Unannounced Secondary Care Inspection

Name of establishment:	**Sandringham**
RQIA number:	**1472**
Date of inspection:	**23 October 2014**
Inspectors' names:	**Loretto Fegan** **Sharon Loane**
Inspection number:	**IN020368**

The Regulation And Quality Improvement Authority
9th Floor, Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 90 517 500 Fax: 028 890 517 501

1.0 General information

Name of establishment:	Sandringham Care Home
Address:	24 Sandringham Court Gilford Road Portadown BT63 5BW
Telephone number:	(028) 3839 4194
Email address:	sandringham@fshc.co.uk
Registered organisation/ Registered provider / Responsible individual	Four Seasons Health Care Ltd Mr James McCall
Registered manager:	Ms Niamh Murray
Person in charge of the home at the time of inspection:	Registered Nurse R Barerra (Deputy Sister) was in charge of the home at the commencement of the inspection. Ms Niamh Murray, registered manager then arrived to the home at approx. 11.00 hours and facilitated the remainder of the inspection.
Categories of care:	NH-I, NH-DE, NH-PH,
Number of registered places:	63
Number of patients accommodated on day of inspection:	60
Scale of charges (per week):	£581 per week
Date and type of previous inspection:	11 September 2013 09 30 – 16 45hrs 12 September 2013 10 00 – 15 50 hrs Unannounced Primary Care Inspection
Date and time of inspection:	23 October 2014 10.00 – 17.15 hours
Name of inspectors:	Loretto Fegan Sharon Loane

1.0 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 are required.

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

1.1 Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to patients 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.

The Regulation and Quality Improvement Authority aims to use inspection to support providers in improving the quality of services, rather than only seeking compliance with regulations and standards. For this reason, annual inspection involves in-depth examination of a limited number of aspects of service provision, rather than a less detailed inspection of all aspects of the service.

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

1.2 Methods/Process

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

- Discussion with the Registered Nurse Manager
- Discussion with staff
- Discussion with patients individually and to others in groups
- Consultation with relatives
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- Review of a sample of care records
- Review of the complaints, accidents and incidents records
- Observation during a tour of the premises
- Evaluation and feedback

1.3 Consultation process

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

Patients	**15**
Staff	**7 (in addition to registered manager)**
Relatives	**2**
Visiting professionals	**0**

Questionnaires were distributed, during the inspection, to patients, their representatives and staff to seek their views regarding the quality of the service.

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Issued to	**Number issued**	**Number returned**
Patients	**3**	**3 (completed by inspector with patients)**
Relatives / representatives	**1**	**1(completed by inspector with relative)**
Staff	**10**	**3**

1.4 Inspection Focus

Prior to the inspection, the registered manager completed a self-assessment using the standard criteria as outlined in appendix 1 of this report. The comments provided by the registered manager in the self-assessment were not altered in any way by RQIA.

However, due to workload pressures and contingency measures within the Regulation Directorate, the themes/standards within the self-assessment were not inspected on this occasion.

This inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

Standard 19 - Continence Management

Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion 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		
Compliance statement	**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.

2.0 Profile of Service

Sandringham Care Home is situated on the outskirts of Portadown.

The nursing home is owned and operated by Four Seasons Healthcare and the current registered manager is Ms Niamh Murray.

Accommodation for patients is provided on the ground floor and comprises sixty three single bedrooms, six sitting rooms and four dining rooms. There is a kitchen, laundry, toilet/washing facilities, staff accommodation and offices. There are also two rooms on the first floor, which are used for training purposes.

The home is registered to provide care for a maximum of 63 persons under the following categories of care:

Nursing care

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
DE	dementia care to a maximum of 32 patients accommodated within the dementia unit.

3.0 Executive Summary

The unannounced secondary inspection of Sandringham Care Home was undertaken by Loretto Fegan and Sharon Loane on 23 October 2014 between 10.00 – 17.15 hours. The inspection was initially facilitated by, Ms R Barerra, deputy sister until the arrival of Ms N Murray, registered manager who facilitated the remainder of the inspection. Ms N Murray and Ms R Barerra were both available for verbal feedback at the conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection on 11 & 12 September 2013.

