Unannounced Care Inspection Report
17 May 2017

Glenview

Type of service: Nursing Home
Address: 9 Cabragh Road, Dungannon, BT70 3AH
Tel no: 028 8776 7132
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Glenview took place on 17 May 2017 from 09.15 to 15.45 hours.

The inspection sought to assess progress with any issues raised 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.

Is care safe?

There were areas of good practice identified throughout the inspection in relation to staff induction, training and development; adult safeguarding arrangements; infection prevention and control practices; and risk management.

Areas for improvement were identified in relation the recruitment processes; fire safety practices; and in relation to the need for refurbishment to the older part of the home.

Is care effective?

There were examples of good practice found throughout the inspection in relation to the care records, review of care delivery and effective communication systems.

No areas for improvement were identified during the inspection.

Is care compassionate?

Areas of good practice were found throughout the inspection in relation to the culture and ethos of the home, treating patient with dignity and respect. Significant improvements had been made to the environment of the dementia unit, which had enhanced the lives of the patients living with dementia. This was commended. A number of comments from the consultation process and the returned questionnaires are included in the main body of the report.

No areas for improvement were identified during the inspection.

Is the service well led?

There was evidence of good practice identified in relation to the governance and management arrangements; management of complaints and incidents; quality improvement processes and maintaining good relationships within the home.

No areas for improvement were identified during the inspection.

The term ‘patients’ is used to describe those living in Glenview which provides both nursing and residential care.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Veronica McElmurry, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 13 December 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

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

2.0 Service details

Registered organisation/registered person: Mervyn John Gregg	**Registered manager:** Veronica Mc Elmurry
Person in charge of the home at the time of inspection: Veronica Mc Elmurry	**Date manager registered:** 29 September 2016
Categories of care: RC-I, NH-DE, NH-I, NH-PH, NH-PH(E) A maximum of 4 residential places in category RC-I and a maximum of 10 patients in category NH-DE.	**Number of registered places:** 45

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection

- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

A poster was displayed in the home, inviting feedback from patients and their representatives. During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with six patients, three care staff, two registered nurses, one domestic staff, four patients' representatives and three visiting professionals.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- seven patient care records
- staff training records for 2016/2017
- accident and incident records
- audits in relation to accidents
- records relating to adult safeguarding
- one staff recruitment and selection record
- complaints received since the previous care inspection
- the system for managing urgent communications, safety alerts and notices
- staff induction, supervision and appraisal records
- records pertaining to NMC and NISCC registration checks
- minutes of staff, patients' and relatives' meetings held since the previous care inspection
- annual quality report
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a selection of policies and procedures.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 13 December 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be followed up during this inspection. Refer to section 4.2

4.2 Review of requirements and recommendations from the last care inspection dated 13 December 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 14 (5) **Stated:** Second time	The registered persons must ensure that no patient is subject to restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other patient and there are exceptional circumstances.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of the restraint register confirmed that the use of restrictive practice in the home had greatly reduced. Any lap belts that were in use had the appropriate consent obtained; risk assessments and care plans completed.	
Requirement 2 **Ref:** Regulation 19 (1)(a) **Stated:** First time	The registered persons must ensure that where a patient is subject to restraint, there is evidence within the care records of regular release and repositioning of the restraint. This refers particularly, but is not limited to, the use of lap belts.	**Met**
	Action taken as confirmed during the inspection: A review of the records pertaining to safety checks for lap belts confirmed that staff had been releasing and repositioning the lap belt in keeping with the care plan.	
Requirement 3 **Ref:** Regulation 13 (1) (a) **Stated:** First time	The registered persons must ensure that patients who are identified as being at risk of dehydration and/or malnutrition; and require their total food and fluid intake to be monitored, should have accurate records maintained. The registered nurses must have oversight of these records and be able to demonstrate evidence of action taken in relation to identified shortfalls, within the patients' care records.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered nurses and a review of the patient care records confirmed that patients' total food and fluid intakes were consistently recorded and monitored by the registered nurses.	

