Unannounced Primary Care Inspection

Name of Establishment:	**Aughnacloy House**
RQIA Number:	**1463**
Date of Inspection:	**21 October 2014**
Inspector's Name:	**Sharon McKnight & Sharon Loane**
Inspection ID:	**IN017189**

The Regulation And Quality Improvement Authority
9th Floor, Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1.0 General information

Name of Establishment:	Aughnacloy House
Address:	2 Tandragee Road Lurgan Craigavon BT66 8TL
Telephone Number:	(028) 3834 6400
Email Address:	aughnacloy.house@btconnect.com
Registered Organisation/ Registered Provider / Responsible Individual	M D Healthcare Ltd Mrs Lesley Megarity
Registered Manager:	Allison Wylie
Person in Charge of the Home at the Time of Inspection:	Allison Wylie
Categories of Care:	NH-DE, NH-I, NH-PH, NH-PH (E) NH-LD
Number of Registered Places:	71
Number of Patients Accommodated on Day of Inspection:	67
Date and Type of Previous Inspection:	Primary Announced Care Inspection 12 December 2013
Date and Time of Inspection:	21 October 2014 09.35 – 17.00
Names of Inspectors:	Sharon McKnight and Sharon Loane

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year is required.

This is a report of an unannounced primary care inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were met.

3.0 Purpose of the inspection

The purpose of this inspection was to consider whether the service provided to patients/residents was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008).

Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/process

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for the preliminary assessment of achievement by the Provider of the DHSSPS Nursing Homes Minimum Standards 2008.

The inspection process has three key parts; self-assessment (including completion of self- declaration), pre-inspection analysis and inspection visit by the inspector.

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

- analysis of pre-inspection information
- discussion with the registered manager

- observation of care delivery and care practices
- discussion with staff
- examination of records
- consultation with patients individually and with others in groups
- tour of the premises
- evaluation and feedback.

Any other information received by RQIA about this registered provider has also been considered by the inspector in preparing for this inspection.

5.0 Consultation process

During the course of the inspection, the inspectors spoke with:

Patients/Residents	Four patients individually and with the majority of patients generally
Staff	9
Relatives	1
Visiting professionals	2

Questionnaires were provided by the inspectors, during the inspection, to patients' representatives and staff to seek their views regarding the quality of the service
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Issued to	**Number issued**	**Number returned**
Patients / residents	0	0
Relatives / representatives	4	4
Staff	12	7

6.0 Inspection Focus

The theme for the inspection year April 2014 – March 2015 is: 'Nursing Care'

Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regular reviewed. (Standard 5)

Under the 'Nursing Care' theme, inspection will focus on three areas of practice:

- management of wounds and pressure ulcers (Standard 11)
- management of nutritional needs of patients and weight loss (Standard 8 & 12)
- management of dehydration (Standard 12).

Only selected criteria from each of the four standards will be inspected across nine areas and incorporated into the Provider's Self-Assessment.

An assessment on the progress of the issues raised during and since the previous inspection was also undertaken.

The inspectors will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.

The registered persons and the inspectors have rated the home's compliance level against each criterion of the standard and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance Statements		
Guidance - Compliance Statements	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Aughnacloy House is a purpose built facility which has been extended and developed to provide accommodation for persons in need of nursing care. It is situated behind Lurgan Hospital, in close proximity to Lurgan town centre.

Bedroom accommodation is provided in single bedrooms, all of which have an en-suite toilet facility. A number of bathrooms and shower rooms are located throughout the home, ensuring that bathing/showering facilities are available to meet the needs of patients. There are adequate car parking facilities at the front and rear of the home.

The home is registered to provide accommodation for 71 persons. The home is divided into two units; the ground floor unit provides nursing care for a maximum of 38 patients who require care under the category of NH(I) - old age not falling into any other category, NH-PH and NHPH(E) nursing care for physical disability under and over 65. The first floor unit provides care for a maximum of 32 patients who require care under the category of NH-DE, dementia, and one patient within the category of NH-LD, learning disability.

MD Healthcare Ltd is the registered provider and Mrs Allison Wylie was the registered manager at the time of this inspection.

8.0 Summary of Inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Aughnacloy House. The inspection was undertaken by Sharon McKnight and Sharon Loane on 21October 2014 from 09.35 to 16.30. The inspection sought to establish the level of compliance achieved regarding the selected DHSSPS Nursing Homes Minimum Standards.

The inspectors were welcomed into the home the registered manager, Mrs Allison Wylie. Verbal feedback of the issues identified during the inspection was given to Mrs Wylie throughout, and at the conclusion of, the inspection.