Prior to the inspection taking place the inspector reviewed the completed self –assessment and other information submitted by the registered manager as part of the pre-inspection process (refer to section 6 and appendix 1). The responses in the returned quality improvement plan (QIP) pertaining to the inspection undertaken on 11 & 12 September 2013 were also reviewed. The inspectors also reviewed incidents submitted to RQIA from the home and followed up specific cases / issues as part of the inspection process.

The inspectors observed care practices which evidenced that the quality of interactions between staff and patients at the time of the inspection demonstrated courtesy, respect and engagement with the patients. Patients including those who were unable to verbally express their views were observed to be well groomed, appropriately dressed and relaxed and comfortable in their surroundings.

Patient spoken with and the questionnaire responses confirmed that patients were happy living in the home. The registered manager agreed to follow up any issues raised. Refer to section 6. 6 for further details about patients and relatives.

Four patients' care records were examined in relation to continence management and support. The care records evidenced that the standard of record keeping in relation to this aspect of care reflected an assessment, care planning and evaluation process which included the promotion of continence / management of incontinence and patient dignity. Discussion took place with the registered manager how the care records could be further developed in relation to: how bladder and bowel continence assessments inform the plan of care, fluid intake and output should be part of the care plan for patients with urinary catheters and that issues identified in relation to evaluation of bowel function are addressed.

A range of policies / procedures, guidance and training was in place to support registered nurses and care staff in relation to continence management. A recommendation was made that all evidence based guidelines are the most recent version and that the associated policies and procedures are reviewed accordingly. It was also recommended that all registered nurses receive an update on male and female catheterisation, care of supra-pubic catheters and management of stoma care until 100% compliance is achieved.

From a review of the available evidence and from discussion with relevant staff and observation, the inspectors can confirm that the level of compliance with the standard inspected was substantially compliant.

Discussion with the registered manager and review of the nursing and care staff duty roster for week commencing 20 October 2014 evidenced that the registered nursing and care staffing levels were in accordance with the RQIA's recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection. The registered manager informed the inspectors that two additional registered nurses have been recruited and are due to take up post in November 2014.

During the inspection, the inspectors spoke individually with a total of four staff; one registered nurse, the deputy sister and two care staff. Three staff completed questionnaires. Staff responses in discussion and in the returned questionnaires were positive regarding the standard of care provided to patients. No issues were raised by staff.

The inspectors undertook an observational tour of the internal environment of the home. Generally all areas were maintained to an acceptable standard of hygiene and décor, however requirements were made in relation to environmental and fire safety issues identified, refer to section 6.9 for further detail.

The inspectors can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a satisfactory standard.

Additional areas were also examined including:

- complaints
- patients under Guardianship

Details regarding these areas are contained in section 6 of the report.

The inspectors reviewed and validated the home's progress regarding the four requirements and three recommendations made at the previous care inspection on
11 & 12 September 2013 and confirmed compliance outcomes as follows: three requirements and one recommendation had been fully complied with; one requirement was substantially

compliant and one recommendation was moving towards compliance. A further recommendation was not validated on this occasion.

Verbal feedback of the inspection outcomes was given to Ms N Murray, registered manager throughout the inspection and at the conclusion of the inspection process.

Conclusion

As a result of this inspection, seven requirements and six recommendations were made; one requirement and one recommendation are restated.

Details can be found in the report and in the quality improvement plan (QIP).

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

The inspector would also like to thank the patients, relatives and staff who completed questionnaires.

4.0 Follow-up on the requirements and recommendations issued as a result of the previous primary unannounced care inspection conducted on 11 and 12 September 2013

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
1	14(4)	It is required that all staff receive additional training to include how poor customer care and safeguarding issues relate to each other. Staff working in the general nursing unit must be prioritised to attend this training first. The acting manager must implement systems to ensure that this training is embedded in practice. Records must be maintained to evidence this.	The registered manager confirmed that additional training was provided to all staff which included how poor customer care and safeguarding issues relate to each other. A record of staff attendance at this training was examined by the inspectors. The registered manager also confirmed that with the exception of one staff member who is currently undergoing an induction programme, there is full compliance with regard to staff undertaking safeguarding training. The registered manager advised of the systems in place to monitor that this training is embedded in practice. Records were available to evidence the outcomes.	**Compliant**

