Unannounced Care Inspection Report
1 June 2016

Hockley Private Nursing Home

Type of Service: Nursing Home
Address: 11 Drumilly Road, Armagh BT61 8RG
Tel No: 028 3887 0365
Inspector: Sharon Loane

1.0 Summary

An unannounced inspection of Hockley Private Nursing Home took place on 1 June 2016 from 10.45 to 16.45 hours.

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

Is care safe?

A review of systems and processes evidenced that care was safe. The recruitment and induction of staff was managed appropriately and training had been provided in all mandatory areas and was kept up to date.

The registered manager and staff spoken with demonstrated their knowledge, skill and experience necessary to fulfil their role, function and responsibilities in general and specifically in relation to adult safeguarding. Staff spoken with described their roles with pride and enjoyed working in the home.

The planned staffing levels were adhered to and reviewed in accordance with the assessed needs of the patients accommodated.

The home was found to be clean, comfortable and warm throughout and the majority of patients' bedrooms were personalised. Fire exits and corridors were maintained clear from clutter and obstruction.

Is care effective?

Staff meetings were held and recorded and staff advised that they felt they could approach management with any concerns. There was evidence of regular communication with representatives within the care records and discussion with representatives confirmed that they were kept updated regarding their relatives wellbeing. However, no meetings had been held for patients and their representatives since June 2015 and a recommendation was made in this regard.

Shortfalls were identified in the delivery of effective care specifically in relation to care planning and record keeping, the management of food and fluids and wound and/or pressure care management. Some of these issues; namely care planning and record keeping had been raised previously and there was limited evidence of improvement since the last care inspection and two recommendations have been stated for a second time. Two requirements and four recommendations have been made at this inspection within the effective domain.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients care plan. Systems were in place to obtain the views of patients, their representatives, staff and other

members of the professional healthcare team. There was evidence of good communication in the home between staff and patients. Patients were very praiseworthy of staff and a number of their comments are included in the report.

Is the service well led?

Discussions with patients, and their representatives and staff were complimentary in regards to the standard of care and management within the home.

Despite matters being raised previously, three recommendations have been stated for a second time. Areas for improvement were also identified within the domain of "well led" in regards to governance arrangements.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	3	8*

*The total number of recommendations above includes three which have been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Marion Wilson, 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 11 February 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

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

2.0 Service details

Registered organisation/registered provider: Elim Trust Corporation / Pastor Edwin Michael	**Registered manager:** Mrs Marion Gertrude Wilson
Person in charge of the home at the time of inspection: Mrs Marion Wilson, Registered Manager	**Date manager registered:** 01 April 2005
Categories of care: RC-I, NH-I	**Number of registered places:** 60

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal information received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report
- pre assessment inspection audit.

During the inspection the inspector met with five patients individually and with others in small groups; two patients' relatives, the nursing sister, two registered nurses, two care staff and two ancillary staff. Ten questionnaires were also issued to relatives and staff and five to patients with a request that they would be returned within one week of the date of inspection.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

The following information was examined during the inspection:

- Validation of evidence linked to previous QIP
- Three patient care records
- A sample of staff duty records
- Staff training matrix
- One staff recruitment file
- Staff induction record
- Complaints record
- NMC & NISCC records

- Incident and accident records
- Records of staff meetings
- A sample of audits
- Annual Quality Report 2015 -2016
- Reports of monthly monitoring visits undertaken in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 11 February 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and accepted by the care inspector and was validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 11 February 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time	The registered person must ensure that the treatment and any other services provided to each patient meets their identified assessed needs and reflects current best practice in relation to the management of weight loss. An urgent actions record was issued.	**Met**
	Action taken as confirmed during the inspection: A review of two patients' care records evidenced that were weight loss had been identified, appropriate actions had been implemented. Risk assessments had been updated and care plans reviewed accordingly. Appropriate referrals had been made and recommendations made were adhered to. There was recorded evidence of ongoing communication with the General Practitioner, Dietician and Speech and Language Therapist (SALT). This requirement has been met.	