Requirement 4 **Ref:** Regulation 12 (1)(a)(b) **Stated:** First time	The registered persons must ensure that the treatment provided to each patient meets their individual needs and reflects current best practice. This refers specifically to where patients are identified as losing weight, registered nurses make timely referrals to the relevant healthcare professionals, such as GPs, dieticians and speech and language therapists (SALT) for advice and guidance to help identify the cause of the patient's poor nutritional intake.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered nurse and a review of one patient care record confirmed that registered nurses had good oversight of patients' weights; any weight loss was identified in a timely manner and appropriate action taken.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 25.3 **Stated:** Second time	The registered persons should ensure that a dementia audit is undertaken, to ensure the quality of care and life afforded to patients in the dementia unit is in accordance with best practice in dementia care.	**Met**
	Action taken as confirmed during the inspection: A dementia audit had been undertaken and significant changes had been made to the environment of the dementia unit. Refer to section 4.5 for further information.	
Recommendation 2 **Ref**: Standard 11 **Stated:** Second time	The registered persons should ensure that the provision of activities on the dementia unit are reviewed, to ensure that the needs of patients who do not partake in group activities are taken into account. Records of the level of engagement/enjoyment should be retained within the care record.	**Met**
	Action taken as confirmed during the inspection: A review of the patient care records confirmed that all patients had social care plans in place; and there was evidence recorded of each patient's level of enjoyment/participation.	

Recommendation 3 **Ref**: Standard 19.4 **Stated:** First time	A recommendation has been made that all staff, as appropriate, receive training in relation to the management of restraint and that the effectiveness of this training is monitored, to ensure that learning has been embedded into practice. Evidence of the training and monitoring, should be retained in the home.	**Met**
	Action taken as confirmed during the inspection: A review of the staff training records confirmed that training had been provided in relation to the use of restraint.	
Recommendation 4 **Ref**: Standard 4.9 **Stated:** First time	A recommendation has been made that contemporaneous records are maintained of all nursing interventions, activities and procedures carried out in relation to each resident. This relates specifically to the repositioning needs of patients.	**Met**
	Action taken as confirmed during the inspection: A review of repositioning records confirmed that patients were repositioned in keeping with the care plan.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home. A review of the staffing rota for week commencing 8 May 2017 evidenced that the planned staffing levels were not consistently adhered to. For example, there was one day where the home was unable to cover a morning shift; and the twilight shift had not been covered on three evenings. Three staff stated that they were often under pressure when the home was short staffed, due to illness or lack of staff. This was discussed with the registered manager who explained that three care staff had recently been recruited and were going through the appropriate checks before starting in post. The dependency levels of patients had been reassessed and when staff were unable to attend, for example, due to illness, the staff stated that they prioritised their workload to ensure that all the patients' needs were met. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty, despite the shortfalls identified; no concerns were raised by patients and/or their representatives.

Staff recruitment records were available for inspection and were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks and satisfactory references were sought, received and reviewed prior to staff commencing work and records were maintained. Information regarding the candidates' reasons for leaving their current /most recent post was not recorded; this information should be sought for all positions where candidates have worked with children or vulnerable adults. This was discussed with the registered manager and a recommendation has been made in this regard.

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 the record to confirm completion and to declare understanding and competence. The registered manager had also signed the record to confirm that the induction process had been satisfactorily completed.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on basic life support, medicines management, 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. Overall compliance with training was monitored by the registered manager. Observation of the delivery of care evidenced that training had been embedded into practice.

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

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

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. The staff understood what abuse was and how they should report any concerns that they had. The registered manager had reported any potential safeguarding incidents to the relevant authorities; RQIA were notified appropriately. A review of documentation confirmed all incidents had been managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures. Where any shortcomings were identified safeguards were put in place.

Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. The registered manager had been identified as the safeguarding champion for the home. Plans were already in place for collating information which would form the annual position report.

Review of patient care records evidenced that a range of validated risk assessments were consistently completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were consistently completed following each incident, care management and patients' representatives were notified appropriately. Post-falls care included review of patients at six, 12 and 24 hours after each incident. Further information in relation to the audits of accidents is detailed in section 4.6.

As discussed in section 4.2, it was evident that action had been taken to reduce the amount of restrictive practice used in the home. In discussion, the registered manager explained that all patients had been reassessed for the use of bedrails and lap belts; and where applicable less restrictive measures were put in place.

Some patients required a pressure relieving mattress on their bed. There was a robust system in place to monitor and record the pressure mattress setting, to ensure their effective use.

Infection prevention and control measures were adhered to and equipment was appropriately stored.