2	19(1)(a), schedule 3, (3)(k)	It is required that the registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence the care delivered.	A review of two patients' repositioning charts identified that on occasions the re-positioning charts did not reflect consistent intervals of re-positioning taking place as would be indicated as best practice for the patients' identified needs. On occasions there were intervals of 4 -5 hours. This requirement is made for a second time and compliance will be followed up during the next care inspection.	**Substantially compliant**
3	19(2) schedule 4(12) (b) & (c)	It is required that incidents of pressure ulcers, grade 2 and above, must be reported to RQIA in accordance with best practice guidelines	The registered manager informed the inspectors regarding pressure ulcer incidence in the home. The inspectors also reviewed the record of incidents and cross referenced this information with incident notifications submitted to RQIA. The inspectors can confirm that there was evidence of compliance with this requirement.	**Compliant**

4	24(3) & (4)	It is required that complaints are managed in keeping with regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005. It is further required that the management of the three recorded complaints is reviewed and the appropriate action taken to comply with regulation.	The inspectors examined the record of complaints and can confirm that complaints were managed in keeping with regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005. The registered manager confirmed that the three recorded complaints identified during the inspection on 11 & 12 September 2014 were reviewed and the appropriate action taken to comply with regulation.	**Compliant**

No	Minimum Standard Ref.	Recommendations	Action taken – as confirmed during this inspection	Inspector's validation of compliance
1	16.2	It is recommended that all induction programmes are reviewed, and where required developed, to include an awareness of safeguarding issues for all staff.	The inspectors reviewed the induction programme and training record of an ancillary staff member employed since the last care inspection. This record confirmed that the induction process included an awareness of safeguarding issues.	**Compliant**
2	16.4	It is recommended that a record is maintained in the home of the outcome of all complaints which are referred to Trust safeguarding teams for screening.	The registered manager confirmed that no complaints were received since the last care inspection which required referral to the Trust safeguarding teams for screening. As this recommendation was not validated by the inspectors on this occasion, it will be carried forward and compliance followed up during the next care inspection.	**Not validated on this occasion**

3	32.1	A number of the vanity units were in a state of poor repair with the mahogany veneer worn and bare wood exposed. These units should be given priority and replaced first.	The registered manager advised the inspectors that this is work in progress and that the tendering process has commenced for this refurbishment plan. The minutes of the relative / patients meeting which took place on 6 March 2014 evidenced discussion regarding this refurbishment plan. This recommendation is made for a second time and compliance will be followed up during the next care inspection. The poor state of repair of a vanity unit in one bedroom viewed by an inspector was identified as an infection control risk. A separate requirement is made in this regard.	**Moving towards compliance**

4.1 Follow up on any issues/concerns raised with RQIA since the previous inspection:

It is not in the remit of RQIA to investigate complaints made by or on the 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.

RQIA have been notified by the home of an ongoing investigation in relation to a potential safeguarding of vulnerable adult (SOVA) issue. The SHSCT safeguarding team are managing the SOVA issue under the regional adult protection policy/procedures and the registered manager has agreed to keep RQIA updated regarding the outcome of the investigation.

RQIA is satisfied that the registered manager has dealt with the potential SOVA issue in the appropriate manner and in accordance with regional guidelines and legislative requirements.

5.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support.	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of four patients' care records evidenced that bladder and bowel continence assessments were undertaken for all four patients. However, some assessments examined did not include detailed information in respect to the patients' bowel function. The continence assessment template being used did not make provision for assessment of a patient requiring a urinary catheter. The promotion of continence, skin care, and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. The care plans reviewed in the main addressed the patients' assessed needs in regard to continence management. However the following issues were identified: • The recommended target for daily fluid intake was not calculated for one patient who had a urinary catheter in place. The daily food and fluid chart only documented fluids that the patient had taken during main meals. This patient's output was also not recorded. It is required that the care plan is reviewed to include intake, output and how signs of infection / blockage are monitored. Review of four patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. There was evidence of evaluation of nursing care taking place in relation to this aspect of care. However the following issues were identified: • All records of bowel movements should be documented on each patient's daily evaluation records • Monthly evaluations in relation to bowel function should be objective, for example evaluations should be	