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. This self-assessment was received on 6 June 2014. The comments provided by the responsible individual/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

As a result of the previous inspection conducted on 12 December 2013 one requirement and six recommendations were issued. These were reviewed during this inspection and the inspectors evidenced that the requirement and five of the recommendations have been fully complied with. Details can be viewed in the section immediately following this summary.

Conclusion

The inspectors can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a good standard and patients were observed to be treated by staff with dignity and respect. Good relationships were evident between staff and patients. Patients were well groomed, appropriately dressed and appeared comfortable in their surroundings. Those patients who were unable to verbally express their views were generally observed to be well groomed, appropriately dressed in clean matching attire and were relaxed and comfortable in their surroundings. Review of bed side charts evidenced that those patients who were being nursed in bed, and unable to summon help, were attended by staff on a regular basis.

There were systems and processes in place to ensure the effective management of the standards inspected.

The inspectors observed the serving of lunch in both units. The serving of the meal was calm and well organised, with those patients who required assistance being attended to in a timely manner. Staff were observed offering encouragement to patients and those patients who were not eating their meal were offered an alternative. Two recommendations are made in regard to the dining experience.

The inspectors undertook a general inspection of the home and examined a number of patients' bedrooms, lounges, bathrooms and toilets at random. The home was fresh smelling throughout, clean and appropriately heated. The inspectors observed a number of mattresses which extended beyond the length of the divan beds. A requirement has been made.

In total, one requirement and nine recommendations have been made as a result of this inspection. One requirement has been made with regard to the recording of patients' weights. Six recommendations are made with regard to the management of nutrition and meal times. A further two recommendations are made in regard to the recording of complaints and the compatibility of beds with mattresses. One recommendation, identified in the previous inspection, is now stated for a second time.

The inspectors would like to thank the patients, relatives, registered manager, registered nurses and staff for their assistance, co-operation and hospitality throughout the inspection process.

The inspectors would also like to thank the relatives and staff who completed questionnaires.

9.0 Follow-Up on the Requirements and Recommendations Issued as a Result of the Previous Care Inspections Conducted on 12 December 2013.

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
1	Regulation 13(1)	It is required that the policy in relation to the safeguarding of vulnerable adults is reviewed and updated to ensure it is reflective with DHSSPS guidance and regional protocols.	Review of the policy in relation to the safeguarding of vulnerable adults dated May 2014 evidenced that this requirement has been complied with.	Compliant

No	Minimum Standard Ref.	Recommendations	Action taken – as confirmed during this inspection	Inspector's validation of compliance
1	26.6	It is recommended that all policies and procedures are subject to a systematic three yearly review.	Policies examined had been subject to a review within the past 3 years. Policies contained the date they had been reviewed.	Compliant
2	16.1	It is recommended that further training is provided for registered nurses in the regional procedure for the protection of vulnerable adults. The training must be reflective of their role and responsibility as the nurse in charge of the home.	Review of training records evidenced that training had been provided to registered nurses in May 2014 and that all registered nurses employed at that time had attended.	Compliant
3	10.7	It is recommended that the use of alarm mats is always discussed with patient, where appropriate, and if the patient is unable to give their consent then consultation with relatives and healthcare professionals, if required, in regard to best interest decisions for the patient, should be undertaken and records maintained of the outcome of these discussions.	Review of care records evidenced that whist care plans were in place for the management of alarm mats records did not reflect who had been involved in making the best interest decision. This recommendation is now stated for a second time.	Moving towards compliance
4	5.3	It is recommended that the condition of the patient's skin is recorded appropriately on the repositioning chart.	Review of six repositioning charts evidenced that this recommendation has been complied with.	Compliant

5	5.6	Alterations made to care records must be dated, timed and signed by the registered nurse making the alteration.	Alterations made in the care records examined had been dated, timed and signed.	Compliant
6	11.7	The manager will confirm to RQIA by end of June 2014 that the competency and capability assessments for registered nurses in the management of wound care have been completed.	RQIA received confirmation from the registered manager on 30 June 2014 that competency and capability assessments in the management of wound care had been completed for all registered nurses employed in the home.	Compliant

9.1 Follow Up on any Issues/Concerns Raised with RQIA since the Previous Inspection such as Complaints or Safeguarding Investigations.

It is not the remit of RQIA to investigate complaints made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

Since the previous inspection on 12 December 2013, RQIA have been notified of safeguarding of vulnerable adults (SOVA) issues. The safeguarding team within the local health and social care Trusts manage the SOVA issues under the regional adult protection policy/procedures. RQIA is satisfied that the registered manager has dealt with SOVA issues in the appropriate manner and in accordance with regional guidelines and legislative requirements.