A review of the home's environment was undertaken and included observations of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was generally found to be warm, well decorated, fresh smelling and clean throughout. A number of ensuite bathrooms required upgrading, particularly in the older part of the home. This was discussed with the registered manager who confirmed that these would be prioritised for action in the ongoing refurbishment programme. A recommendation has been made in this regard. The refurbishment plan, including timescales should be submitted to RQIA, with the returned QIP.

Although the majority of fire exits were observed to be clear of clutter and obstruction, one fire exit on the dementia unit was observed to have wheelchairs and other items stored there. This matter was discussed with the registered manager who ensured that the items were immediately removed. To ensure the safety and wellbeing of patients in the home, a requirement has been made in this regard.

Areas for improvement

Areas for improvement were identified in relation the recruitment processes; ensuring that escape routes are free of obstruction at all times; and in relation to the refurbishment of the older part of the home.

Number of requirements	1	**Number of recommendations**	2

4.4 Is care effective?

The home used an electronic system for assessing, planning and evaluating patients' care needs. Review of seven patient care records evidenced that a range of validated risk assessments were consistently completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT), dieticians, diabetes nurse specialist or the home feed coordinator.

There were areas of good practice identified throughout the review of the care records. For example, where patients were identified as requiring a modified diet, the relevant risk assessments were completed. The prescribed modified diets and recommended strategies for ensuring correct feeding techniques were utilised were included in the care plan.

Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day; for some patients, this information was communicated to the community dietician on a weekly basis, as part of an 'inreach' programme. Discussion with the kitchen staff evidenced that they had an up to date list of all patients who required food fortification.

There was also good practice identified in relation to the management of diabetes. The signs and symptoms of hypoglycaemia and hyperglycaemia were included in the care plan; and the protocol for managing fluctuations in blood sugars was maintained in the medication kardex. There was evidence that blood glucose monitoring was undertaken, in keeping with the prescribed insulin regimen.

Where patients were unable to eat orally and required feeding by percutaneous endoscopic gastrostomy (PEG) tube, there was evidence that the care of the PEG tube was appropriately managed. A review of the records confirmed that the placement of the tube was regularly checked and that any equipment used, was changed regularly in line with best practice. Where a patient had a wound, there was evidence of regular wound assessments and review of the care plan regarding the progress of the wound; dressings had been changed according to the care plan. Pain assessments were also completed every time the wound assessments were completed. This is good practice and is commended. Wound care records were also supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines.

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 and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored. The electronic system also had a function, which alerted the registered nurses to the number of days each patient had been without bowel movements. Through discussion, it was evident that registered nurses had oversight of these records on a daily basis.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005. The patient register was reviewed by the registered manager on a regular basis and was up to date.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager.

Discussion with the registered manager and review of records evidenced that patient and/or relatives meetings were also held on a regular basis. Minutes were available. Patients and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients stated that they felt they were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. The staff were also aware of the requirements regarding patient information and confidentiality.

We observed the lunch time meal in the dining room on the first floor. We saw that the atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set in advance of the patients being seated and specialist 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 and was correct on the day of the inspection. The food served appeared very appetising and all patients spoken with stated that it was always very nice.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. All those consulted with stated that there was always something to do; a list of activities was displayed in the home. There was also evidence that the provision of activities on the dementia unit had increased; there were numerous photographs of patients displayed, where they were participating in various activities, such as gardening and arts and crafts.

Significant changes had been made to the environment of the dementia unit which enhanced the environment for those patients accommodated on this unit. For example, following the completion of a dementia audit, the dining room had been painted and curtains and aprons were displayed to make the dining room have a more homely feel. Each patient had a display box at their bedroom door, which contained either memorabilia or symbols of their earlier lives; old photographs of the patients were on some of their bedroom doors. A list of suggested activities was displayed on the activities board, which care staff could choose from, when the activities coordinator was not on duty. Discussion with the registered manager also confirmed that plans were in place to enhance the outdoor spaces behind the dementia unit, which would further enhance the experience of the patients who were living with dementia.

Consultation with staff confirmed that they felt they had the necessary skills to communicate effectively with one patient who was identified as having difficulties with communicating. All staff were aware of the patients' needs and gave examples of how they communicated with this patient to ensure that the patient did not become frustrated.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. The annual quality report was reviewed and provided a comprehensive overview of the comments made by all those involved.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included praise for 'the kindness and compassion shown to (their relative), who was treated with the utmost dignity and respect, especially in their final days'.

