Unannounced Care Inspection Report
1 June 2017

St Francis

Type of Service: Nursing Home
Address: 71 Charles Street, Portadown, BT62 4BD
Tel No: 0283835 0970
Inspector: Donna Rogan

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care/and residential care for up to 25 persons.

3.0 Service details

Organisation/Registered Provider: Mary Bernadette Breen	**Registered Manager:** Laura Lavery (Manager; awaiting application)
Person in charge at the time of inspection: Adelaide Hartley (staff nurse in charge)	**Date manager registered:** Laura Lavery – awaiting application "registration pending"
Categories of care: Nursing Home (NH) PH – Physical disability other than sensory impairment I – Old age not falling within any other category	**Number of registered places:** 25 comprising: 1 - NH-PH 24 - NH-I

4.0 Inspection summary

An unannounced inspection took place on 1 June 2017 from 09.30 to 16.30 hours.

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

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staff recruitment practices; staff induction, training and development; adult safeguarding arrangements; infection prevention and control practices; risk management. The culture and ethos of the home promoted treating patients with dignity and respect. There was also evidence of good practice identified in relation to the management of complaints and incidents.

Areas requiring improvement were identified in relation to the management of wound/pressure ulcer care; ensuring records are made available for inspection; management audits; the management of care records; the management of one named patient's care records; the inappropriate storage of equipment in bathroom areas and regulating the heating in the lounge area.

Patients said that they were satisfied with the care and services provided and described living in the home, in positive terms.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	5	*4

*The total number of areas for improvement includes one standard which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Cathal Breen, director, Adelaide Hartely, staff nurse in charge and Laura Lavery, manager, by telephone following the inspection as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection dated 27 April 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 27 April 2017. Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection.

5.0 How we inspect

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing.
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection the inspector met with 12 patients, four care staff, one registered nurse, two kitchen staff, one domestic staff and three patients' representatives. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

The following records were examined during the inspection:

- staffing arrangements in the home
- one staff recruitment and selection record
- staff induction records
- staff training records for 2016/2017
- accident and incident records
- records relating to adult safeguarding
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- three patient care records
- three patient supplementary care charts including food and fluid intake charts and repositioning charts
- compliments records
- RQIA registration certificate
- certificate of public liability insurance
- a selection of policies and procedures
- complaints received since the previous care inspection
- minutes of staff' and relatives' meetings held since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 27 April 2017

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector and will be validated at the next medicines management inspection.

6.2 Review of areas for improvement from the last care inspection dated 22 February 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The DHSSPS Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 11 **Stated:** First time	The registered provider should ensure that more formal arrangements are put in place in order to evidence activities in the home. Records should be maintained of patient participation in a more structured and meaningful way.	**Met**

	Action taken as confirmed during the inspection: An activity therapist has been employed in the home. Formal activities occur four days a week and carers state that they conduct activities the other three days. Records are maintained of the activities occurring in the home alongside patient participation.	
Area for improvement 2 **Ref**: Standard 35 **Stated:** First time	The registered provider should ensure that all personnel within the senior management team have established roles and responsibilities identified in order to assist the acting home manager in the smooth operation of the nursing home. Each role should have a definitive job description alongside contractual arrangements.	**Met**
	Action taken as confirmed during the inspection: Management have established their roles and responsibilities. Contractual and job descriptions have been agreed.	
Area for improvement 3 **Ref**: Standard 41 **Stated:** First time	The registered provider should continue to monitor the staffing levels in terms of numbers and skill mix in keeping with the dependency of the patients accommodated in the home. Numbers and skill mix should be altered accordingly. The dependency levels should be reviewed and adjusted accordingly during the twilight hours as discussed. Evidence of such reviews should be maintained and available for inspection. The registered person should continue to ensure that sufficient registered nursing hours and sufficient management hours are provided, to ensure the safe and effective delivery of care and management of the home. The duty rotas should be prepared at least three weeks in advance to ensure forward planning and to foresee any difficulties in terms of appropriately staffing the home.	**Partially met**