more specific than only recording "no concerns" Issues identified in relation to assessment, care planning and evaluation of bowel and bladder function have been incorporated into a requirement pertaining to care records. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The registered manager confirmed that the following policies and procedures were in place; • continence management / incontinence management • stoma care • catheter care The registered manager also advised that a range of guidance documents were available in the home which included: • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence • RCN guidance on catheter care and continence care The registered manager advised the inspectors that the home are focusing on this aspect of care over the forthcoming months and that plans are in place to ensure that all staff are aware of the relevant policies / procedures and evidence based guidelines. The inspector had a cursory view at the range of information available, however it was observed that some of the policies and procedures had not been reviewed following more recent evidence based guidelines becoming available. Discussion took place with the registered manager to ensure that all evidence based guidelines are the most recent version and that the associated policies and procedures are reviewed accordingly. NA recommendation has been made in this regard.	Substantially compliant

The registered manager informed the inspectors that a period of intensive training is planned for registered nurses and care assistants to support the implementation process of new continence products, commencing in January 2015. The inspectors also evidenced that the management of incontinence is included during the induction period for of new staff, which is good practice.	

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support.	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not reviewed on this occasion	Not reviewed on this occasion
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the registered manager and deputy sister confirmed that there is ongoing training for registered nurses in relation to; male and female catheterisation and ca re of supra-pubic catheters, however there was not recent training for nurses in the management of stoma care. While the inspector acknowledges that a further two nurses are scheduled to attend training in November 2014 on catheterisation, a recommendation has been made that all registered nurses receive an update on male and female catheterisation, care of supra-pubic catheters and management of stoma care as there are currently patients in the home receiving care in this regard.	Substantially compliant

Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

6.0 Additional Areas Examined

6.1 Care Practices

The inspector evidenced that the quality of interactions between staff and patients at the time of the inspection demonstrated courtesy, respect and engagement with patients.

Patients including those who were unable to verbally express their views were observed to be well groomed, appropriately dressed and relaxed and comfortable in their surroundings.

However, the following care practices were observed and discussed with the member of staff present and also the registered manager:

- One patient's catheter bag was found to touch the ground. This care practice issue has been incorporated into a requirement made in relation to infection prevention and control.
- A medicine trolley was found open and unattended on the corridor while the registered nurse was attending to the patient in a bedroom; while the bedroom door was open, the medicine trolley was out of view of the nurse. A requirement has been made to ensure that medicines are stored safely and securely.
- One patient whom the inspector greeted was experiencing pain, discussion took place with the deputy sister and registered manager regarding this and the inspector cross referenced the medicine administration record with the care records in relation to pain management for the patient. It was evident that appropriate referrals had been made to the General Practitioner and medication was administered as prescribed. It was agreed that further contact would be made with the GP regarding the patient's pain management. It was also agreed that separate pain assessments would be completed in relation to different sites that the patient was experiencing pain. This has been incorporated into a requirement made in relation to care records.
- A number of patients in the nursing dementia unit were observed not wearing footwear. Staff provided the inspector with rationale for this practice. This information was not recorded in the patients care record and nursing staff were advised that each patient requires an individual assessment. In addition this information needs to be reflected in the patients care records. This has been incorporated into a requirement made in relation to care records.
- A patient was observed sitting in a specialised chair with no footplate to load their feet. The patient was not wearing any footwear and the staff were transferring the patient whilst seated in the chair. This unsafe practice was discussed with the nurse on duty outlining the health and safety implications to the patient. This practice needs to be risk assessed and safety measures put in place. A requirement has been made.

6.2 Complaints

It is not in the remit of RQIA to investigate complaints made by or on the 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.

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 management of complaints with the registered manager and reviewed the complaint record. This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements.

6.3 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 patients' monies were being managed in accordance with legislation and best practice guidance.