10.0 Inspection Findings

10.1 Management of Nursing Care – Standard 5

The inspectors can confirm that at the time of the inspection there was evidence to validate that patients received safe and effective care in the home.

There was evidence of comprehensive and detailed assessment of patient needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments, for example Braden pressure ulcer risk assessment and the Malnutrition Universal Screening Tool (MUST) were also used to supplement the general assessment tool. The assessment of patient need was evidenced to inform the care planning process.

Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis and as and when required. There was also evidence that the referring health and social care trust (HSCT) maintained appropriate reviews of the patient's satisfaction with the placement in the home, the quality of care delivered and the services provided.

Patients spoken with commented positively in regard to staff and the care they receive and that they were happy in the home. Those patients who were unable to verbally express their views were generally observed to be well groomed, appropriately dressed in clean matching attire and were relaxed and comfortable in their surroundings.

Compliance Level: Compliant

10.2 Management of Wounds and Pressure Ulcers – Standard 11 (selected criteria)

The inspectors evidenced that prevention of pressure ulcers and wound care were well managed.

There was evidence of appropriate assessment to identify the risk of the development of pressure ulcers. Care plans for the management of risks of developing pressure ulcers and wound care were maintained.

A daily repositioning chart was in place for patients with a wound and also for patients who were assessed as being at risk of developing pressure ulcers and unable to reposition themselves. Review of a sample of these charts evidenced that patients' skin condition was inspected for evidence of change at each positional change and that patients were repositioned in bed regularly. The frequency with which patients were required to be repositioned was not always recorded in the care plan and when it was the frequency was not always consistently recorded on the repositioning chart. A recommendation is made.

Review of care records evidenced timely referral to tissue viability specialist nurses (TVN) for guidance, support and referral to the HSCT regarding the supply of pressure relieving equipment if appropriate. Staff spoken with were knowledgeable regarding the referral process.

Following review of patients' care records the inspectors evidenced that wound management in the home was well managed. Details of the wounds and frequency with which they required to be dressed were recorded in patients' care plans. The care records contained an initial wound assessment and an assessment of the wound following each dressing renewal. Review of care records evidenced that prescribed dressing regimes were adhered to.

Review of the records of incidents revealed that the incidence of pressure ulcers, grade 2 and above, were reported to RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005**.**

Compliance Level: Compliant

10.3 Management of Nutritional Needs and Weight Loss – Standard 8 and 12 (selected criteria)

The inspectors reviewed the management of nutrition and weight loss within the home.

Review of care records evidenced that a Malnutrition Universal Screening Tool (MUST) to identify those patients at risk of malnutrition was completed on admission and reviewed monthly.

Patients' weights were generally monitored on a monthly basis. It is recommended that the frequency with which patients are weighed is reviewed if patients are actively losing weight. Records evidenced that staff were actively managing those patients at risk of weight loss with evidence of referral to GP's and dietetic services.

The inspectors noted that a number of patients' weights recorded in September 2014 showed excessive weight loss. For example one patient's records evidenced a recorded weight loss of more than 10 kilogrammes with their recorded weight returning to within its normal range in October 2014. There was no recorded evidence of any action being taken in September to determine if the recorded weights were accurate. It is required that the registered manager ensure that appropriate action is taken when significant variances in patients' recorded weights are identified, action should also include checking if the recorded weights are accurate.

The registered nurses confirmed that there were procedures in place for referral to the dietician in the local healthcare trust. Staff spoken with were knowledgeable regarding the referral process. Discussion with staff evidenced that they were knowledgeable of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

The inspectors discussed the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients with the registered manager and a number of staff. A food preference record, to record patients dietary likes and dislikes, was in use. However, the inspectors noted that the records in the dementia unit did not contain detailed information. It is recommended that for those patients who are unable to express their views that their relatives/representatives are involved in completing this record.

A daily menu choice sheet is completed for each patient. Care staff also record the quantity of each meal consumed by individual patients. Following review of these records the inspectors were satisfied that patients, including those on a therapeutic diet, were offered a choice at each meal.

