Unannounced Care Inspection Report
4 August 2016

Rivervale Country

Type of Service: Nursing Home
Address: 56a Dunamore Road, Cookstown, BT80 9NT
Tel No: 02886751787
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Rivervale Country took place on 4 August from 9.45 to 16.30 hours. The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

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

Is care safe?

The staffing levels, which were subject to regular review, were generally adhered to and staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was well maintained in the home. New staff underwent a structured orientation and induction programme at the commencement of employment and all staff consulted with felt well supported in their roles, through supervisions, training and annual appraisals. Recruitment processes were found to be in keeping with regulation and care standards and all registered nurses and care staff had valid registrations with the relevant professional bodies. Accidents and incidents were managed appropriately. Although the staff consulted with all stated that they would report any incidents of actual or potential abuse, the staff were unaware of the procedure to follow, in line with regional safeguarding protocols and the home's policy and procedure. Whilst RQIA acknowledge that the home was free from odours and outbreaks of infection, observations on the day of inspection evidenced that infection prevention and control measures were not consistently adhered to. Three requirements have been made in regards to the staff's knowledge of adult safeguarding protocols; the reporting of actual and potential safeguarding incidents; and infection prevention and control issues. Compliance with these requirements will drive improvements in this domain.

Is care effective?

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate, and there was evidence of regular communication with patient representatives within the care records. 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. All those consulted with were confident that any concerns raised would be addressed by the management. However, improvements are required in relation to care planning; wound care; equipment checks, bowel monitoring; contemporaneous record keeping; and the pre-admission process. Two requirements and four recommendations have been made in this domain.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients who were unable to verbally express their views were observed to be appropriately dressed and appeared to be relaxed and comfortable in their surroundings. Consultation with seven patients individually and with others in smaller groups, confirmed that patients were afforded choice, dignity and respect. A number of positive comments were made regarding the staff and have been included in the report. Patients stated that they were involved in decision making about their own care and the staff consulted with demonstrated a detailed

knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Patients were offered a choice of meals, snacks and drinks throughout the day and the atmosphere in the dining room was quiet and tranquil and patients were encouraged to eat their food. Patients consulted with also confirmed that they were able to maintain contact with their families and friends and there was a list of activities available to patients to choose to participate in. Religious services were provided on a regular basis. There were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. All respondents expressed a high level of satisfaction within the domain of compassionate. However, the use of camera monitors in two patients' bedrooms was not in keeping with RQIA Guidance on the Use of Overt Closed Circuit Televisions (CCTV) and there was no evidence of formal consent or consultation with care management. A requirement had been made in this regard. Following the inspection, the registered manager confirmed to RQIA, by telephone on 05 August 2016, that the monitors had been removed from use.

Is the service well led?

There was a clear organisational structure within the home and there was a system in place to identify the person in charge of the home, in the absence of the registered manager. A review of the staff duty roster identified that the registered manager had been working on six consecutive days; however, assurances were provided that recruitment of a registered nurse was in progress. Patients were aware who the registered manager was and the staff consulted with confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. There were systems and processes in place to ensure that urgent communications, safety alerts and notices were managed appropriately and the home's policies and procedures were currently under review. The home was operating within its registered categories of care. Although all those consulted with confirmed that they were aware of the home's complaints procedure, we were unable to ascertain if complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 as the complaints record shown to the inspector was not the most up to date record. Monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. There were systems in place to monitor and report on the quality of nursing and other services provided; however, a number of the audits and other records requested by the inspector were not available for inspection. A recommendation has been made in this regard.