Requirement 2 **Ref:** Regulation 13(1) (a) (b) **Stated:** First time	The registered person must ensure that patients identified with swallowing difficulties are referred to SALT and reviewed as and when required. A care plan should be developed and or updated to reflect any recommendations made and care is provided accordingly. A system should be developed to ensure that all staff is knowledgeable in relation to the consistency of fluids suitable for the needs of patients.	**Met**
	Action taken as confirmed during the inspection: A review of two patient's care records assessed for swallowing difficulties evidenced that appropriate actions had been implemented. Care plans adhered to any recommendations made by SALT and food and fluids were administered accordingly. A discussion with care staff confirmed that they were knowledgeable in relation to the consistency of fluids required for the needs of the patients. A discussion with the assistant cook confirmed that catering staff were provided with information regarding patients' dietary needs and had a copy of the SALT assessment. This requirement has been met.	
Requirement 3 **Ref:** Regulation 14 (4) **Stated:** First time	The registered person shall make arrangements, by training or by other measures that the registered manager and relevant others understand their specific role in relation to safeguarding. The correct procedures must be adhered to and reported to relevant authorities.	**Met**
	Action taken as confirmed during the inspection: A discussion with the registered manager confirmed that they were knowledgeable in regards to their specific role in relation to adult safeguarding. The registered manager advised that Adult Safeguarding Training was mandatory for all staff to update annually. Other staff spoken with also demonstrated their understanding and knowledge in line with their roles and responsibilities. This requirement has been met.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 4 Criteria (1) (7) **Stated:** First time	It is recommended that continence assessments and care plans are completed comprehensively to include all aspects of continence management. **Ref Section: 5.3**	**Not Met**
	Action taken as confirmed during the inspection: A review of patient care records for a recent admission did evidence some improvement. However, assessments and care plans previously written had not been updated and /or reviewed in accordance with the recommendation made at the last inspection. Despite individual supervision sessions being carried out with registered nurses, it was disappointing that any learning and/or actions had not been embedded into practice. This recommendation has been stated for a second time and failure to comply with this care standard is likely to lead to enhanced enforcement action.	
Recommendation 2 **Ref**: Standard 37 Criteria 4 **Stated:** First time	It is recommended that the information recorded in the bowel record is entered into the electronic records to ensure that patients' care records are accurate and up to date.	**Not Met**
	Action taken as confirmed during the inspection: A review of two patients' bowel management records evidenced that information was not recorded within the electronic record. There was evidence that care staff had recorded the information onto a paper record however the registered nurse had not fulfilled their responsibility to transfer the information into the electronic record to ensure that patients care records are accurate and up to date. This recommendation has been stated for a second time and failure to comply with this care standard is likely to lead to enhanced enforcement action.	

Recommendation 3 **Ref**: Standard 39 **Stated:** First time	It is recommended that registered nurses receive training in relation to the management of weight loss to include the Malnutrition Universal Screening Tool (MUST) and ensure that learning has been embedded into practice.	**Met**
	Action taken as confirmed during the inspection: The nursing sister advised that training and supervision had been provided for registered nurses in relation to the management of weight loss and the MUST assessment tool. A record was available to confirm this information and there was evidenced within the care records reviewed that the learning had been embedded into practice. This recommendation has been met.	
Recommendation 4 **Ref**: Standard 4 **Stated:** First time	It is recommended that care plans are in accordance with the regime of care prescribed and are reviewed and updated according to ongoing re-assessment and appropriate to the patients individual needs.	**Not met**
	Action taken as confirmed during the inspection: A review of care records evidenced that this recommendation had not been met. Please refer to section 4.4 for further details. This recommendation has been stated for a second time and failure to comply with this care standard is likely to lead to enhanced enforcement action.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review sample of the staffing rota for week commencing 30 May 2016 evidenced that the planned staffing levels were adhered to. Discussions with patients, representatives and staff evidenced that there were no concerns regarding staffing. Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty.

The recruitment processes were discussed with the registered manager and one personnel file was reviewed. This review evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2.

Discussion with staff and a review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

Staff consulted confirmed that they shadowed experienced staff until they felt confident to care for patients unsupervised. A review of one induction record included a written record of the practice and theory elements completed and the signature of the staff member and the person mentoring the new employee. The registered manager also signed the record upon completion of the induction period.