The inspectors observed the serving of the lunch time meal in both units. The menu was a choice of breaded chicken and chips, fish cakes, potato waffles and baked beans or sandwiches. The serving of the meal was calm and well organised with those patients who required assistance being attended to in a timely manner. Staff were observed offering encouragement to patients and those patients who were not eating their meal were offered an alternative. The tables were nicely presented with tablecloths, cutlery and a selection of condiments. Patients were offered a choice of fruit cordial, milk or a cup of tea with their lunch. An A4 sized copy of the planned menu was displayed in both dining rooms, alongside a pictorial menu of the evening meal. There was no meaningful menu displayed for lunch. It is recommended that the displaying of the menu is reviewed and displayed in a suitable manner so that patients and their relatives/representatives know what is available at each mealtime.

When the inspectors arrived in the home the patients were finishing their breakfast. The inspectors observed that the porridge was brought to each dining in a covered stainless container. There were no arrangements to keep the porridge warm throughout the serving of breakfast. It is recommended that hot food served at any meal should be transported and stored in a heated trolley until it is served.

Compliance Level: Substantially compliant

10.4 Management of Dehydration – Standard 12 (selected criteria)

The inspectors examined the management of hydration during the inspection which evidenced that the fluid requirements and fluid intake details for patients were recorded and maintained for those patients assessed at risk of dehydration.

Patients were observed to be able to access fluids with ease throughout the inspection. Staff were observed offering patients regular drinks throughout the inspection. Fresh drinking water was available to patients in lounges, dining rooms and bedrooms.

The inspectors examined the management of hydration which evidenced that individual food and fluid records were maintained for all patients. There was a daily fluid target identified and intake chart was totalled at the end of each 24 hour period. The inspectors noted in a number of patients' records that, whilst they were consuming adequate fluids they were not achieving their daily target. The method used to calculate daily fluid targets was discussed with the registered manager. It is recommended that the current method for calculating daily fluid targets is reviewed and alternative good practice guidance consider to help identify more achievable daily targets.

Following review of care records and observation of care delivery the inspectors were satisfied that hydration was being appropriately managed in the home.

Compliance Level: Compliant

11.0 Additional Areas Examined

11.1 Records Required to be Held in the Nursing Home

Prior to the inspection a check list of records required to be held in the home under Regulation 19(2) Schedule 4 of The Nursing Homes Regulations (Northern Ireland) 2005 was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that generally the required records were maintained in the home and were available for inspection. One area for improvement was identified with the complaints record. This is further discussed in section 11.4.

11.2 Patients Under Guardianship

There were no patients currently under guardianship resident at the time of inspection in the home.

11.3 Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspectors discussed deprivation of liberty with the registered manager who was aware of the Human Rights Act 1998 and deprivation of liberty issues.

11.4 Complaints

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being pro-actively managed.

The inspectors discussed the recording of complaints with the registered manager who explained that there was a record for registered nurses to complete when they receive a complaint. The registered manager recorded written complaints and complaints involving staff. However, further discussion with the registered manager evidenced that one identified complaint had been managed by the human resources department within MD Healthcare Ltd. There was no record of the complaint held within the home. It is recommended that the recording of complaints within the home is reviewed to ensure that there is a record of all complaints made and action taken is available in the home.

11.5 Patient Finance Questionnaire

Prior to the inspection a patient financial questionnaire was forwarded by RQIA to the home for completion. The evidence provided in the returned questionnaire indicated that, at the time of inspection, patients' monies were being managed in accordance with legislation and best practice guidance.

11.6 NMC Declaration

Prior to the inspection the registered person was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC.

11.7 Stake Holder Participation

11.7.1 Patient Comments

During the inspection the inspectors spoke with four patients individually and with a number in groups. Patient responses were positive with regard to the care they were receiving.

11.7.2 Patient Representative/Relatives' Comments

During the inspection the inspectors spoke with one relative. In addition, four relatives completed and returned questionnaires. All of the comments and responses received were positive.

11.7.3 Staffing Comments

During the inspection the inspectors spoke to nine staff and received seven completed questionnaires from staff following the inspection. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes. One respondent indicated that they were dissatisfied with the time available to listen and talk to patients.

Staff comments included:

"There is a good relationship between staff and residents….."
"…there is plenty of training opportunities in house and outside for staff."
"I enjoy working here."
"It would be great of staff had more time for one to one with residents."

11.7.4 Visiting Healthcare Professionals

The inspectors spoke with two healthcare professional during the inspection. Both were confident that staff knew their patients and that appropriate, timely referrals were made to the trust. Confirmation was also provided that recommendations made following assessment were communicated to the staff team and implemented as prescribed.

11.8 General Environment

The inspectors undertook a general inspection of the home and examined a number of patients' bedrooms, lounges, bathrooms and toilets at random. The majority of patients'/residents' bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling throughout, clean and appropriately heated.