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	6	*6

* The total number of requirements and recommendations above includes one recommendation that was not met and has been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Eileen McKenna, Registered Nurse, and then by telephone with the responsible person and registered

manager on 8 August 2016, as part of the inspection process. The timescales for completion commence from the date of inspection. Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an announced estates inspection undertaken on 28 April 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

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

2.0 Service details

Registered organisation/registered person: Rivervale Country	**Registered manager:** Helena Margaret O'Neill
Person in charge of the home at the time of inspection: Eileen McKenna, registered nurse	**Date manager registered:** 1 April 2005
Categories of care: RC-DE, RC-I, RC-MP(E), RC-PH(E), RC-MP, RC-PH, NH-DE, NH-I, NH-PH, NH-PH(E), NH-MP, NH-MP(E) A maximum of 3 persons in residential categories. No more than 1 resident in category RC-DE and no more than 5 patients in category NH-DE	**Number of registered places:** 20

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

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

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with seven patients, three care staff, one registered nurse and three patients' representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training records for 2015/2016
- accident and incident records
- one staff recruitment and selection record
- complaints records
- competency and capability of one registered nurse with the responsibility of being in charge of the home
- staff induction records
- records pertaining to NMC registration checks
- minutes of staff, patients' and relatives' meetings held since the previous care inspection
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a selection of policies and procedures.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 28 April 2016

The most recent inspection of the home was an announced estates inspection. The completed QIP was returned and approved by the estates inspector.

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

4.2 Review of requirements and recommendations from the last care inspection dated 20 October 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 32.1 **Stated:** First time	The following policies and guidance documents should be developed and made readily available to staff: • A policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.* • A policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines which* should include the referral procedure for specialist palliative care nurses; the procedure for managing shared rooms; the process for notifying RQIA in the event of a death; and management of a sudden or unexpected death.	**Not Met**
	Action taken as confirmed during the inspection: The nurse in charge was unable to access the policies, therefore we were unable to examine compliance with this recommendation. This recommendation was not met and has been stated for the second time.	
Recommendation 2 **Ref**: Standard 32.1 **Stated:** First time	It is recommended that registered nursing staff record efforts made to establish patients' preferences in respect of end of life care and that for patients who do not wish to discuss this, a record should be also be maintained in line with the policy on end of life care. Where a decision is made regarding end of life care, a care plan should be developed and should include identified religious, spiritual and cultural needs.	**Met**
	Action taken as confirmed during the inspection: A review of care records confirmed that end of life care arrangements were discussed with patients and/or their representatives, as appropriate. Care plans were in place to address religious, spiritual and cultural needs.	

4.3 Is care safe?

The nurse in charge of the home 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 25 July 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

Staff consulted confirmed that new staff underwent a structured orientation and induction programme at the commencement of employment, to ensure they developed their required knowledge to meet the patients' needs; this included shadowing experienced staff until they felt confident to care for the patients unsupervised. However, induction records were not available for inspection. Refer to section 4.6 for further detail.

Staff consulted with stated that they felt supported in their practice and confirmed that they were mentored through one to one supervision and that they completed annual appraisals with the registered manager. A review of two records confirmed that a competency and capability assessment was undertaken on an annual basis with all registered nurses who were given the responsibility of being in charge of the home, in the absence of the registered manager. Further detail is discussed in section 4.6.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas. A review of staff training records confirmed that staff completed face to face training on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult safeguarding. A training matrix had been developed which provided information to enable the registered manager to review staff training and see when updates/refresher training were due.

There were systems in place for the recruitment and selection of staff. Where nurses and carers were employed, their PIN numbers were checked on a regular basis with the Nursing and Midwifery Council (NMC) to ensure that their registrations were valid. Staff consulted with stated that they had only commenced employment once all the relevant checks had been completed. The review of recruitment records evidence that enhanced criminal records checks were completed with AccessNI.

On the day of the inspection, we were also unable to access information in regards to the registration status of the care staff, to ensure that they were currently registered with the Northern Ireland Social Care Council (NISCC). Following the inspection, the registered persons confirmed to RQIA, by email on 19 August 2016, that all care staff held were currently registered with NISCC.