6.4 NMC declaration

Prior to the inspection the registered manager 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 to RQIA indicated that all nurses, including the registered manager, were appropriately registered with the NMC.

6.5 Patients under Guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) Order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection.

The registered manager confirmed that there were no patients accommodated at the time of inspection in the home who were subject to guardianship arrangements.

6.6 Patients and relatives comments

During the inspection, the inspectors spoke with fifteen patients individually and three of these patients provided responses to the questionnaire, which the inspector completed on their behalf.

Patient spoken with and the questionnaire responses confirmed that patients were treated with dignity and respect, that staff were polite and respectful, that they could

call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home.

Patients' comments included:

- "couldn't wish for better care"
- "staff are more than good to me"
- "food is very good"
- "meat not tender, not enough greens"

The inspector discussed any issues raised by patients with the registered manager. This included the comment regarding the meat and vegetables and also that one patient informed the inspector that they would prefer to have their door closed at night. The registered manager agreed to follow up the issues raised.

The inspector spoke with one relative during the inspection, the relative provided responses to the questionnaire which the inspector completed on their behalf. The relative's responses indicated that they were content with all aspects of care provided and felt staff communicated well with them.

6.7 Staffing levels and staff comments

Discussion with the registered manager and review of the nursing and care staff duty roster for week commencing 20 October 2014 evidenced that the registered nursing and care staffing levels were in accordance with RQIA's recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection. It is recommended that the nurse designated in charge of the home in the absence of the registered manager is clearly identified on the duty rota. The registered manager informed the inspectors that two registered nurses are due to take up posts in November 2014.

During the inspection, the inspectors spoke individually with four staff ; two registered nurses and two care staff and three staff completed questionnaires. Staff responses from both discussion and the returned questionnaires indicated that staff received an induction and completed a range of training commensurate with their roles and responsibilities.

Staff were satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes. No issues / concerns were raised by staff.

6.8 Record keeping

In accordance with Regulation 19 (2) Schedule 4, a number of records are required to be kept in a nursing home. Prior to this inspection the registered person completed and returned a declaration to confirm that all documents listed were available in the home. The inspector sampled a number to confirm this as follows:

- duty roster record
- record of complaints
- record of accidents/ incidents

- record of training
- record of visitors to the home

The registered manager explained that all accidents/ incidents are recorded on the home's datix electronic system and that notification is forwarded to RQIA in accordance with legislative requirements. The inspectors reviewed a random sample of entries listed on the monthly overview generated from the datix system and also followed up specific cases / issues that were notified to RQIA. Records examined were found to be maintained in accordance with legislative requirements.

Review of specific aspects of four patient care records evidenced that generally a good standard of record keeping was maintained. However, a number of areas for improvement were identified (refer to sections 5.0 & 6.1).

6.9 Environment

The inspectors undertook an inspection of the premises and viewed the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and maintained to an acceptable standard of hygiene and decor.

However, the following issues were identified:

- one bedroom had a mal-odour, a requirement is made to address the malodour
- one store room fire door was inadvertently wedged open by a trolley due to the amount of items stored in the room, a requirement is made to ensure fire doors are not wedged open
- a vanity unit's mahogany veneer in one identified bedroom was worn and had visible areas of bare wood exposed. One armchair was found to be torn with foam exposed. These issues have been incorporated into a requirement relating to infection prevention and control.
- One electrical wall socket was cracked, although the inspector acknowledges this was not an active wall socket, a recommendation is made to review this
- Some channels on a television owned by a patient were not available. The registered manager agreed to review the situation in relation to the identified TV, the inspectors acknowledge that work was successfully carried out in the home to address this problem generally.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Niamh Murray, 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:

Loretto Fegan or Sharon Loane
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Loretto Fegan and Sharon Loane_ **Date**
Inspector/Quality Reviewer

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**
Prior to admission to the home, the Home Manager or a designated representative from the home carries out a pre admission assessment. Information gleaned from the resident/representative (where possible), the care records and information from the Care Management Team informs this assessment. Risk assessments such as the Braden Tool are carried out, if possible, at this stage. Following a review of all information a decision is made in regard to the home's ability to meet the needs of the resident. If the admission is an emergency admission and a pre admission is not possible in the resident's current location then - a pre admission assessment is completed over the telephone with written comprehensive, multidisciplinary information regarding the resident being faxed or left into the home. Only when the Manager is satisfied that the home can meet the residents needs will the admission take place.	Provider to complete