The inspectors observed a number of mattresses which extended beyond the length of the divan bed base. This is a potential falls hazard for patients. The mattresses provided should be compatible with the divan beds they are placed on. It is therefore recommended that these mattresses are reviewed to ensure that they do not constitute a risk to patient safety.

12.0 Quality Improvement Plan

The details of the quality improvement plan appended to this report were discussed with Allison Wylie, registered manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the quality improvement plan.

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

Enquiries relating to this report should be addressed to:

Sharon McKnight
The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
On admission the resident is assessed as to their needs in regard to activities of daily living. This includes a skin assessment and completion of a body map, Braden Risk Assessment, Abbey Pain Scale, falls risk assessment, MUST and moving and handling risk assessment. GAIN Nutritional and Oral Health Assessment, Food likes and Dislikes,, Food Intolerances, Allergies, Sensitivities, Continence Assessments, Bed Type & Bed Rail, Pressure Relieving Mattress Assessment, Nurse Call Assessment, Advanced Directives, End of Life Care Plans, Resuscitation Status. Any information received from the Care Management team or hospital discharge team in respect of intermediate care admissions informs the assessments for the immediate care needs. Within 11 days of admission a complete care plan	Compliant

is available. A new Resident and their Representative are invited to attend a care review within 14 days of admission. A further review is conducted by their Care Manager from the Trust within 8 weeks from their admission date, and by invitation attended by their Link/Key worker, General Practitioner, Family Representative and Home Representative. Any party can request to speak with the Care Manager who is independent of the home in private. A copy of the most recent Care Review is stored with each Residents Individual Care Plan for the Resident and their Family Representative to peruse at any time. The next of kin receives their own signed, personal copy of this document from the Care Manager. Anyone involved in the care package can raise comments regarding this document at any time with the nurse in charge . This encourages 360 degree involvement of all interested parties in the individualised care plan. Each Resident has their own Named Nurse, the purpose of this is to ensure that good relations are achieved as swiftly as possible with each resident and their family. The named staff are a point of contact for the next of kin and the resident. The staff willl endeavour to build strong, caring relations based on trust and respect. We believe that when Residents are listened to and made to feel valued they will become open and will share information. Care plans for each area of care are developed for each resident to ensure optimum outcomes and promote rehabilitation and independence where possible. The Nurse Manager or a Senior Nurse carries out all pre admission assessemenst wihich are then developed and updated by the Nursing Staff during the initial 11 days of admission. Additonal information or changes to care needs are added to the care plan by Nurse in Charge of each shift and evaluated monthy by the Named Nurse or key worker. Must tool is completed within 24 hours of admission and nutritional care plan put in place A Pre-admission risk assessment is completed which includes nutritional, pain and continence assessments where possible and a full assessment is carried out on admission to the home using all relevant information gained form the pre-admission assessment. The form has been reviewed in August 2013 for completeness.	

Information received form the Multi-disciplinary team is reviewed in completing the risk assessments. A decision is then made as to whether the home has the capacity and equipment to meet the prospective resident's needs. Pre admission and admission assessments includes, , Braden Risk Assessment, Abbey Pain Scale, MUST and moving and handling risk assessment. GAIN Oral Health Assessment, Food likes and Dislikes,, Food Intolerances, Allergies, Sensitivities, Continence Assessments, Nurse Call Assessment, Advanced Directives, End of Life Care Plans, Resuscitation Status. Bed Type and the use of bed rails, equipment and pressure relieving aids are discussed with Intermediate Care Services and the home ensures that the equipment is available prior to admission to meet the needs of each client, Southern Health and Social Care trust August 2011 continence assessment are used and re-evaluated after admission, the Bristol Stool Chart is used .	

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
On admission a named nurse is allocated to each new resident who assesses, discusses plans and agrees care plans with residents and their representative. Dependency scales are completed and based on these and the risk assessments and the Multi-disciplinary team input, The number of staff required and activities requiring assistance are identified to maximise independence. Care plans are developed using dependency scales and assessments of daily living to promote independence and rehabilitation where possible. Staff are encourage to do tasks 'with' rather than 'for' a resident. Care plans are reviewed monthly and consent is obtained initially from the resident and their representative and ongoing or where change occurs. Staff work closely with Residents and their relatives to discuss and agree interventions which best meet the needs of the resident. We aim to promote independence and opportunities for rehabilitation. Daily outcomes of care delivered is monitored and recorded in the care records. Residents and their next of kin are kept up to date regarding all changes made to care plans and are encouraged to speak to staff daily or when they visit. Care Managers and other multidisciplines who visit a resident also make a record of there input/findings in the care records. All trained staff are knowledgeable in wound management. One staff member has undertaken would management link nurse training to cascade knowledge and skills throughout the home to trained staff and provide advice. Based on wound assessments and evaluation, referral forms are completed and forwarded to the Trust TVN or GP as required. Where appropriate, advice will be sought from other professionals such as dieticians and podiatrists. There is a referral process in place to obtain advice and support from the other healthcare providers. There is a direct referral to the Tissue Viability Nurse, Chiropodist/ Podiatrist and via GP referral the Dietician, OT and Physiotherapist. Nursing staff maintain care by continuous reassessment and under the guidance of the TVN and HSE Northern Ireland	Compliant