All staff consulted with stated that they were aware of their specific roles and responsibilities in relation to adult safeguarding and all staff consulted with stated that they would report any incidences of abuse immediately to the registered manager or responsible person. Following the inspection, the registered persons confirmed to RQIA, by email on 19 August 2016, that all staff had received training on adult safeguarding. Despite this, the staff consulted with were unsure as to whether or not there was a whistleblowing policy and the nurse in charge was

unaware of the out of hours procedure for notifying safeguarding concerns to the relevant health and social care trusts. Although the registered persons provided assurances that the information was available in the home, the nurse in charge was unaware of the telephone numbers for the relevant safeguarding teams. Contact details were provided by the inspector. A requirement has been made in this regard.

The complaints record reviewed evidenced that no complaints had been received since October 2008. Following the inspection, the registered manager informed the inspector by telephone that a new complaints book was in place, which contained a recent complaint. The details of this complaint related to an act of omission in undertaking hourly supervision checks during the night, in respect of one identified patient. This incident had not been managed in accordance with the regional safeguarding protocols. RQIA had also not been notified in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. Following the inspection, the registered manager confirmed by email to RQIA, that this incident had been reported to the relevant safeguarding agencies within the Health and Social Care Trusts. A requirement has been made in this regard.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were generally completed following each incident, care management, patients' representatives and RQIA were notified appropriately.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. The areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items.

Whilst RQIA acknowledge that the home was free from odours and outbreaks of infection, observations on the day of inspection evidenced that infection prevention and control measures were not consistently adhered to. For example, the staff were observed to bring the clean linen trolley into each patients bedroom. Staff were also observed using a paper bag, which was hanging on the dirty laundry skip, to dispose of incontinence pads. A toilet which was in use by patients was also observed to have no toilet seat and the pull cord did not have a plastic covering. A rusted commode frame was also observed in the sluice room. These practices posed an infection prevention and control risk. A requirement has been made in this regard.

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

Areas for improvement

A requirement has been made that all staff are made aware the home's policies and procedures and regional safeguarding protocols in relation to adult safeguarding. A flowchart should be developed and made available for all staff, which illustrates clearly the procedure to follow when reporting actual or potential safeguarding incidents.

A requirement has been made that all actual or potential safeguarding incidents must be reported in line with regional safeguarding protocols. Records pertaining to any allegation of abuse must be appropriately maintained.

A requirement has been made that infection prevention and control practices are reviewed and monitored to ensure compliance with best practice in infection prevention and control within the home.

Number of requirements:	3	Number of recommendations:	0

4.4 Is care effective?

A review of four patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. However, the review of care records evidenced inconsistencies in the completion of risk assessments. For example, one patient had a pressure ulcer which required daily dressing changes. Although there was evidence that the wound had been dressed in line with the care plan, wound assessments had not been completed since 12 July 2016. A requirement has been made in this regard. A recommendation has also been made that wound care records are supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines.

A review of the recommendations made by the tissue viability nurse (TVN) included that the home liaise with the mattress company regarding pressure mattress settings of one identified patient. On the day of the inspection, the mattress setting was set for a load weight of 150kg, despite the patient only weighing 68kg. This meant that the effectiveness of the pressure relieving mattress was not assured. A review of the equipment checks records evidenced that whilst checks had been done, the records did not specify the individual settings of each mattress. Following the inspection, this was discussed by telephone with the registered manager, who provided assurances that the specific mattress settings would be entered onto the equipment checks records. A recommendation has been made in this regard.

Records in relation to patient's bowel patterns were reviewed and evidenced gaps in completion. For example, in one patient care record, there were gaps in completion of up to six days. There was no evidence that the Bristol Stool Chart had been used to classify the type of stool observed and there was evidence that faecal 'leaking' had been recorded six times within an eight day period. There was no evidence within the care records of any oversight by registered nurses or of any action taken to address the matter. A requirement has been made in this regard.

