Unannounced Care Inspection Report
5 and 6 December 2017

Aughnacloy House

Type of Service: Nursing Home
Address: 2 Tandragee Road, Lurgan, Craigavon, BT66 8TL
Tel no: 028 3834 6400
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 for up to 71 persons.

3.0 Service details

Organisation/Registered Provider: MD Heathcare Ltd **Responsible Individuals:** Mrs Lesley Megarity	**Registered Manager:** Ms Constance Mitchell
Person in charge at the time of inspection: Ms Constance Mitchell	**Date manager registered:** 12 February 2015
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH (E) - Physical disability other than sensory impairment – over 65 years.	**Number of registered places:** 71 comprising: 33 – NH-DE (dementia) The home is also approved to provide care on a day basis only to 4 persons.

4.0 Inspection summary

An unannounced inspection took place on 5 December 2017 from 09:35 to 16:45 and 6 December 2017 from 09:35 to 16:15.

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 inspection assessed progress with any areas for improvement identified 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 and staffing arrangements. 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, ensuring the delivery of care promotes and makes proper provision for the nursing, health and welfare of patients and enhancing the dining experience for patients.

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, individual staff supervision and annual appraisal, review of the competency and capability assessments for registered nurses, the frequency of staff meetings, the management of dehydration and dementia awareness. A number of the areas identified have been incorporated into an overarching standard in respect of the governance arrangements in the home. Whilst the areas identified were operational in the home, they should be more robust.

Patients said they were happy living in the home. Comments included, "Couldn't be better." 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	*3	*8

*The total number of areas for improvement includes one regulation and one standard which have been stated for a second time and one standard which has been carried forward for review at the next care inspection.

Details of the Quality Improvement Plan (QIP) were discussed with Constance Mitchell, 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 24 August 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 24 August 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.

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

The following records were examined during the inspection:

- duty rota for all staff from 27 November to 3 December 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
- five patient care records
- five 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 24 August 2017

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

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 2 February 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (7) **Stated:** First time	The registered provider must make suitable arrangements to minimise the risk of infection and the spread of infection between patients and staff by reconvening Infection Prevention and Control audits on a regular basis. Action plans should have timescales and the person/s responsible identified.	**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 inappropriate storage in bathrooms, unprotected pull cords in some bathroom and toilet facilities and not all sluice rooms were locked. Refer to section 6.4 for further detail. **This area for improvement has not been met and has been stated for a second time.**	

Area for improvement 2 **Ref:** Regulation 16 (2) (b) **Stated:** First time	The registered provider must ensure that the patient's plan is kept under review by ensuring that: • Care plans are further developed to be more person centred in relation to patients who are at risk of falls or of developing pressure ulcers and in response to one identified patient's personal hygiene and dress needs. • Risk assessments are reviewed in accordance with best practice. • Intentional rounding charts are recorded contemporaneous.	**Met**
	Action taken as confirmed during the inspection: The review of five patient care records evidenced that the issues identified in the above area for improvement had been addressed. However, further areas for improvement were identified following the review of patient care records. Refer to section 6.5 and 7.2	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 41 **Stated:** First time	The registered provider should monitor staffing levels to ensure the assessed needs of patients are met on a timely basis.	**Met**
	Action taken as confirmed during the inspection: The review of the staff duty rota and discussion with staff evidenced that staffing levels were in accordance with patients' assessed needs and dependency.	
Area for improvement 2 **Ref:** Standard 38 **Stated:** First time	The registered provider should ensure that employment gaps are explored when recruiting staff	**Met**
	Action taken as confirmed during the inspection: The review of two staff selection and recruitment files evidenced that employment gaps had been explored when recruiting staff.	