	Action taken as confirmed during the inspection: Since the previous inspection the manager has continued to monitor the numbers and skill mix of the staffing levels in keeping with the dependency of patients accommodated. It was assessed that an additional registered nurse would be employed from 09.00 to 13.00 hours. However, this has recently not been sustained due to staffing difficulties. The manager informed RQIA that this arrangement would recommence from the week commencing 12 June 2017 when staff return from leave. Staff stated that they still felt that staff during the evening shift were, "under pressure". Duty rotas were being prepared at least three weeks in advance. This recommendation has been partially met and is stated for a second time to ensure staffing arrangements are continued to be monitored and adjusted accordingly.	
Area for improvement 4 **Ref**: Standard 16 **Stated:** First time	The registered provider should ensure that all complaints are recorded appropriately, in order to ensure transparency and to ascertain any common trends which could be addressed. All staff should be informed of this process.	**Met**
	Action taken as confirmed during the inspection: The complaints record was being maintained in accordance with DHSSPS guidelines.	
Area for improvement 5 **Ref**: Standard 7 **Stated:** First time	The registered provider should make arrangements to meet with relatives as soon as possible. A record of the meeting should be retained and available for inspection.	**Met**
	Action taken as confirmed during the inspection: A relatives meeting was held on 5 April 2017. The minutes of the meeting were available upon request.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The nurse in charge confirmed the planned daily staffing levels for the home and stated that they have recently been unable to fill the second registered nurse from the hours of 09.00 to 13.00 hours due to unplanned leave. Discussion with the staff nurse confirmed that this will improve from 12 June 2017 as staff currently on leave are returning from that date. The manager also confirmed by telephone following the inspection that they have been able to secure employment of two additional registered nurses. A review of the staffing rota for the week commencing 22 May 2017 evidenced that the planned staffing levels were generally adhered to. For example, the second nurse was not always on duty as planned. An area for improvement was stated for the second time in that the staffing levels continue to be regularly reviewed and amended to ensure the assessed needs of the patients were met.

Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. Discussion with patients and their representatives evidenced that there were no concerns regarding staffing levels. Two staff members stated that they felt under pressure and that they would like to spend more time with the patients. They stated that the twilight hours were particularly demanding. However, all those spoken with confirmed that the patients' needs were always met. These comments were relayed to the manager by telephone during feedback.

Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

Discussion with the administrator and a review of one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, Schedule 2. Where nurses and carers were employed, their registrations were checked with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC), to ensure that they were suitable for employment. The review of recruitment records evidenced that enhanced criminal records checks were completed with AccessNI and satisfactory references had been sought and received, prior to the staff member starting their employment. For agency staff, their profile was maintained, which included information on the AccessNI check and NMC/NISCC checks; the validity of the registration details provided were also checked by the manager.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed and dated the record to confirm completion and to declare understanding and competence. Discussion with staff and a review of records confirmed that agency staff; and staff from other homes within the organisation, also received an induction to the home.

The nurse in charge or the administration team were unable to provide evidence of supervision, competency and capability assessments or appraisal. Discussion with the nurse in charge confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. However, due to the unavailability of records we were unable to validate that they had been undertaken. An area for improvement was made that records required under legislation for inspection should be made available upon request.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all the homes' mandatory areas and records were kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. The records reviewed confirmed that most staff had, so far this year, completed their mandatory training in keeping with the home's policies and procedures.

Observation of the delivery of care evidenced that training had been embedded into practice. Overall compliance with training was monitored by the manager and following discussion with the director it was agreed that this information should be included in the responsible persons' monthly monitoring visit in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the administrator and review of records evidenced that the arrangements for monitoring the registration status of nursing staff were appropriately managed in accordance with the NMC. Similar arrangements were in place to ensure that care staff were registered with NISCC.

Staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The staff understood what abuse was and how they should report any concerns that they had. The relevant contact details were available for all staff to access; and the whistleblowing procedure was also displayed near the front entrance to the home. One area was raised in relation to an identified patient; this issue was discussed in detail with the manager and the relevant safeguarding team. The manager agreed to refer this issue to the safeguarding team in the relevant Health Care Trust. The issue should also be reported to RQIA under Regulation 30 of The Nursing Home Regulations (Northern Ireland) 2005. An area for improvement was made in this regard.

Review of two patient care records evidenced that validated risk assessments were completed as part of the admission process and were reviewed as required. These risk assessments informed the care planning process. One identified patient's care records evidenced that risk assessments were not completed since their admission and care plans had not been formulated to meet their needs. Details can be viewed in section 6.5 (Is care effective?) where an area for improvement was made.

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

Where patients required bedrails, to maintain their safety whilst in bed, there was evidence that risk assessments had been completed; and that regular safety checks had been carried out when the patients were in bed. The care plans reflected the assessment outcomes.