On admission to the home an identified nurse completes initial assessments using a patient centred approach. The nurse communicates with the resident and/or representative, refers to the pre admission assessment and to information received from the care management team to assist her/him in this process. There are two documents completed within twelve hours of admission - an Admission Assessment which includes photography consent, record of personal effects and a record of 'My Preferences' and a Needs Assessment which includes 16 areas of need - the additional comments section within each of the 16 sections includes additional necessary information that is required to formulate a person centred plan of care for the Resident. In addidtion to these two documents, the nurse completes risk assessments immedidiately on admission. These include a skin assessment using the Braden Tool, a body map, an initial wound assessment (if required), a moving and handling assessment, a falls risk assessment, bed rail assessment, a pain assessment and nutritional assessments including the MUST tool, FSHC nutritional and oral assessment. Other risk assessments that are completed within seven days of admission are a continence assessment and a bowel assessment, Following discussion with the resident/representative, and using the nurse's clinical judgement, a plan of care is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations. This can be evidenced in the care plan and consent forms. The Home Manager and Regional Manager will complete audits on a regular basis to quality assure this process	

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**
A named nurse completes a comprehensive and holistic assessment of the resident's care needs using the assessment tools as cited in section A, within 7 days of admission. The named nurse devises care plans to meet identified needs and in consultation with the resident/representative. The care plans demonstrate the promotion of maximum independence and focuses on what the resident can do for themselves as well as what assistance is required. Any recommendations made by other members of the mutidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable.	Provider to complete

Registered nurses in the home are fully aware of the process of referral to a TVN when necessary. There are referral forms held in a designated file in the nurse's office, the Tissue Viability Nurse's details are also held in this file - name, address and telephone no. Once the form has been sent it, is then followed up by a telephone call to the TVN where advice can be given prior to their visit. Referrals are also made via this process in relation to residents who have lower limb or foot ulceration to either the TVN or a podiatrist. If necessary, a further referral is made to a vascular surgeon by the G.P, TVN or podiatrist. Where a resident is assessed as being 'at risk' of developing pressure ulcers, a Pressure Ulcer Management and Treatment plan is commenced. A care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. The care plan will give due consideration to advice received from other multidisciplinary members. The treatment plan is agreed with the resident/representative, Care Management and relevant members of the MDT. The Regional Manager is informed via a monthly report and during the Reg 29 visit. The Registered Nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Dietician referral forms are held within the home. These forms can be completed by staff in the home and faxed directly to the dietician for referral. The dietician is also available over the telephone for advice until she is able to visit the resident. All advice, treatment or recommendations are recorded on the MDT form with a subsequent care plan being compiled or current care plan being updated to reflect the advice and recommendations. The care plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in the home and other members of the MDT are kept informed of any changes.	

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**
he Needs Assessment, risk assessments and care plans are reviewed and evaluated at a minimum of once a month or more often if there is a change in the resident's condition. The plan of care dictates the frequency of review and re assessment, with the agreed time interval recorded on the plan of care. The resident is assessed on an ongoing daily basis with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the Home Manager's attention. The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.	Provider to complete

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**
The home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to. The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading sysytem. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime or if the condition of the pressure ulcer changes. There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', ' PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in relation to nutritional care, diabetic care, care of subcuteanous fluids and care of percutaneous endoscopic gastrostomy (PEG)..	Provider to complete

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 records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are comtemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines - Record keeping:Guidance for nurses and midwives. Records of the meals provided for each resident at each mealtime are recorded on a daily menu choice form. The Catering Manager also keeps records of the food served and include any specialist dietary needs. Residents who are assessed as being 'at risk' of malnutrition, dehyration or eating excessively have all their food and fluids recorded in detail on a daily basis using a FSHC food record booklet or fluid record booklet. These charts are recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. The nurse utilises the information contained in these charts in their daily evaluation. Any deficits are identified with appropriate action being taken and with referrals made to the	Provider to complete

relevant MDT member as necessary. Any changes to the resident's plan of care is discussed with them and/or their representative. Care records are audited on a regular basis by the Manager with an action plan compiled to address any deficits or areas for improvement - this is discussed during supervision sessions with each nurse as 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**
The outcome of care delivered is monitored and recorded on a daily basis on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan of care or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their represenatatives are involved in the evaluation process.	Provider to complete