Wound Care Formulary 2nd Edition April 2011, Crest Guidelines 1998, HNSSB Wound Management Manual 2005. Wound care is audited monthly during the Regulation 29 Home Visit and if further improvements to care and training are quantified this will be included within the monthly action plan. The Home operates a Nursing Competency and Capability Assessment and skills based audit to ensure all nursing staff attain the level of expertise required for this standard. Upon identification of a resident at risk of pressure ulcers, obtained via the risk assessments, Braden, mobility and MUST, a risk management plan is developed which identifies actions to be taken to manage the risk of pressure sores. A referral is made to the Tissue Viability Nurse when a Resident is deemed at risk of developing a pressure ulcer. A care plan is agreed and implemented to monitor effectiveness of the care. All staff are informed via the Care Plan of the treatment plan and evaluation process. Families are kept fully informed on treatment recommendations. Dietician referrals are made if deemed appropriate. A Care Management meeting may be necessary to discuss the emerging needs of the Resident. The Home will keep all individuals informed of any changes. Staff will ensure that the Residents comfort and dignity will be maintained at all times, by ensuring that the Resident is pain free, with clean dressings and odour free wounds. In the event of break through pain, the Home Remedy Management Plan can be exercised with the Residents consent. Residents who have lower limb or foot ulceration are referred to tissue viability and podiatory. Within the nursing home there are referral arrangements for the dietician to assess individual nutritional requirements who then draw up a nutritional plan taking into account recommendations from relevant health professionals and these plans are adhered to.	

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Assessment of wounds us carried out at six day intervals or sooner if required, depending on care plan or attendance of the TVN, AHP or GP, or if change is noted when wound is being dressed or resident expresses increased pain or displays other symptoms. The Staff work with the multidiciplinary team members to ensure that care plans reflect best practise to ensure that care provided is meeting the needs of the Resident. Care of the Resident is onging 24 hours per day. Changes to care delivery are documented on the day of the changes and care plans are amended by the Nurse in Charge of the shift. The Named Nurse will evaluate the care plan as indicated by needs of Resident but not later than on a monthly basis.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing interventions are supported using validated tools and procedures follow national guidelines. In respect of wound prevention, NICE pathways are followed, risk scores in respect of nutrition are obtained through use of dependency scales and MUST. Crest guidelines, the Northern Ireland Wound Formulary and the Northern Trust wound care management guidelines are used to inform decision making regarding products to be used to treat wounds. Nursing staff attend regular courses and mandatory updates. Our Wound Care Link Nurse ensures that our validated tools are current and best practice. All risk assessments used within the home are evidence based and assessment	Compliant

tools are directed by policies and procedures supported by evidence base guidelines for example, Crest Guidelines 1998, MUST, GAIN, NICE, HSE Northern Ireland Wound Care Formulary 2nd Edition April 2011, RQIA standards etc, and are recorded as per NMC guidelines Crest guidelines are used to screen residents who have skin damage. The HSE Northern Ireland Wound Care Formulary 2nd Edition April 2011,European pressure ulcer advisory panel (EPUAP) and the NHSSB Wound Management Manual 2005 are referred to. The Homes Link Nurse ensures that the Homes Validated Tools are up to date with current practice and legislation and informs staff on any changes. Open wound assessment charts are completed to record appropriate treatment and a care plan is developed. The wound care administration chart is completed and open wound observation used for monitoring progress as per the care plan. The Abbey Pain scale is completed. The Staff work with the multidiciplinary team members to ensure that care plans reflect best practise to ensure that care provided is meeting the needs of each Resident. Care of the Resident is onging 24 hours per day. Changes to care delivery are documented on the day of the changes and care plans are amended by the Nurse in Charge of the shift. The Resident, their next of kin and the Link Worker are informed immediately. The Named Nurse will evaluate the care plan as indicated by the needs of the Resident no more than monthly as long as needs have not changed. If the Nurse in Charge or the Named Nurse is concerned at any time they will seek the opinion of an expert, in the best interest of the Resident. Nutritional guidelines and menu checklist 2014 for residential and nursing homes and must tool are used by staff on a daily basis	