Area for improvement 3 **Ref:** Standard 39 **Stated:** First time	The registered provider should ensure that: • Training records includes the names of staff who attend and • All outstanding mandatory training should be completed for year 2016/17	**Partially Met**
	Action taken as confirmed during the inspection: The review of staff training records evidenced that some areas of mandatory training, for example; infection prevention and control and adult safeguarding still required to be completed by a number of staff. **This area for improvement has not been met and has been stated for a second time.**	
Area for improvement 4 **Ref:** Standard 35 **Stated:** First time	The registered provider should ensure the system for checking the registration status of nurses with the Nursing and Midwifery Council (NMC) is further developed to provide a robust assurance at the end of each month.	**Met**
	Action taken as confirmed during the inspection: The review of the monitoring systems in place to assure that nursing staff are registered with the Nursing and Midwifery Council (NMC) was satisfactory.	
Area for improvement 5 **Ref:** Standard 46 **Stated:** First time	The registered provider should ensure that water outlets which are “little used” in the identified sluice are subject to a twice weekly usage in compliance with legionella infection control procedures.	**Met**
	Action taken as confirmed during the inspection: Maintenance records evidenced that all water outlets were subject to a twice weekly usage in compliance with legionella infection control procedures.	

Area for improvement 6 **Ref:** Standard 44 **Stated:** First time	The registered provider should submit a variation application to RQIA in relation to the proposed change of use for the sluice on the first floor.	**Carried forward to the next care inspection**
	Action taken as confirmed during the inspection: The registered manager stated that the application had not been progressed by the organisation at this stage. **Action required to ensure compliance with this regulation/standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.**	
Area for improvement 7 **Ref:** Standard 35 **Stated:** First time	The registered provider should further develop the audit process in relation to patient care records.	**Met**
	Action taken as confirmed during the inspection: A review of the quality monitoring/assurance processes in the home evidenced that the registered manager completed regular audits of patient care records. Where deficits were identified a remedial action plan was developed by the registered manager. However, the process did not identify issues evident at the time of the inspection. Refer to sections 6.5 and 7.2	

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 27 November 2017 to 3 December 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. In discussion with a patient's representatives' it was commented that there was poor visibility of staff in the home, however it was also stated that they were aware the home was very large and spacious in design and this may be the reason that staff were no always visible.

The administration of the morning medications by two registered nurses was observed to still be on-going at midday. This was discussed with nursing staff and the registered manager. Registered nurses stated that it took time to administer medications in the morning due to the volume of medications prescribed for patients at this time and the dependency needs of patients. The registered manager should review the deployment of staff in regard to the morning routine in the home, to ensure the needs of patients are met in a timely way. This has been identified as an area for improvement, In accordance with the safe administration and storage of medications guidelines.

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; one staff member returned their questionnaire prior to the issue of this report and stated that they were satisfied with the staffing arrangements in the home. There were no questionnaires returned from patients or patient representatives.

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. 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 evidence that a system was in place to monitor the registration status of care staff.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and records were maintained. 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 records reviewed confirmed that the registered manager had a system in place to monitor staff compliance with training requirements. However, the review evidenced that a number of areas, for example; infection prevention and control, adult prevention and protection from harm and COSHH (control of substances hazardous to health) that all staff had not completed their training. This was discussed with the registered manager who stated the statistics were lower as the identified staff were either on sick leave or were bank staff.

Ensuring staff complete their mandatory training should be viewed as a priority by the registered manager. This had previously been identified as an area for improvement under the care standards and has been stated for a second time.

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. This may have been as a result of the recording system in place, however, 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 under the care standards. Refer to section 6.7 for further information in respect of governance arrangements.

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 confirmed 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. The adult safeguarding policy reflected the new regional operational procedures.

Review of five 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 December 2016 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. Patients' bedrooms were single room accommodation with an en-suite facility. 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, not all pull cords in bathrooms and/or toilets had protective covering, 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 aids and there was evidence of communal clothing on a trolley stored inappropriately in a bathroom. This had previously been identified as an area for improvement under regulation and has been stated for a second time. Refer to section 7.2.

Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately.