Care plans were generally reviewed on a regular basis; however, a number of care plans were undated and unsigned, therefore we were unable to determine when they had been formally written. Registered nurses also entered the month, rather than the actual date, when updating assessments. The personal care records reviewed also evidenced that records also were not maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records and fluid intake records confirmed that entries were not recorded contemporaneously. For example, at 14.00 hours had yet to complete the repositioning or fluid intake records. This meant that we could not be assured of the accuracy of the records. A recommendation has been made in this regard.

Pre-admission assessments were undertaken prior to patients being admitted to the home. However, they were not very detailed and provided little information which could be used in determining the patients' needs. A recommendation has been made in this regard.

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

Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

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. Discussion with the nurse in charge and a review of records confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. 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. Discussion with the nurse in charge and review of records evidenced that patients and/or relatives meetings were held on a regular basis and records were maintained. Minutes of the meetings held were reviewed and confirmed attendance and the detail of the issues discussed.

Areas for improvement

A requirement has been made that patients' needs are assessed with particular reference to wound and/or pressure care management.

A recommendation has been made that wound care records are supported by the use of photography in keeping with the home's policies and procedures and the NICE guidelines.

A recommendation has been made that the records of equipment checks are further developed, to include recording of the individual setting specified for each pressure relieving mattress.

A requirement has been made that accurate records are maintained in regards to patients' bowel patterns. Bowel records must be monitored by registered nurses and records maintained of any action taken.

A recommendation has been made that registered nursing staff should receive training in developing care plans. This training should also address the deficits in contemporaneous recording observed in this inspection, in accordance with NMC guidelines for record keeping and should include the legal aspects of care planning and record keeping.

A recommendation has been made that the pre-admission process is further developed, to ensure that a comprehensive assessment of nursing care needs is undertaken to determine prospective patients' care needs.

Number of requirements:	2	Number of recommendations:	4

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients consulted with stated that they knew how to use their call bells and stated that staff usually responded to their needs in a timely manner.

Patients who were unable to verbally express their views were observed to be appropriately dressed and appeared to be relaxed and comfortable in their surroundings. Consultation with seven patients individually and with others in smaller groups, confirmed that patients were afforded choice, dignity and respect; staff consistently used their preferred name and spoke to them in a polite manner. Comments received included: "they are quite polite", "you couldn't get better", "just perfect" and "I am far better off here, than at home".

Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Two patients had camera monitors, in use. This was discussed with the nurse in charge, who stated that these were used so that the staff could keep an "extra eye" on the patients, whilst they were in their bedrooms. However, there was no evidence that consent had been obtained from the patients/their representatives for its use and there was also no evidence within the care records that care management had been informed of this practice. There was also no policy in place regarding its use. Although the staff were observed to turn the cameras off when delivering personal care, it was concerning that the impact on patients' privacy had not been considered. Following the inspection, this matter was discussed with the registered manager, who confirmed that the cameras/monitors had been removed from use. A requirement has been made in this regard.

Patients were consulted with regarding meal choices. Patients were offered a choice of meals, snacks and drinks throughout the day. The menu was displayed clearly in the dining room and was correct on the day of inspection. We observed the lunch time meal being served in the dining room. The atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set and specialist cutlery and plate guards were available to help patients who were able to maintain some level of independence as they ate their meal. The lunch served in both units appeared very appetising and patients spoken with stated that it was always very nice.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home.

We saw a list of activities displayed in the lounges on the ground floor. Although there was no dedicated person employed to carry out activities with the patients, discussion with patients and staff confirmed that there were sufficient activities provided by the care staff. There was also evidence of regular activities provided by external providers. For example, on the day of the inspection, the patients participated in creating floral arrangements and all those who participated stated that they enjoyed this very much. There was also evidence that the hairdresser visited on a regular basis and a weekly church service also took place.

Discussion with the nurse in charge and a review of records 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. Views and comments recorded were analysed and areas for improvement were acted upon.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment praised the staff for the "dedicated care and attention" given to their relative when they were receiving end of life care".