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**
Care Management Reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the resident's file. Any recommendations made are actioned by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals.	Provider to complete

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**
The home follows FSHC policy and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs on admission and review on an ongoing basis. The care plan reflects type of diet, any special dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if necessary. The home has a 4 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives - residents meetings, one to one meetings and food questionnaires. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied. Copies of instructions and recommendations from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs. Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything from the daily menu an alternative meal of their choice is provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety	Provider to complete

of condiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room, with the 4 week menu displayed in a menu display folder and on the wall outside the kitchen.	

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**
Registered nurses have received training on dysphagia and enteral feeding techiques (PEG) on 6/3/14 and 22/5/14/. Further training on dysphagia and feeding techiques for care staff was provided on 9/6/14 . This was supported by clinical supervision to all care staff. The Speech and Language therapist and dietician also give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document - 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language therapist are incorporated into the care	Provider to complete

plan to include type of diet, consistency of fluids, position for feeding, equipment to use and assistance required. The kitchen receive a copy of the SALT's recommendations and this is kept on file for reference by the kitchen. Special diets are displayed on a white board in the fridge room. Meals are served at the following times:- Breakfast - 8.30am-9.30am Morning tea - 11am Lunch - 12.30pm-1.15pm Afternoon tea - 2.30pm Evening tea - 4.50pm Supper - 7.30pm-8pm There are variations to the above if a resident requests to have their meals outside of these times. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. There are foods available outside of these times for those resident's who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedrooms, these are replenished on a regular basis. Any matters concerning a resident's eating and drinking are detailed on each individual care plan - including for eg. likes and dislikes, type of diet, consistency of fluid, any special equipment required and if assistance is required. A diet notification form is completed for each resident with a copy given to the kitchen and one held in the care file. Meals are not served unless a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Appropriate aids such as plate guards and specialised cutlery are available as necessary and as indicated in the plan of care. Each nurse has completed an education e-learning module on pressure area care. The home has a link nurse who has received enhanced training, to provide support and education to other nurses within the home on an ad hoc basis. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the home have a competency assessment completed. Competency assessments have a quality assurance element built into the process.	

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Secondary Unannounced Care Inspection

Sandringham

23 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 Ms N Murray, 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	19(1)(a), schedule 3, (3)(k)	It is required that the registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence the care delivered. **Ref – Section 4.0, Follow up on Previous Issue**	Two	Registered Nurses have been instructed to ensure that all re-positioning charts are completed correctly and on time. Registered Nurses must check each chart and sign to indicate that they are completed accurately and on time	From date of previous inspection
2	13 (7)	The registered person must make suitable arrangements to minimise the risk of infections and toxic conditions and the spread of infections between patients and staff by: • Ensuring urinary catheter bags do not touch the ground • Replacing identified vanity unit • Re-upholstering / replacing identified specialist chair **Ref – Section 6.0 (6.1 & 6.9)**	One	Registered Nurses have been reminded of the importance of following strict Infection Control Procedures. The Catheter bag in question has been reassessed for a leg bag each morning which should alleviate the problem identified Quotes have been obtained for the replacement of 20 vanity units The identified specialist chair are to be disgarded when a new chair arrives	From date of inspection