A number of patients had pressure relieving mattresses on their beds, to prevent skin breakdown. The correct mattress settings were indicated on the mattress pumps, to ensure their effective use.

Infection prevention and control measures were adhered to. However, there was inappropriate storage of equipment observed in bathrooms. An area for improvement was made in this regard. There were processes in place to check that emergency equipment, such as the suction machines were regularly checked as being in good order and fit for use.

A review of the home's environment was undertaken which included a number of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, tidy, well decorated. One issue was raised in relation to the heat in the lounge area. Some patients and staff felt that the temperature was too warm and that that it was too "clammy" and difficult to work in. This was discussed with the director who agreed to get an engineer to review the heating system. An area for improvement was made that the temperature in this room should be monitored throughout the day, adjusted as necessary and records maintained. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, infection prevention and control, risk management and the home's environment.

Areas for improvement

There were three areas for improvement made in relation to the Regulations. They refer to the management of one identified patient's care which was required to be referred to the relevant safeguarding team. The second area for improvement refers to the availability of records required by legislation to be made available for inspection at all times.

Two areas for improvement, made in relation to the Standards, refer to the management of the heating in the identified lounge area and the inappropriate storage of equipment. An area for improvement is also made for a second time under the Standards in relation to continuing to monitoring staffing levels to ensure they are appropriate to meet the needs of patients.

	Regulations	Standards
Total number of areas for improvement	2	2

6.5 Is care effective?

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

Review of two patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. One care record reviewed did not have any assessments or care plans in place. An area for improvement is made in this regard.

This patient had been admitted to the home for a significant period of time and was identified as having complex needs. The patient had a dressing which appeared not to have been changed for a while. A review of the daily record did not indicate when the dressing had last been tended to. The nurse in charge confirmed that the dressing had been changed the day previous to the inspection. However, this had not been recorded. The record did not indicate the condition of the wound or its current state. There was no initial wound or ongoing wound assessment completed; neither was there photographic evidence to support the condition of the wound. There was no plan of care regarding a medication regime, the moving and handling techniques required to manage their day to day events, there was no nutritional guidance prepared and the patient was at times unable to express their needs. Due to the above findings we felt this patient was at high risk and contacted the safeguarding team to provide them with information. The manager was requested to refer the issues raised under the safeguarding protocols to the safeguarding team in the relevant Health Care Trust and forward an untoward incident form under Regulation 30 of The Nursing Home Regulations to the RQIA as a matter of urgency. An area for improvement has been made in this regard in section 6.4. (Is care safe?).

There were a number of improvements required in relation to the overall management of wound/pressure ulcer care. Two patients identified as requiring wound care did not have their care records updated in accordance with National Institute of Clinical Excellence, (NICE) guidelines. The body maps were not always up to date, there were no initial wound or ongoing wound assessments completed. The records did not reflect the current state of the wound for example using sizing, description or dimensions. The care record did, however confirm when the wounds had been redressed. As previously stated a number of records were not made available for review during the inspector. This included audits for the management of wound care, care records and infection control. We were unable to establish if they were regularly conducted or if there was any planned action made by the manager in relation to these areas. An area for improvement was made that the overall management of wounds is reviewed and a process is introduced to ensure compliance is adhered to in keeping with the NICE guidelines. Records should be maintained of the review.

An improvement was also made under the standards in relation to ensuring formal evaluations of care are sufficient and meaningful.

There were a number of examples of good practice found throughout the inspection in this domain. For example, registered nurses were aware of the local arrangements and referral process to access other relevant professionals including general practitioner's (GP), speech and language therapist (SALT), dietician and tissue viability nurse specialists (TVN). Discussion with the registered nurse and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

A sampling of food and fluid intake charts confirmed that patients' fluid intake was monitored. The patients' total daily fluid intakes were also recorded in a format which enabled the registered nurses to have an overview of the patients' fluid intake over the previous weeks and months. This is good practice and was commended by the inspector.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans.

Patients' bowel movements were monitored by the registered nurses on a daily basis, to ensure that any changes from the patients' usual bowel patterns were identified and timely action taken.

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

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective.

Staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The most recent general staff meeting was held on 8 February 2017. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities.

All those consulted with confirmed that if they had any concerns, they could raise these with the staff and/or the manager. A relatives' meeting had been held on 5 April 2017 and records were available.