In addition to speaking with patients, relatives and staff, questionnaires were provided to the registered manager for distribution; ten for staff and relatives respectively; and five for patients. Nine relative, three patients and six staff had returned their questionnaires within the timescale for inclusion in this report. All respondents gave positive outcomes although no additional written comments were received.

Areas for improvement

A requirement has been made that the practice of using camera monitors is reviewed to ensure compliance with the home's policy and procedure and RQIA's Guidance on the use of Overt Close Circuit Televisions (CCTV).

Number of requirements:	1	Number of recommendations:	0

4.6 Is the service well led?

Discussion with the nurse in charge and staff evidenced that there was a clear organisational structure within the home. Staff consulted with were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager. A review of the staff duty roster identified that the registered manager had been working on six consecutive days. This was discussed with the registered manager following the inspection, who stated that a registered nurse was in the process of being recruited.

Patients were aware of who the registered manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

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

Plans were in place to have an external provider systematically review the policies and procedures for the home. This was currently in progress and will be ratified by the responsible person, when completed.

Observation of patients evidenced that the home was operating within its registered categories of care. Following the inspection, discussion was undertaken with the responsible person

regarding the categories of care for which the home is registered. The responsible person stated that the home used the current categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Although the staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure, the current complaints record was not available on the day of inspection, therefore we were unable to ascertain if 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. However, patients/representatives consulted with confirmed that they were confident that staff/management would manage any concern raised by them appropriately.

Discussion with the nurse in charge and review of records evidenced that monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives.

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

- medicines management
- care records
- infection prevention and control
- health and safety

These audits were not accessed on the day of the inspection, as the nurse in charge was not aware of the specific audits undertaken by the registered manager. A recommendation has been made in this regard.

Areas for improvement

A recommendation has been made that the registered nurses with responsibility of being in charge of the home, in the absence of the registered manager, are able to access all information, as requested by the regulator. This refers particularly to information regarding NISCC registrations, supervision and appraisal records, induction records, complaints records and any audits undertaken by the registered manager.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Eileen McKenna, Registered Manager and then by telephone with the responsible person and registered manager on 8 August 2016, as part of the inspection process. The timescales commence from the date of inspection.

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

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

5.1 Statutory requirements

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

5.2 Recommendations

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

5.3 Actions taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal 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 14 (4) **Stated:** First time **To be completed by:** 1 October 2016	The registered persons must ensure that all staff are made aware the home's policies and procedures and regional safeguarding protocols in relation to adult safeguarding. A flowchart should be developed and made available for all staff, which illustrates clearly the procedure to follow when reporting actual or potential safeguarding incidents. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Further to our letter dated 18th August 2016 which confirmed that staff had received training in respect of the homes policy and procedures and regional safeguarding protocols in relation to adult safeguarding. The flowchart and numbers were in the Adult Safeguarding File and the relevant numbers were also in the main telephone book. Our training company confirmed that training was in line with the most up to date legistation and recommendations. Staff have again been made aware of the policy and procedure.
Requirement 2 **Ref:** Regulation 30 (1) (d)(g) **Stated:** First time **To be completed by:** 1 October 2016	The registered persons must ensure that all actual or potential safeguarding incidents are reported in line with regional safeguarding protocols. Records pertaining to any allegation of abuse must be appropriately maintained. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: All actual or potential safeguarding incidents will be reported in line with regional safeguarding protocols, and recordss will be maintained appropriately.
Requirement 3 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** 1 October 2016	The registered persons must ensure that infection prevention and control practices are reviewed and monitored to ensure compliance with best practice in infection prevention and control within the home. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Infection prevention and control practices are taken very seriously in this home and staff have been reminded of the issue raised at inspection. We invest heavily on resourses to help and prevent infection outbreakes, and in the 26 years of business have never had an outbreak of infection in this home. We have a strict sanatizing system in place which ensures all areas of the home are fully sanitized at least weekly. Communal areas, sluice room and toilets are sanitized daily.