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

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas. Training was provided by both internal and external providers via face to face training. A review of training records for 2015 evidenced that the majority of staff had met mandatory training requirements. The registered manager advised that a letter of concern was issued to staff who did not attend organised training and appropriate actions were taken.

Discussion with the registered manager and nursing sister and staff confirmed that there were systems in place to ensure that staff received support and guidance. Staff were coached and mentored through supervision, competency and capability assessments and annual appraisals.

Review of three patients' care records evidenced that a range of risk assessments were completed as part of the admission process to accurately identify risk and inform the care planning process.

The registered manager and staff spoken with demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibilities in relation to adult safeguarding. A previously stated requirement in relation to adult safeguarding had been met.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the last care inspection evidenced that these had been appropriately notified to RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. It was also noted that the registered manager submitted follow-up information to RQIA detailing any actions or lessons learned.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, and lounge/s, dining room/s and storage areas. The home was found to be warm and fresh smelling throughout.

Fire exits were observed to be clear of clutter and obstruction. Items such as specialised seating and medicine cabinets were observed in the link corridor between the Lodge and Mews. The registered manager advised that these items were being stored in this area temporarily until they were collected by the relevant companies. Infection prevention and control measures were adhered to.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0

4.4 Is care effective?

The home used an electronic system for assessing, planning and recording patients' care needs and a review of three patient care records evidenced that risk assessments were reviewed and updated on a regular basis. There was evidence in the majority of records examined that risk assessments informed the care planning process, although some shortfalls were identified.

Areas for improvement had been identified at the previous care inspection of 11 February 2016 in relation to certain aspects of the care planning process. Whilst some improvements were observed, there was continued evidence of deficits in the care planning process and record keeping. For example, a previous recommendation made in relation to continence assessments and bowel management had not been actioned satisfactorily and despite a previous recommendation made in regards to the review of care plans in accordance with prescribed care by other healthcare professionals there was still evidence that this had not been met fully.

The following issues were identified in the named care records provided to the registered manager. One care record examined in relation to wound management identified that the care being delivered was not consistent with the treatment prescribed by the Podiatrist. The wound care records evidenced that the dressings were renewed twice weekly, when the care plan advised alternate days. The nursing sister advised that the treatment regime had been amended by the Podiatrist however there was no recorded evidence to support this information. Other shortfalls were identified in regards to best practice for wound/pressure management, for example, the open wound charts were not completed fully and a body map was not available for this patient. Furthermore, a review of a second care record for a patient admitted with wounds and /or pressure damage evidenced that a body map was not completed until five days following their admission. A requirement has been made.

A review of supplementary charts in relation to the management of food and fluid intake charts evidenced shortfalls. A review of records for one identified patient evidenced that the patient had been prescribed various nutritional supplements. However, a review of a sample of food and fluid intake charts evidenced that the supplements were not being recorded in a consistent manner and the records did not reflect that the patient had received their prescribed supplements. There was evidence that the 24 hour fluid intake received was totalled. Although there was no recorded information to evidence registered nurses had any oversight into the fluid intake of patients over a 24 hour period or had taken any actions to address deficits in regards to same. A sample review of food and fluid intake charts for another identified patient identified similar shortfalls and it was concerning that on two identified occasions the 24 hour fluid intake was recorded as 100 -150mls and registered nurses had not raised any concerns or taken any action. Entries recorded in the patients daily progress notes included "fluids encouraged" or "eating and drinking well". This matter was concerning and has the potential to impact on the patient's health and welfare and was discussed with the nursing sister who advised and assured that these deficits were attributed to staff not recording

the required information. Whilst we acknowledged that staff were observed assisting patients with food and fluid intake during this inspection, a requirement has been made in relation to the overall management of food and fluids and a recommendation has been made in regards to completing contemporaneous nursing records.

A sampling review of repositioning records evidenced that patients were not been repositioned according to their care plans. A review of one identified care record advised that the patient required 3-4 hourly positional changes however, no repositioning record was available. A discussion with staff at various grades advised that the identified patient refused all methods of repositioning, although this information was not recorded within the care plan evaluations. The nursing sister advised that the patient's non-compliance with care in this regard would be discussed further with the patient's representatives and the Trust and the care plan would be updated accordingly.