During the inspection, we met with six patients, three care staff, two registered nurses, one domestic staff, four patients' representatives and three visiting professionals. Some comments received are detailed below:

Staff

"The care is excellent".
"This is a very good home".
"The care is good, the patients are well looked after".
"All is fine here, I have no concerns".
"I am happy enough".
"I might be going too far saying it is excellent, but it is certainly very, very good".

As discussed in section 4.3, three staff commented in relation to the staffing levels. Given that observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty; these comments were relayed to the registered manager to address.

Patients

"It is very good, I have no complaints".
"It is all very good, I couldn't say a word against them".
"It is exceptional, they do what you want".
"I am very happy".
"I would rate them very highly".
"They are all very good and very friendly".

Patients' representatives

"'I am happy enough".
"It is very good, we are very happy with the care given".
"They are well looked after here".
"Everything is fine".

Visiting Professionals

"The care is excellent, communication is very good".
"It is fairly good".
"The staff can be very busy at time but staffing is a problem in a lot of homes, the nurses are excellent".

One visiting professional commented that the home would benefit from additional raiser/recliner chairs. This was relayed to the registered manager to address.

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. Three staff, one patient and four relatives had returned their questionnaires, within the timeframe for inclusion in this report. Comments and outcomes were as follows:

Patients: the respondent indicated that they were either 'very satisfied' that the care in the home was safe, effective and compassionate; no written comments were received.

Relatives: respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well led. No written comments were received.

Staff: two respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well led. One respondent indicated that they were 'unsatisfied' with the care provided in all four domains; however they agreed that the patients were safe and protected from harm; that they received the right care at the right time; and that the patients were treated with dignity and respect.

Written comment included 'though the care assistants are under a lot of pressure, the residents' needs are always met'. Following the inspection, these comments were relayed to the registered manager to address.

Any comments from patient representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.6 Is the service well led?

Observation of patients and discussion with the registered manger 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. The home's statement of purpose had also been updated and was kept at the reception to the home.

There was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

It was evident that action had been taken to improve the effectiveness of the care; all requirements and recommendations made at the previous care inspection had been met. All those consulted with described the registered manager in positive terms; comments included that they were 'very approachable' and 'very good'. Discussions with staff confirmed that there were good working relationships within the home.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action had been taken to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. The registered manager also completed an annual analysis of accidents within the home, which provided an overview in relation to the number of falls, the category of care the patients were in and any particular month where the numbers of accidents in the home had increased. This had been discussed with staff, to see if they could identify any reasons why there had been an increase. This is commended.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were proactively reviewed and where appropriate, made available to key staff in a timely manner.

Discussion with the registered manager and 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.

Areas for improvement

No areas for improvement were identified during the inspection.

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

5.0 Quality improvement plan

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

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

Matters to be addressed as a result of this inspection are set in the context of the current registration of the 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.

5.1 Statutory requirements

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

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to Web Portal for assessment by the inspector.

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

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 27 (4) (b) **Stated:** Firsttime **To be completed by:** immediate from the day of the inspection	The registered persons must ensure that precautions are in place that minimise the risk of fire and protect patients, staff and visitors in the event of a fire. This refers specifically to the observed practice of storing wheelchairs and other items in front of the fire exit on the dementia unit. **Ref: Section 4.3**
	Response by registered providerdetailing the actions taken: This area is now kept clear of equipment with additional signage to increase everyone's awareness.
Recommendations	
Recommendation 1 **Ref**: Standard 38 **Stated:** First time **To be completed by:**14 July 2017	The registered persons should ensure that recruitment records include information to explain the reasons for leaving previous employment. **Ref: Section 4.3**
	Response by registered providerdetailing the actions taken: Recruitment records are now undergoing closer scruitiny, ensuring recording when an employee has not left their current employment.
Recommendation 2 **Ref**: Standard 44 **Stated:** First time **To be completed by:**14 July 2017	The registered persons should ensure that all parts of the home are well maintained and remain suitable for their stated purpose. This refers specifically to the bedrooms and ensuites in the older part of the home. **A refurbishment plan with timescales must be submitted to RQIA with the returned QIP.** **Ref: Section 4.3**
	Response by registered providerdetailing the actions taken: All ensuites (7 in total) in the "older" part of the Home have been priced for new flooring, wall panelling, and new sanitary wear. Rooms 4 and 6 will be complete by 30th June 2017 with the remainder planned for completion in July, August and September 2017.

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

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