections 6.2 and 6.4
	Response by registered person detailing the actions taken: Regional guidance is maintained and audits are done in accordance with legislation except for the IPC of slings. this has been rectified and an dry anti bacterial spray is now used on communial slings between uses
Area for improvement 3 **Ref:** Regulation 20 (1) (i) **Stated:** First time **To be completed by:** 15 January 2018	The registered person shall ensure the identified safeguarding champion for the home has completed the necessary training for the role and the regional procedures of July 2015 are embedded into practice in the home. Ref: Section 6.4
	Response by registered person detailing the actions taken: The Safeguarding Champion is the Registered Manager and he has received training within the HSCB. He has not attended training relating specific to care homes and awaits dates from the local Trust.

Area for improvement 4 **Ref:** Regulation 27 (4) **Stated:** First time **To be completed by:** 31 December 2017	The registered person must ensure that fire safety procedures are in accordance with legislation including: • the provision and maintenance of personal emergency evacuation plans for patients (PEEP's) • the recommendations of the fire risk assessors report are addressed in a timely manner Ref: Section 6.4
	Response by registered person detailing the actions taken: RQIA estates inspector visited the home on the 04.12.17 and the Fire report was discussed. Minimal work is required as several issues in the main report are not accurate. The RM is completing the PEEP's
Area for improvement 5 **Ref:** Regulation 27 (4) (f) **Stated:** First time **To be completed by:** 31 December 2017	The registered person must ensure that fire safety procedures are in accordance with legislation including: • ensure, by means of fire drills and practices at suitable intervals, that the persons working in the nursing home and, so far as practicable, patients, are aware of the procedure to be followed in the event of fire. Evidence must be present that staff had completed the required attendance at fire safety awareness training on a minimum of two occasions per year. Ref: Section 6.4
	Response by registered person detailing the actions taken: Fire Safety will be increased to twice a year
Area for improvement 6 **Ref:** Regulation 14 (3) **Stated:** First time **To be completed by:** 31 January 2017	The registered person must ensure that staff complete the practical module in respect of safe moving and handling training. Ref: Section 6.4
	Response by registered person detailing the actions taken: Manual Handling Practical will be completed in 2018 for all staff

Area for improvement 7 **Ref:** Regulation 10 **Stated:** First time **To be completed by:** 31 January 2018	The registered person shall ensure that effective quality monitoring and governance systems are implemented. For example; robust quality audits regarding the following should be present: • infection prevention and control • fire safety • the environment • staff training • competency and capability assessments • staff support systems Ref: Sections 6.4, 6.5 and 6.7
	Response by registered person detailing the actions taken: Audits will be reviewed and any action required to update to meet legislation will be actionned. The home has an audit system in place which covers all the areas above but will be developed to ensure follow up of action plans.
Area for improvement 8 **Ref:** Regulation 20 (1) (c) (i) **Stated:** First time **To be completed by:** 31 January 2018	The registered person shall ensure that training is provided for staff in relation to: • the management of behaviours that challenge • the care planning process (for registered nurses) • percutaneous endoscopic gastrostomy tube (PEG) feeding • deprivation of liberty in dementia care Ref: Section 6.5 and 6.6
	Response by registered person detailing the actions taken: All the above have been added to the training plan for Qtr 1 2018
Action required to ensure compliance with The Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref:** Standard 4.8 **Stated:** First time **To be completed by:** 31 December 2017	The registered person shall ensure that repositioning records reflect the frequency of the change of position prescribed and are determined in accordance with guidance in respect of pressure relieving equipment. Ref: Section 6.5
	Response by registered person detailing the actions taken: The care booklets indicate the repositioning regieme on the front prescription sheet. These are transferred to new booklets on the 1st of each month. it was dissapointing that on the inspection - the 1st - not all booklets had been completed for handover to the next month. A system is now in place for the Night Staff to do on the evening of the last day to prevent any details not being in place for 8am on the 1st of the month

Area for improvement 2 **Ref:** Standard 35.6 **Stated:** First time **To be completed by:** 31 December 2017	The registered person shall ensure that the auditing of patient care records is completed in a systematic, consistent and robust manner. Where shortfalls are identified evidence should be present that the shortfall has been addressed and validated by the registered manager. Ref: Section 6.5
	Response by registered person detailing the actions taken: This area has been addressed within Area for improvement 7 above. Audit plans will be in place in line with legislation for commencement Qtr 1 2018
Area for improvement 3 **Ref:** Standard 40 **Stated:** Second time **To be completed by:** 15 January 2018	The registered provider should ensure that a more structured and systematic approach to staff appraisal and supervision is established. Ref: section 6.2 and 6.4
	Response by registered person detailing the actions taken: Staff appraisals are in place and are at 85% of staff. The Manager does not feel any action is required to correct this. Supervison sessions will be structured in 2018 and group supervision used to allow this rather than indepenedent supervison which can not be structured as is based on activy analysis.
Area for improvement 4 **Ref:** Standard 41.7 **Stated:** First time **To be completed by:** 31 December 2017	The registered person shall ensure that there is a system in place to identify the person in charge of the home in the absence of the registered manager. Ref: Section 6.7
	Response by registered person detailing the actions taken: The PIC is noted on the TV in the main entrance to allow all visitors to know who is in charge. The manager will now also highlight the roster
Area for improvement 5 **Ref:** Standard 22.10 **Stated:** First time **To be completed by:** 31 December 2017	The registered person shall ensure that falls/accidents that occur in the home are reviewed and analysed on a monthly basis to identify any patterns or trends and that the appropriate action is taken. Ref: Section 6.7
	Response by registered person detailing the actions taken: Time,place and person audit will be added to the accident analysis at the end of each month

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

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