A further review of repositioning records for another identified patient evidenced that they also were not being repositioned according to the required care interventions with gaps of up to and including six hours. This has been subsumed in a previous requirement made. Information regarding repositioning was completed using an electronic record which provided a section for staff to comment on the condition of patient's skin for example; "yes", "no" and "not applicable". When staff selected "no" there was no additional information recorded to describe the condition of the skin. This matter was discussed with management and a recommendation has been made to review the template for recording the repositioning needs of the patients in line with best practice guidelines.

The inspection findings identified an additional need for the registered nurses to attend training and gain competency in the nursing process and record keeping. A recommendation has been made in this regard.

There was evidence within the care records reviewed, that patients and/or their representatives, if appropriate were involved in the care planning process. There was also evidence of regular communication with representatives within the care records and discussion with representatives confirmed that they were kept updated regarding their relatives wellbeing.

Discussion with the registered nurse in charge and staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff recognised the importance of the handover reports in ensuring effective communication and continuity of care. Staff spoken with confirmed that the shift handover provided the necessary information regarding any changes in patient's condition.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The registered manager advised that management meetings were also held on a regular basis. A review of minutes for the most recent staff meeting, 10 February 2016, confirmed that records were maintained appropriately. Staff also confirmed that if they had any concerns, they could raise these with the management team.

Discussion with the registered manager and a review of records evidenced that patients and /or relatives meetings had not been held since May 2015. The registered manager advised that the home had an open door policy and that relatives could speak with them at any time. During the inspection, relatives were observed approaching the registered manager to discuss the care of their loved one. Whilst this was acknowledged, it was agreed that meetings should

be organised to provide a forum for patients and /or their relatives to discuss the home and any other matters. A recommendation has been made.

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. A questionnaire completed by a relative suggested that the home should consider a "suggestion box"; this was discussed with the registered manager post inspection, who agreed to action this suggestion.

Areas for improvement

A requirement has been made in relation to the management of food and fluids to include: nutritional supplements.

A requirement has been made in relation to the management of wounds and/or pressure care to include; the "repositioning needs" of patients and care is recorded in keeping with best practice guidelines.

It is recommended in accordance with NMC guidelines, contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each resident.

It is recommended that registered nurses are provided with training, as appropriate on the nursing process.

It is recommended that the current template for recording patients "repositioning care" is reviewed to ensure that it provides detailed information in regards to the "condition of the skin" when checked.

Meetings should be organised to provide an open forum for patients and /or their relatives to discuss the home and any other matters and a record retained. A recommendation has been made.

Number of requirements	**2**	**Number of recommendations**:	**4**

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that they were afforded choice, privacy, dignity and respect. Staff were observed to knock on patients bedroom doors before entering and kept them closed when providing personal care. Patients advised that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and were offered a choice of meals, snacks and refreshments throughout the day.

Patients consulted with stated that they knew how to use their call bells and stated that staff responded to their needs in a timely manner and acknowledged that at times they may have to wait a short time if other patients were being attended to. Patients also confirmed that they were able to maintain contact with their families and friends. Two activity staff were employed and provided a range of activities and patients spoken with advised that there was something to suit all interests and they enjoyed participating.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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

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

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager and, staff and relatives and a review of compliments, there was evidence that the staff cared for the patients and relatives in a kindly manner.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives**.** Responses received were in the majority positive and some additional comments made by patients and their representatives : included, staff not responding to patients needs appropriately and set times for care delivery, these comments were discussed with the registered manager post inspection and assurances were given that these issues would be reviewed and addressed appropriately.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.6 Is the service well led?

Discussion 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. Patients and their representatives and staff commented positively regarding the visible presence and the responsiveness of the registered manager and it was very evident from observations made that the registered manager knew all the patients and their relatives.

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 current and displayed appropriately. A certificate of public liability insurance was also displayed and up to date. The registered manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis and staff confirmed that they had access to the home's policies and procedures.