There was information available to staff, patients, representatives in relation to advocacy services; and the contact details of relevant advice lines were also displayed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the knowledge and working relations and access to relevant professionals including General Practitioner's (GP), Speech and language therapist (SALT), dietician and Tissue Viability Nurse Specialists (TVN). Care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were effectively communicated to staff and reflected in the patient's record.

Areas for improvement

As previously stated in section 6.4 the management of one patient was referred to the safeguarding team in the relevant Healthcare Trust and areas for improvement were made in this patient's care record. Three further areas for improvement were made in relation to updating an identified patient's care record in relation to assessments and care planning; the overall management of wound care; and improvements to the formal evaluations of care.

	Regulations	Standards
Total number of areas for improvement	2	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with 12 patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care.

Patients stated that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and their feedback had been listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

We observed the lunch time meal being served in the lounge and dining rooms. The lunch served appeared appetising and patients spoken with stated that they were satisfied with the meals provided. The atmosphere was quiet and tranquil and patients were encouraged to eat their food; assistance was provided by staff, as required. Tables were set with tablecloths and specialist cutlery and plate guards were available to help patients who were able to maintain some level of independence as they ate their meal. The menu was displayed. All patients consulted with stated that they received daily choices regarding their food and fluid intake.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. Two staff members were designated to provide activities in the home. Patients consulted with stated that there were different activities they could participate in. There was evidence of a variety of activities in the home and discussion with patients confirmed that they were given a choice with regards to what they wanted to participate in. There were various photographs displayed around the home of patients' participation in recent activities. There was evidence of regular church services to suit different denominations. Social records were in place to provide information to staff to ensure that patients' social care needs were met individually.

The care plans detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for the patients, as appropriate. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met. At the time of the inspection no one was receiving end of life care.

Discussion with the manager via telephone confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided and confirmed that an annual quality audit had been undertaken in April 2017. However, this information was not available on inspection. The manager confirmed by that the views and comments made would be analysed and displayed when received. It was also confirmed that any areas for improvement will be acted on.

Patients and three patient representatives spoken with confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

From discussion with the manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and their relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included praise for the care and attention given to a patient, when receiving end of life care.

During the inspection, we met with 12 patients, four care staff, one registered nurse, two kitchen staff, one domestic staff and three patients' representatives. There were no staff questionnaires returned in time for their comments to be included. Four relatives' questionnaires were returned in time and six patient questionnaires were retuned in time. Some comments received verbally and in the returned questionnaires are detailed below:

Staff

"We are under pressure during twilight hours to get everything done."
"When we have a full complement of staff things go very well and the shift runs smooth."
"I am happy."
"It is grand, I've been here a while now."
"It is alright."
"The care is very good, I have no concerns."
"The care is very good; the patients get everything they need."
"The heat at times in the day room is overwhelming and at times it is so hard to work in it."
"We could do with more staff in the evenings"

Two staff members commented in relation to being under pressure and stated that they would like to have more time to spend with the patients. Given that observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty, these comments were relayed to the manager to address.

Patients

"It is very good."
"I am very happy here"
"The staff are so good and kind"
"We are all treated the same"
"I couldn't complain, they all work so hard."
"The food is excellent"
"Very satisfied that care is safe, effective and compassionate".

Patients' representatives

"'It is fantastic. I could not say a bad word about them."
"My relative is well cared for"
"It's clean and tidy and staff are helpful"
"Staff are lovely and caring, hardworking, but under pressure"
"A suggestion box-comment box totally private/incognito would help"
"Designated carers for individuals would help family know who to ask".
"I am satisfied that the service is well led".

We also issued ten questionnaires to staff and relatives respectively and eight questionnaires to patients. Seven staff, eight patients and four relatives had returned their questionnaires, within the timeframe for inclusion in this report. Any comments from patient representatives and staff in returned questionnaires received after the return date will be shared with the manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients. Mealtimes and activities were well managed.

Areas for improvement

There were no areas for improvement identified in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Discussion with staff and observation of patients evidenced that the home was operating within its' registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussions with the staff confirmed that there were good working relationships and that management were responsive to suggestions or concerns raised. All those consulted with described the manager in positive terms; comments included 'she is very approachable' and 'she's very good'. Staff described how they felt confident that the manager would respond positively to any concerns/suggestions raised.

There was an 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. There was a system in place to identify the person in charge of the home, in the absence of the manager.