Fire exits and corridors were observed to be clear of clutter and obstruction. There were personal emergency evacuation plans (PEEP's) for patients in the home which were reviewed on a regular basis.

The annual fire risk assessment of the home was undertaken on 25 April 2017. Evidence was present that the recommendations of the report had been actioned and validated by the Deputy Director of MD Healthcare.

Areas of good practice

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

Areas for improvement

The following area was identified for improvement under regulation; adherence to regional infection prevention and control procedures. This has been stated for a second time.

Areas for improvement identified under the care standards included; the regular review of the competency and capability assessments of registered nurses and the recording of planned staff supervision and annual appraisal. These areas have subsumed into the standard regarding governance arrangements and are detailed in section 7.2. Ensuring staff complete mandatory training requirements has been stated for a second time. A further area for improvement that was identified was in relation to ensuring the administration of morning medications is completed in a timely manner.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

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

Review of five 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 due to shortfalls identified in the care records selected for review. For example; one patient's care record was incomplete as the comprehensive assessment of need and care plans had not been completed within the timescale stated in the Care Standards for Nursing Homes 2015. The registered manager had identified this deficit during the auditing of the care record and had given a generous timescale for remedial action to be taken.

Shortfalls were identified in wound care management. A review of the care records for an identified patient did not evidence that the wound was dressed as per the instructions of the Tissue Viability Nurse (TVN) and a care plan was not present. There was a lack of evidence that registered nurses had contacted the TVN at the requested time and photographic evidence of the status of the wound was not present. 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. A patient was observed displaying a specific behaviour. In discussion with a staff member it was stated this behaviour had been on-going for 'a month or so.' There was no evidence of a care plan to support the patient and guide staff regarding this behaviour in the patient's care records. Specific information should have been present as to how the behaviour presented, the triggers for the behaviour and how the patient was to be supported.

Shortfalls were also identified in the management of patients' receiving nutrition via a percutaneous endoscopic gastrostomy tube (PEG). Two care records 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.

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 and the management of enteral feeding must be addressed. This has been identified as an area for improvement under regulation.

Due to the shortfalls identified in the planning and delivery of care an area for improvement under the care standards. Training should be provided for staff in relation to the management of behaviours that challenge, the care planning process (for registered nurses), wound care management 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 evident that the issues identified on inspection had not been identified 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 generally maintained in accordance with best practice guidance, care standards and legislative requirements. 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. Supplementary care records evidenced that care staff were recording the daily fluid intake of patients. However, patient care records did not reflect what the desired daily fluid intake of a patient should be and the action to be taken if the desired intake was not met. 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 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 21 March 2017 and day and night care staff was also 21 March 2017. Meetings were also held with catering staff and housekeeping staff. Staff did not raise any issues regarding communication in the home however the frequency of staff meeting should increase in accordance with the care standards. This has been identified as an area for improvement. Refer to section 6.7 for further information in respect of governance arrangements.

The serving of the midday meal was observed. Tables were attractively set with cutlery, condiments and napkins. The day's menu was not displayed in the dining rooms or on the dining tables to inform patients of the meal to be served. The meal service on the ground floor was quite lengthy. Staff were observed serving patients their meal at the table and then focused on tray service, therefore there was little supervision of patients during the meal service and patients could not readily call on staff for assistance. A registered nurse came to assist one patient when requested by care staff. Care staff were observed heating a patient's meal in a microwave, there was no evidence that the temperature of the meal from the microwave had been taken prior to serving the patient. One patient was observed being assisted with their meal, after a substantial wait, whilst the patient's specialised seat remained in the 'tilt' position, this had the potential to increase the risk of choking. 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 meal service should be reviewed to ensure it is a pleasurable experience for the patients and effectively time managed by staff. This has been identified as an area for improvement under regulation.

Areas of good practice

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

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 comprehensive approach to assessing, planning and evaluating care. The patient dining experience should be reviewed and enhanced.