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 include drug alerts; equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. A copy of the complaints procedure was displayed and patients and representatives spoken with confirmed that they were aware of the home's complaints procedure and as previously discussed were confident that staff/management would manage any concern raised by them appropriately.

Discussion with the registered manager confirmed that systems were in place to obtain the views of patients and their representatives on the quality of the service provided. A review of the last annual quality report referenced the details of another service included in the group. This matter was discussed with the general manager following the inspection and it was agreed that the report should only reference the service for which the report has been compiled.

A review of notifications of incidents and accidents to RQIA since the last care inspection confirmed that these were managed appropriately. The registered manager was also very efficient at providing RQIA, and the staff/team with any follow-up information and/or actions to be taken and any lessons learned. This is good practice.

Discussion with the registered manager and review of records evidenced that some audits had been completed, via the "key check" electronic system. However, there was limited evidence that the information had been analysed and there was no evidence of any actions taken to address any identified deficits. Given that deficits were identified within the "Is care effective" domain specifically in relation to care records and care delivery, we were not assured that the homes governance arrangements were robust enough to assure the safe delivery of quality care within the home. A requirement has been made.

Discussion with the registered manager and review of records evidenced that Regulation 29 monitoring visits were completed in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Although these were completed it was noted that they did not identify the shortfalls evidenced at this inspection. This matter was discussed with the Group Manager completing the monitoring visits and a recommendation has been made that these visits should be reviewed with regards to the organisations governance arrangements.

Areas for improvement

Governance arrangements to monitor audit and review the quality of nursing and other services provided within the nursing home should be implemented and completed on a regular basis. An action plan should be developed for any identified improvements and the follow–up actions required. A requirement has been made.

The content of the report prepared in accordance with Regulation 29 of the Nursing Homes Regulations Northern Ireland (2005) should be reviewed and developed to monitor the robustness of the homes governance arrangements. A recommendation has been made.

As previously discussed in this report a number of recommendations have been stated twice under the effective domain and must be considered as areas for improvement in the well led domain.

Number of requirements	1	Number of recommendations:	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager as part of the inspection process. The timescales commence from the date of inspection.

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

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

5.1 Statutory requirements

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

5.2 Recommendations

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

5.3 Actions taken by the Registered Provider

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

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

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 13 (1)(a) **Stated:** First time **To be completed by:** 11 July 2016	The registered person must ensure that the home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. It is therefore required that where nursing needs are identified care must be delivered to ensure individual patient needs are met. This refers particularly to the management of patients who are at risk of dehydration and malnutrition and require their total fluid intake to be monitored and prescribed nutritional supplements should be recorded on the fluid chart accordingly. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Staff who are assigned to monitor food and fluid intake have their work checked by a Registered Nurse prior to the end the shift. Supervision is given when necessary and accountability is stressed. A checklist has been added to the Day/Night Report document which is prepared for the Nurse Manager. In signing this, the Registered Nurse is responsible for having ensured that the fluid intake records are correct. An sudit reveals that the total fluid intake, including nutritional supplements is being recorded. Nutritional care plans have been expanded and a nutritional audit is in place to monitor those patients who are at risk of malnutrition. Staff are informed of the necessary actions through the audit tool.
Requirement 2 **Ref**: Regulation 12 (1)(a)(b) **Stated:** First time **To be completed by:** 11 July 2016	The registered provider must ensure that the treatment provided to each patient meets their individual needs and reflects current best practice. This relates specifically to the management of wound management and pressure care to include; the “repositioning needs” of patients and care is recorded in keeping with best practice guidelines. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Regarding wound management and the repositioning needs of the patients, we were advised by the software consultant that a comment box is not provided on the template when "No" is selected in answer to skin condition. The Care Assistant is to report to the Registered Nurse in order for the skin to be checked and a professional evaluation recorded. When "No" is selected, this is flagged up on the Progress Notes for the Registered Nurse's attention. Wound Care: Visiting professionals usually personally record the treatment regime for the specific patients. In future they will be reminded. Regarding the management of wounds, further training and audit of records is continuing to ensure that advice from the MDT is reflected in

	the care plan and in related documents
Requirement 3 **Ref**: Regulation 17 (1) **Stated:** First time **To be completed by:** 11 July 2016	The registered provider must implement a robust system to review the quality of nursing and other services provided by the home. **Ref: Section 4.4 & 4.5**
	Response by registered provider detailing the actions taken: More frequent audits and an expanded audit based on the software system continue to be implemented. Random checks are also being carried out. Registered Nurses are also auditing the Care Plans for which they are responsible.