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

There were no records in relation to auditing made available during the inspection. We were unable to verify that there were systems in place to monitor and report on the quality of nursing and other services provided. For example, audits were not made available in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and the management of bed rails. An area for improvement was made in this regard.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection, confirmed that these were appropriately managed.

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

A review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. Following discussion with the director it was agreed that the timing of these unannounced monitoring visits would be varied in the future in order to capture all services provided throughout the day and night.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the management of complaints and incidents, quality improvement and maintaining good working relationships within the home.

Areas for improvement

An area for improvement is made that the manager ensures that audits are completed in order to monitor and report on the quality of nursing and other services provided.

	Regulations	Standards
Total number of areas for improvement	1	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Cathal Breen, director, Adelaide Hartley, staff nurse and Laura Lavery, manager, by telephone following the inspection as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

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

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The DHSSPS Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP to Nursing.Team@rqia.org.uk for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 19 (3) **Stated:** First time **To be completed by:** 30 June 2017	The registered person shall ensure that records required under legislation for inspection should be made available upon request. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: All Staff have been made aware of the folder required which is in managers office.
Area for improvement 2 **Ref:** Regulation 13 (1) **Stated:** First time **To be completed by:** 8 June 2017	The registered person shall ensure that the safeguarding issue is referred to the safeguarding team in the relevant Health Care Trust as discussed. The issue should also be reported to RQIA. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: All Safeguarding issues will be referred to the correct areas.
Area for improvement 3 **Ref:** Regulation 15 **Stated:** First time **To be completed by:** 2 June 2017	The registered person shall ensure that the identified care plan is updated to reflect assessments and care planning in keeping with the patient's needs. The manager should ensure regular care record audits are completed to ensure care records are updated in a timely way. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: All care plans have been updated and all residents have been all reassessed.
Area for improvement 4 **Ref:** Regulation 12 (1)(b) **Stated:** First time **To be completed by:** 30 June 2017	The registered person shall ensure that the overall management of wounds is reviewed and a process is introduced to ensure compliance is adhered to in keeping with the NICE guidelines. Records should be maintained of the review. **Ref: Section 6.5**

	Response by registered person detailing the actions taken: All wounds are reviewed and all wound care documentation updated and completed in keeping with NICE guidelines.
Area for improvement 5 **Ref:** Regulation 17 (1) **Stated:** First time **To be completed by:** 17 July 2017	The registered person shall ensure that audits are completed in order to monitor and report on the quality of nursing and other services provided. **Ref: Section 6.7**
	Response by registered person detailing the actions taken: All audits have been completed and are in a folder ready for inspection when required.
Action required to ensure compliance with The DHSSPS Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref**: Standard 41 **Stated:** Second time **To be completed by:** 31 July 2017	The registered provider should continue to monitor the staffing levels in terms of numbers and skill mix in keeping with the dependency of the patients accommodated in the home. Numbers and skill mix should be altered accordingly. The dependency levels should be reviewed and adjusted accordingly during the twilight hours as discussed. Evidence of such reviews should be maintained and available for inspection. The registered person should continue to ensure that sufficient registered nursing hours and sufficient management hours are provided, to ensure the safe and effective delivery of care and management of the home. The duty rotas should be prepared at least three weeks in advance to ensure forward planning and to foresee any difficulties in terms of appropriately staffing the home. **Ref: Section 6.2**
	Response by registered person detailing the actions taken: Duty rotas prepared 3/52 in advance. Skill mix is adhered to when possible when a full quota of Staff are available. If dependency increases or changes this will be looked at and staff changed accordingly.

Area for improvement 2 **Ref**: Standard 44 **Stated:** First time **To be completed by:** 30 June 2017	The registered person shall ensure that the temperature of the identified lounge should be monitored throughout the day, adjusted as necessary and records maintained. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: Boiler was immediately serviced and identified that the control panel needed replaced. Unfortunately the person replacing the control panel was on holidays and due to come back this week.
Area for improvement 3 **Ref**: Standard 44.1 **Stated:** First time **To be completed by:** 30 June 2017	The registered person shall ensure that inappropriate equipment is not stored in bathrooms and W/c's. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: Equipment was only stored as a temporary measure when the hairdressing room was being used which is only on a Thursday.
Area for improvement 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 17 July 2017	The registered person shall ensure formal evaluations of care are sufficient and meaningful. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: All careplans have been reviewed and updated accordingly.

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address

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