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing daily evaluations are completed showing tasks and care carried out on the day and record outcomes for residents. In relation to wound care, the Open Wound Observation Chart and the Wound Care Administration Chart are completed contemporaneously with the treatments or procedure and note progress in relation to the resident. Care plans are reviewed at least monthly.	Compliant

Individual tastes where possible are met the organisation uses the guidelines (nutritional guidelines and menu checklist 2014) in composing menus to ensure a sufficient offering of protein, carbohydrates vegetables and snacks to meet nutritional requirements. Analysis of menu cycle is carried out at menu change times using general menu checklist. We currently have no vegetarians or ethnic residents however guidelines are available to the home if required. Action plan is in place for residents who refuse a meal. Weights are observed for weight gain related to over eating and dietary advice is given if necessary and referral to dietician if necessary	

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Daily evaluation notes are completed daily and reviewed at least monthly. If change is noted then staff take appropriate actions which may include involvement of AHP or GP. Where there is a change to care, this is agreed with the resident and their next of kin. Families are encouraged to contribute at annual meetings and at formal reviews. Outcomes of care delivered is recorded on a daily basis into the Residents Care Plan. Residents have twice yearly reviews and outside of this Care reviews can be called when deemed necessary. The Resident and their family are involved where possible in reviewing care provision and contributing to the Care Planning Process. All care plans are reviewed monthly or sooner if the needs of Resident require it. Multidisciplinary experts are involved in evaluating progress and also document their findings in the care plan.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Residents/representatives participate in annual reviews carried out by the HSC trust as well as relatives residents annual meeting within the home. Service users are consulted informally at the time of reg29 pic visit and formally through questionnaires. Results of reviews and minutes of review meeting are recorded and changes are made to nursing care plans with the agreement of residents/representative where required. Residents/representatives are kept informed of progress towards agreed goals and documented in relatives contact sheet and at annual relatives meetings Review meetings are scheduled to be held with the service users, their next of kin or significant other. Where the Trust fails to arrange the review, a letter or e-mail is sent to the Care Manager requesting the review is carried out. This is then followed up until such times as the review is held. Where on-going issues persist with the Trust failing to hold care reviews, this is raised at the contract review meetings. Care continues to be reviewed in-house in the normal way until such times as the Trust review is held. All residents at Aughancliy House whether self funding or not are care managed in line with the Trust guidelines.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Preferences for residents are taken into account on admission and at care plan stage including meal preference form, dysphagia if present, must tool is completed to identify those residents who may require additional nutritional support and referral to dietician if necessary Menus are designed with a 3 week rotation and without repitition taking into account residents likes, dislikes and type of diet including diabetic, soft, puree. Residents are offered choice at each meal time, the relevant guidance is followed using Nutritional guidelines and menu checklist for residential and nursing homes 2014 and menus are tested against the general menu checklist maintained within guidelines Menus offer choice of two options at meal times and specific tastes are catered for where possible alternatives are offered if a resident does not like what is on the menu for that day	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nurses are knowledgable in swallow awareness and supervise HCAs in assisting with eating and drinking. Residents who have swallow difficulties are referred to the speech and language team and advice is incorporated into care plan, all staff including kitchen staff are made aware of changes to residents dietary needs. For those residents who require enteral feeding nurses competencies are measured against guidelines for enteral feeding	Substantially compliant

Within the home meals are provided at conventional times, breakfast served 9am, lunch 12.45pm, dinner 4.45pm and supper 8.30pm. Hot, cold drinks, milkshakes, fresh fruit and snacks are available 24hrs per day upon request. Fresh drinking water is available in residents day room and bedrooms. For those who are unable to manage drinking themselves staff regularly assist residents. Nutritional needs are detailed in each residents care plan including if they need assistance with meals and fluids this is updated if any changes are made during shift and handover If residents are at risk they are encouraged to eat in the dining room where they can be supervised or assisted if resident chooses to stay in bedroom for their meal they are then facilitated for one to one supervision. Necessary aids and equipment are provided All nurses are knowledgeable in wound management. One nurse has undergone link nurse training in wound management at Beeches Management Centre, which enables her to cascade knowledge throughout the home. Staff are able to assess and grade wounds and apply wound care products and dressings. Nursing staff have the expertise and skill to assess and apply wound care products and equipment, they follow the policies and procedures of the home designed and updated using best practice validated tools and they always liaise with the Link Nurse or the Tissue Viability Nurse to ensure that their practise is in line with current standards and their concerns are alleviated. Wound care is audited monthly during the Regulation 29 Home Visit and if further improvements to care and training are quantified this will be included within the monthly action plan. The Home operates a Nursing Competency and Capability Assessment and skills based audit to ensure all nursing staff attain the level of expertise required for this standard.	