Recommendations	
Recommendation 1 **Ref**: Standard 4 Criteria (1) (7) **Stated:** Second time **To be completed by:** 11 July 2016	It is recommended that continence assessments and care plans are completed comprehensively to include all aspects of continence management. **Ref Section: 4.2 & 4.4** **Response by registered provider detailing the actions taken:** This issue has been addressed by undertaking further supervision sessions with Registered Nurses.
Recommendation 2 **Ref**: Standard 37 Criteria 4 **Stated:** Second time **To be completed by:** 11 July 2016	It is recommended that the information recorded in the bowel record is entered into the electronic records to ensure that patients' care records are accurate and up to date. **Ref : Section 4.2 &4.4** **Response by registered provider detailing the actions taken:** A checklist, as noted in Requirement 1, is in place and it is the responsibility of the Registered Nurse in charge overnight to transfer the information from the paper record to the electronic system. The Registered Nurse signs the checklist to indicate that this has been completed.
Recommendation 3 **Ref**: Standard 4 **Stated:** Second time **To be completed by:** 11 July 2016	It is recommended that care plans are in accordance with the regime of care prescribed and are reviewed and updated according to ongoing re-assessment and appropriate to the patients individual needs. **Ref: Section 4.2 & 4.4** **Response by registered provider detailing the actions taken:** Registered Nurses are allocated time for care planning and to audit those care plans they have compiled. Attention has been drawn to the importance of the care plan being updated when MDT advice has been received. It has been stressed to Registered Nurses that they are accountable for their record keeping.
Recommendation 4 **Ref**: Standard 4 Criteria 9 **Stated:** First time **To be completed by:** 11 July 2016	It is recommended in accordance with NMC guidelines, contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each resident. **Ref: Section 4.4** **Response by registered provider detailing the actions taken:** As stated in the response to Requirement 1, a checklist has been provided and Registered Nurses are responsible for ensuring the completion of records.

Recommendation 5 **Ref**: Standard 19.4 **Stated:** First time **To be completed by :** 11 July 2016	It is recommended that registered nurses are provided with training, as appropriate on the nursing process. Evidence of the training provided, should be retained in the home. **Ref: Section 4.4** **Response by registered provider detailing the actions taken:** To date, it has not been possible to arrange formal training. We continue to try to access this training.
Recommendation 6 **Ref**: Standard 23 **Stated:** First time **To be completed** 11 July 2016	It is recommended that the current template for recording patients "repositioning care" is reviewed to ensure that it provides detailed information in regards to the "condition of the skin" when checked. **Ref: Section 4.4** **Response by registered provider detailing the actions taken:**
Recommendation 7 **Ref**: Standard 7 **Stated:** First time **To be completed** 11 July 2016	It is recommended that patients and relatives meetings are organised and records are kept to include; list of attendees, the agenda, details of discussion and any agreed actions. **Ref: Section 4.4** **Response by registered provider detailing the actions taken:**
Recommendation 8 **Ref**: Standard 35.7 **Stated:** First time **To be completed by:** 11 July 2016	It is recommended that the content of the report prepared in accordance with Regulation 29 of the Nursing Homes Regulations Northern Ireland (2005) should be reviewed and developed to monitor and report on the delivery of nursing and other services provided and the robustness of the homes governance arrangements. **Ref: Section 4.6** **Response by registered provider detailing the actions taken:** Response provided by the General Manager: The Monthly Monitoring Report has been reviewed. The template has been down-loaded from the RQIA website. The content will allow the General Manager to ensure the delivery of nursing and other services is provided to the highest possible standard. Any shortcomings will be identified and addressed appropriately and in a timely manner.

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

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