3	13 (4) (a)	The registered person must ensure that the management of medicines is in accordance with legislative requirements, professional standards and DHSSPS guidance • medicine trolleys should not be left unattended when open **Ref – Section 6.0 (6.1)**	One	Registered Nurses have been reminded of the importance of ensuring that the Medicine Trolley is not left unattended at any time. Medicine Competencies are being updated and this issue will be addressed as part of this process along with supervision sessions.	From date of inspection
4	16 (2) (b)	The registered person must ensure that the patients' care records are kept under review by ensuring the issues identified are addressed as follows: • the supplementary bowel and bladder assessments inform the care plan • care plans for patients with urinary catheters include fluid intake and output • issues identified in relation to evaluation of bowel function are addressed • one identified patient's pain management is reviewed following a pain assessment specific to site and further contact with the GP • footwear is included in the care planning process for the identified patients **Ref – Section 5.0 (19.1) & Section 6.0 (6.1)**	One	The Bowel and bladder assessments used are part of the Care Planning process are Four Seasons Health Care standard assessment tools which are currently under review. The Registered Nurses have been instructed to ensure that all bowel movements are recorded on the appropriate docementation. The pain assessment in question has been reviewed and further advice taken from the residents General Practitioner The Care Plan in question has been updated to reflect the residents choice regarding footwear	From date of inspection

5	18 (2) (j)	The registered person must ensure that the offensive odour is addressed in the identified bedroom **Ref – Section 6.0 (6.9)**	One	The odour has been addressed and new flooring has also been authorised.	From date of inspection
6	27 (4) (d)	The registered person must make adequate arrangements for detecting, containing and extinguishing fires by • ensuring the fire door in store is not wedged open **Ref – Section 6.0 (6.9)**	One	All staff have been instructed on the importance of ensuring that no fire door is wedged open. This will be monitored by the Fire Wardens and Home Managers	From date of inspection
7	12 (2) (a)	The registered person must ensure that the seating arrangement for one patient is reviewed to avoid the risk of foot entrapment. **Ref – Section 6.0 (6.1)**	One	A request has been sent to the Trust Occupational Therapist to carry out a seating assessment on the resident in question.	From 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	16.4	**For review during next inspection** It is recommended that a record is maintained in the home of the outcome of all complaints which are referred to Trust safeguarding teams for screening. **Ref – Section 4.0, Follow up on Previous Issue (as not reviewed)**	One	This was addressed at the time of the last inspection. There is documented evidence in the home of the outcome of any Safeguarding issues which have been referred to the trust	From date of previous inspection
2	32.1	A number of the vanity units were in a state of poor repair with the mahogany veneer worn and bare wood exposed. These units should be given priority and replaced first. **Ref – Section 4.0 , Follow up on Previous Issue**	Two	20 Vanity Units have been identified as needing replacement. Quotes have been obtained and these will be replaced over the next 2 months	Two months from date of inspection
3	19.2	It is recommended that all evidence based guidelines are the most recent version and that the associated policies and procedures are reviewed accordingly **Ref – Section 5.0, (19.4)**	One	The Policies and procedures used in the home are devised by Four Seasons Health Care and used throughout their homes. These policies and procedures are currently under review.	Two months from date of inspection

4	19.4	It is recommended that all registered nurses receive an update on male and female catheterisation, care of supra-pubic catheters and management of stoma care until 100% compliance is achieved **Ref – Section 5.0, (19.4)**	One	The Training Department have been contacted regarding the provision of this training for staff. Training is planned for January 2015	By 31 March 2015
5	30.4	It is recommended that the nurse designated in charge of the home in the absence of the registered manager is clearly identified on the duty rota **Ref – Section 6.0 (6.7)**	One	This has been addressed and is recorded on all off-duty rota's	From date of inspection
6	32	It is recommended that the following is reviewed and action taken if appropriate • cracked electrical socket in bedroom (dementia nursing unit) • availability of channels on identified TV **Ref – Section 6.0 (6.9)**	One	The cracked socket has been replaced. The gentleman in question was offered the opportuniy to have a booster box fixed to his TV so that he could receive RTE. However, he declined this and said he was happy with what he had in place	By 30 October 2014

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	Niamh Murray
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	JP Watson Jim McCall DIRECTOR OF OPERATIONS 4.12.14.

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable			
Further information requested from provider			

QIP Position Based on Comments from Registered Persons				Inspector	Date
		Yes	No		
A.	Quality Improvement Plan response assessed by inspector as acceptable	X		Sharon McKnight	**19-12-14**
B.	Further information requested from provider				