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	COMPLIANCE LEVEL
	Compliant

Quality Improvement Plan

Primary Unannounced Care Inspection

Aughnacloy House

21 October 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Alison Wylie, registered manager, either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Statutory Requirements

This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Nursing Homes Regulations (NI) 2005

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	13(1)(a)	The registered manager must ensure that appropriate action is taken when significant variances in patients' recorded weights are identified; this should include checking if the recorded weights are accurate. **Ref section 10, 10.3**	One	The Registered manager will ensure that appropriate actions will be taken if and when significant variances in patients' recorded weights are identified, this will include a monthly review of all patients' weights over 3-6 months, as per the MUST guidelines, taking appropriate steps to manage weight loss/gain. This will also include ensuring the recorded weights are accurate.	From the date of inspection.

Recommendations

These recommendations are based on The Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	10.7	It is recommended that the use of alarm mats is always discussed with patient, where appropriate, and if the patient is unable to give their consent then consultation with relatives and healthcare professionals, if required, in regard to best interest decisions for the patient, should be undertaken and records maintained of the outcome of these discussions. **Ref section 9**	Two	The use of alarm mats, will be discussed and the outcome of these discussions will be recorded, with the patient, where appropriate, if patient is unable to give their consent then consultation will take place with designated NOK and healthcare professionals, if required, in regard to best interest decisions for the patient.	By the end of November 2014.
2	5.3	The frequency with which patients are required to be repositioned should be recorded in the care plan and consistently recorded on the repositioning chart. **Ref section 10.0, 10.2**	One	The registered manager will ensure that the frequency with which patients are required to be repositioned should be recorded in their care plan and consistently recorded on the repositioning chart.	By the end of November 2014.

3	8.2	The frequency with which patients are weighed should be reviewed if patients are actively losing weight. **Ref section 10, 10.3**	One	The registered manager will ensure that patients who are actively losing weight are weighed according to the MUST guidelines.	By the end of November 2014.
4	12.1	Those patients who are unable to express their views their relatives/representatives should be involved in completing the food preference record. **Ref section 10.0, 10.3**	One	The registered manager will ensure that for those patients who cannot express their views, their relatives/representatives will be involved in completing the food preference record as close to admission as possible	By the end of November 2014.
5	12.4	The displaying of the menu should be reviewed and displayed in a suitable manner so that patients and their relatives/representatives know what is available at each mealtime. **Ref section 10, 10.3**	One	The menu will be displayed in a suitable manner, at each mealtime, so that patients, relatives/representatives know what is available for the meal	By the end of November 2014.
6	12.9	Hot food served at any meal should be transported and stored in a heated trolley until served to the patients. **Ref section 10, 10.3**	One	The registered manager will ensure that breakfast, porridge, will be transported in a heated trolley to ensure it remains hot enough until served to the patients	By the end of November 2014.

7	12.1	The current method for calculating daily fluid targets should be reviewed and alternative good practice guidance consider to help identify more achievable daily targets. **Ref section 10, 10.4**	One	The registered manager in conjunction with other senior staff is undertaking a review of documentation, with a view to utilising the GULP hydration assessment tool. Where a patient is not reaching their target volume, their GP will be made aware of this and a review of the target volume undertaken to ensure an appropriate/achievable target is made for individual patients	By the end of November 2014.
8	17.10	The recording of complaints should be reviewed to ensure that there is a record of all complaints made and action taken available in the home. **Ref section 11.4**	One	The registered manager will ensure that all complaints received will have a record held within the home. Any confidential complaints will have a summary of the complaint with the outcome held in the complaints file.	From the date of inspection.
9	32.8	Mattresses which extend beyond the length of the divan bed should be reviewed to ensure that they do not constitute a risk to patient safety. **Ref section 11.8**	One	A risk assessment of each case was undertaken following the inspection, a planned refurbishment is on-going and further discussions regarding equipment provision is planned with SHSCT.	From the date of inspection.

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person/identified responsible person:

NAME OF REGISTERED MANAGER COMPLETING QIP	Connie Mitchell 29/01/2015
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Lesley Megarity

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	X	Sharon McKnight	2-02-15
Further information requested from provider			