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, care records reflect the desired daily fluid intake of patients as staff are recording the information, staff training in respect of relation to the management of behaviours that challenge, the care planning process (for registered nurses), wound care management and percutaneous endoscopic gastrostomy tube (PEG) feeding.

	Regulations	Standards
Total number of areas for improvement	2	3

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.

Aughnacloy House 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 both of the lounge areas were unsupervised. Staff were assisting other patients who were not in the lounge areas and were therefore not available. This was discussed with the registered manager who was advised to review the deployment of staff and the daily routine of the unit so as to ensure best practice 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 care standards.

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.

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, "Sincere thanks for the care and support," "Staff were always helpful and courteous," "Place of choice for dementia care," and, "Your care, help and support especially in the final days was very much appreciated."

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

"This is a good home."
"(Manager) and (deputy manager) listen to you and try and sort things out."
"Good teamwork, we all help each other out."

Patients

"Staff are very good to me."
"I would like more activities."
"I prefer to stay in my room, staff are very good to me."
"Like it well enough."
"Food has improved over the last while; it's powerful, very tasty."

"They're (staff) all lovely here."
"Couldn't ask for better."
"Need more staff."

Patients' representative

"Good enough home."
"Feel communication from staff could be better."
"Complaints are appropriately managed."
"Would like to see more interaction between patients and staff."

We also issued ten questionnaires to staff and relatives respectively and eight questionnaires to patients. There were no questionnaires returned from relatives or patients within the timeframe for inclusion in this report. One staff member completed and returned a questionnaire. The staff member was satisfied that care was safe and that patients were treated with kindness, dignity and respect. The staff member was undecided if the delivery of care was effective and if the home was well led. An additional comment was made by the staff member, "Shortage of staff members at times can lead to extra stress being added to other staff".

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.

Areas for improvement

An area for improvement was identified regarding reviewing the deployment of staff and the organisation of the day in the dementia unit.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

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 in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents. The results of audits did not always evidence that they had been analysed and appropriate actions taken to address any shortfalls identified and that the necessary improvement had been embedded into practice, for example; infection prevention and control audits. 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; evidence of the regular review of the competency and capability assessments of registered nurses; a more robust approach to evidencing individual supervision and staff annual appraisal has taken place, ensuring annual mandatory training (areas as identified by the home) is completed and increasing the frequency of staff meetings/communication in the home. This has been identified as an area for improvement under the care standards. Refer to sections 6.4 and 6.5 for further detail.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection, confirmed that these were appropriately managed. A review of the patient falls audit evidenced that these were analysed to identify patterns and trends, on a monthly basis.

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 establishing good working relationships within the home.

Areas for improvement

The following area identified for improvement under the care standards was in respect of enhancing the governance arrangements and outcomes of systems that relate to the quality of nursing and other services provided by the home.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Constance Mitchell, 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 where action is required 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 13 (7) **Stated:** Second time **To be completed by:** 31 January 2018	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: The registered manager has ensured that matters highlighted during inspection have been addressed and corrected and will be monitored as part of the IC&P audit process to ensure compliance with regional guidelines.
Area for improvement 2 **Ref:** Regulation 13 (1) (b) **Stated:** First time **To be completed by:** 31 January 2018	The registered person shall ensure that care is prescribed and delivered to ensure the proper provision for the nursing, treatment and supervision of patients. Ref: Section 6.5
	Response by registered person detailing the actions taken: The registered manager will ensure that care is prescribed and delivered to ensure the proper provision for the nursing, treatment and supervision of residents. Supervision sessions for RNs, on care planning, delivering, evaluating and the audit process for nurses was held on19/12/17, with further sessions scheduled over coming months. Protocol for admission assessments and care plans, standard 4 (of Care Standards for Nursing Homes 2015) and "template" care plans are available to all nurses for guidance. Registered manager has reviewed the timescale within the care plan audit action plan - to ensure more timely responses to actions/directions.
Area for improvement 3 **Ref:** Regulation 12 (1) (a) and (b) **Stated:** First time **To be completed by:** 31 January 2018	The registered person shall ensure the dining experience for patients is enhanced through a review of the daily routines of the home, the deployment of staff and is reflective of current best practice. Ref: Section 6.5
	Response by registered person detailing the actions taken: The registered manager has reviewed daily routines and the deployment of staff to improve the residents dining experience. Catering staff will provide direct support to serving meals so that care staff can focus on ensuring the residents have their meals in a timely manner and ensure a pleasurable dining experience.