Requirement 4 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time **To be completed by:** 1 October 2016	The registered persons must ensure that the patients' needs are assessed with particular reference to wound and/or pressure care management. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Ongoing training with tissue viability has been arranged. Staff have been reminded to follow guidelines to ensure that all assessments and appropriate charts are updated
Requirement 5 **Ref:** Regulation 15 (2)(a) **Stated:** First time **To be completed by:** 1 October 2016	The registered persons must ensure that accurate records are maintained in regards to patients' bowel patterns. Bowel records must be monitored by registered nurses and records maintained of any action taken. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Staff have been retrained on the use of the Bristol Stool Chart and reminded to maintain appropriate records on bowel pattern as necessary.
Requirement 6 **Ref:** Regulation 13 (8) (a) **Stated:** First time **To be completed by:** 1 October 2016	The registered persons must ensure that the practice of using camera monitors is reviewed to ensure compliance with the home's policy and procedure and RQIA's Guidance on the use of Overt Close Circuit Televisions (CCTV). **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: The monitors have been removed and the families have been made aware that these are not allowed in the Nursing Home.

Recommendations	
Recommendation 1 **Ref**: Standard 32.1 **Stated:** Second time **To be completed by:** 1 October 2016	The following policies and guidance documents should be developed and made readily available to staff: • A policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.* • A policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines which* should include the referral procedure for specialist palliative care nurses; the procedure for managing shared rooms; the process for notifying RQIA in the event of a death; and management of a sudden or unexpected death. **The above policies should be submitted to RQIA with the returned QIP.** **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: A Policy on communicating effectively, Breaking Bad News and Palliative and End of Life Care including Specialist palliative care nurses, managing shared rooms , the process for notifying RQIA in the event of Death, and or sudden or unexpected death had been developed an were in place since December 2015 as requested by inspector at that time. A copy is attached with this quip.
Recommendation 2 **Ref**: Standard 21 **Stated:** First time **To be completed by:** 1 October 2016	The registered persons should ensure that wound care records are supported by the use of photography in keeping with the home's policies and procedures and the NICE guidelines. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Wound care records will be supported by the use of photography in keeping with NICE guidelines.
Recommendation 3 **Ref**: Standard 23.5 **Stated:** First time **To be completed by:** 1 October 2016	The registered persons should ensure that the records of equipment checks are further developed, to include recording of the individual setting specified for each pressure relieving mattress. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Records of equipment checks will be further developed to include recording of individual settings specified for each pressure relieving mattress.

Recommendation 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 1 October 2016	The registered persons should ensure that registered nursing staff, receive training in developing care plans. This training must also address the deficits in contemporaneous recording observed in this inspection, in accordance with NMC guidelines for record keeping and should include the legal aspects of care planning and record keeping. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: This training will occur in relation to care plan development and record keeping. A new computerised system had been discussed at management level which will incorporate care planning and record keeping. This is currently underway and will take some time to complete.
Recommendation 5 **Ref**: Standard 1.3 **Stated:** First time **To be completed by:** 1 October 2016	The registered persons should ensure that the pre-admission process is further developed, to ensure that a comprehensive assessment of nursing care needs is undertaken to determine prospective patients' care needs. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Pre-admission assessments will be developed as comprehensive as possible in relation to the information obtainable and given at time of assessment.
Recommendation 6 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 1 October 2016	The registered persons should ensure that registered nurses with responsibility of being in charge of the home, in the absence of the registered manager, are able to access all information, as requested by the regulator. This refers particularly to information regarding NISCC registrations, supervision and appraisal records, induction records, complaints records and any audits undertaken by the registered manager. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: Staff have been advised on how to access necessary information required by the regulaltor on inspection.

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