Action required to ensure compliance with The Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref**: Standard 44 **Stated:** First time **To be completed by:** 28 February 2018	The registered provider should submit a variation application to RQIA in relation to the proposed change of use for the sluice on the first floor. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.**
Area for improvement 2 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 31 January 2018	The registered person shall ensure the administration of medicines is completed in a timely manner through the review of daily routines and the deployment of staff. Ref: Section 6.4 **Response by registered person detailing the actions taken:** The registered manager and charge nurse reviewed the daily routines and deployment of staff to ensure the administration of medications was completed in a more timely manner. The routine has become embedded in practice with all staff supporting the change.
Area for improvement 3 **Ref:** Standard 4.8 **Stated:** First time **To be completed by:** 31 January 2018	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 registered manager with key personnel will ensure that all supplementary repositioning records reflect the frequency of the change of position prescribed and care plans will reflect this also and include information relating to the monitoring of mattress settings based on the weight of the resident in accordance with guidance in respect of pressure relieving equipment.
Area for improvement 4 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 31 January 2018	The registered person shall ensure that, where applicable and where, that patient care records reflect the desired daily fluid intake for patients identified as being at risk of dehydration. Ref: Section 6.5 **Response by registered person detailing the actions taken:** The registered manager and key personnel will ensure that where applicable the residents' care records will reflect the desired daily fluid intake for those identified as "at risk" of dehydration and have a plan to indicate when to seek medical advice/assistance when the desired daily is not met.

Area for improvement 5 **Ref:** Standard 39 **Stated:** First time **To be completed by:** 28 February 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 • wound care management Ref: Section 6.5
	Response by registered person detailing the actions taken: The registered manager has scheduled training for week beginning 26/02/18 to ensure staff have completed their outstanding annual training. This includes training for; * the management of behaviours that challenge; * the care planning process for RNs; * and wound care management. * Training for nurses using PEG tube has been requested from appropriate person within the Trust, we await a date for training. The registered manager will ensure all staff attend this scheduled training week.
Area for improvement 6 **Ref:** Standard 35.6 **Stated:** First time **To be completed by:** 28 February 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 • the auditing of patient care records • the frequency of staff meetings • 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: The registered manager and key personnel have improved monitoring and governance systems to ensure effective quality audits are available, actioned and validated for IC&P. The audit for care plans has been reviewed and updated with an audit & re-audit schedule provided for team leads. Evidence of staff meetings will be filed appropriately and frequency increased to alternate months. Training matrix is audited monthly for training report. Registered manager has developed more robust systems to ensure staff competency & capability assessments and support systems are provided, evidenced and monitored.

Area for improvement 7 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 28 February 2018	The registered person shall ensure the daily routines in the dementia unit and staffs understanding, and skills in respect of dementia care are in accordance with best practice for persons living with dementia. Ref: Section 6.6
	Response by registered person detailing the actions taken: The registered manager and key personnel have reviewed the daily routine and staff deployment to improve residents experience in dementia nursing.
Area for improvement 8 **Ref:** Standard 39 **Stated:** Second time **To be completed by:** 10 February 2018	The registered provider should ensure that: • All outstanding mandatory training should be completed for year 2016/17 Ref: Section 6.2
	Response by registered person detailing the actions taken: The registered manager has scheduled training 26/02/18, to ensure outstanding training is completed for year 2017. Staff who are outstanding will be advised of training to attend.

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

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