Unannounced Care Inspection Report
24 May 2016

Glenview

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1.0 Summary

An unannounced inspection of Glenview Care Home took place on 24 May 2016 from 9.15 to 15.30 hours. The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There were safe systems in place for the recruitment and selection of staff. Registration checks were conducted on a regular basis to ensure that all staff were registered with the relevant professional bodies. New staff completed an induction programme and there were systems in place to monitor staff performance and compliance with mandatory training. The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adults safeguarding and any potential safeguarding concern had been managed appropriately and in accordance with the regional safeguarding protocols. The home was clean, reasonably tidy, well decorated and warm throughout. Infection prevention and control measures were adhered to and fire exits and corridors were maintained clear from clutter and obstruction. Despite this, weaknesses were identified which led to a reduction in positive outcomes for patients. Two requirements and one recommendation have been made to secure compliance and drive improvement. These relate specifically to the staffing levels on the dementia unit; restrictive practices; and the accurate recording of the hours worked by the activities coordinator in delivering direct patient care.

Is care effective?

A range of risk assessments were completed and the outcomes were reflected in the care plans. With the exception of deficits identified in the management of restrictive practices, there was evidence that outcomes of the assessments had informed the care planning process. Personal care records evidenced that patients who were at risk of developing pressure damage, were repositioned in line with their care plans. The records also evidenced that patients' total fluid intake had been monitored and appropriate action taken in response to any identified deficits. Communication was well maintained in the home and all those consulted with expressed their confidence in raising concerns with the home's staff/ management. However, a requirement has been made in relation to the completion of specific risk assessments and care plans for patients who require the use of lap belts.

Is care compassionate?

Staff interactions were observed to be compassionate, caring and timely and all patients and relatives consulted with provided positive comments in relation to the care. The staff consulted with raised concerns regarding the staffing levels within the home, specifically in relation to the nursing dementia unit. Weaknesses were also identified and three recommendations have been made in relation to improvements required in the dementia environment; the meal time experience; and the provision of activities.

Is the service well led?

There was a clear organisational structure within the home. All comments received in relation to the responsiveness of the registered manager were all positive. The home was observed to be operating within the categories of care for which the home is registered. RQIA had been

informed appropriately of any notifiable incidents and there were systems in place to review urgent communications, safety alerts and notices where appropriate. There were systems in place to monitor and report on the quality of nursing and other services provided. However, a requirement has been made to ensure that the annual quality audit is completed and a recommendation has also been made to ensure that the system for auditing care records is further developed. A requirement has also been stated for the second time in regards to the Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, monitoring visit.

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	*5	*6

*The total number of requirements and recommendations above includes one requirement that was not met and has been stated for the second time. Two recommendations were not met; one of which has been stated for the second time. One recommendation that was not met resulted in a requirement being made during this inspection.

Details of the QIP within this report were discussed with the 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 care inspection

The most recent inspection of the home was an unannounced care inspection conducted on 14 September 2015. The completed QIP was returned and approved by the care inspector. The QIP was validated at this inspection. Please refer to section 4.2 below.

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. There were no areas that required to be followed up in this inspection.

2.0 Service details

Registered organisation/registered person: Glenview Mervyn John Gregg Jennifer Elizabeth Gregg	**Registered manager:** Eleanor Elizabeth Caroline Sands
Person in charge of the home at the time of inspection: Eleanor Elizabeth Caroline Sands	**Date manager registered:** 1 April 2005
Categories of care: RC-I, NH-DE, NH-I, NH-PH, NH-PH(E)	**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

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with four patients, five care staff, two nursing staff and four patient's representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- staff training records
- accident and incident records
- notifiable incidents
- audits
- records relating to adult safeguarding
- complaints records
- recruitment and selection records
- NMC and NISCC registration records
- staff induction, supervision and appraisal records
- staff, patients' and relatives' meetings
- staff, patients' and patients' representative questionnaires
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- policies and procedures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 14 September 2015

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

4.2 Review of requirements and recommendations from the last care inspection dated 14 September 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 15 (e) **Stated:** First time	The registered persons must ensure that the home only accommodates patients within the category of care for whom they are registered. Patients with a diagnosis of dementia must be continually reviewed, to ensure that they are accommodated in the appropriate category of care.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and observations on the day of inspection, confirmed that all patients were accommodated within the correct categories of care for which the home is registered.	
Requirement 2 **Ref**: Regulation 29 (5) (a) **Stated:** First time	A copy of the regulation 29 monitoring reports must be retained in the home and available for inspection.	**Not Met**
	Action taken as confirmed during the inspection: There was no evidence that the regulation 29 monitoring visit had been completed since March 2016. **This requirement was not met and has been stated for the second time.**	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 19 (1) **Stated:** Second time	It is recommended that patients and residents continence assessments are fully recorded and completed appropriately.	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that continence assessments were completed appropriately.	
Recommendation 2 **Ref**: Standard 19.4 **Stated:** Second time	It is recommended that a Continence Link Nurse be appointed in the home.	**Met**
	Action taken as confirmed during the inspection: There was an identified continence link nurse identified in the home.	
Recommendation 3 **Ref**: Standard 19.4 **Stated:** Second time	It is recommended that regular audits of the management of patients and residents who are continent be undertaken and the findings acted upon to enhance already good standards of care	**Met**
	Action taken as confirmed during the inspection: There was evidence that audits of patients' continence needs had been completed.	

Recommendation 4 **Ref**: Standard 32.1 **Stated:** First time	All policies and procedures should be reviewed to ensure that they are subject to a three yearly review. • A policy on palliative and end of life care should be further developed in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines* and should include the out of hours procedure for accessing specialist equipment and medication, the management of shared rooms and the procedure for managing an unexpected death. The policies and guidance documents listed above, should be made readily available to staff.	**Partially Met**
	Action taken as confirmed during the inspection: A policy on palliative and end of life care was reviewed and included the out of hours procedure for accessing specialist equipment and medication; and the management of shared rooms. There was no evidence that the procedure for managing an unexpected death had been included in the policy. **This recommendation was partially met, therefore the element of the recommendation, regarding unexpected deaths will be stated for the second time.**	

Recommendation 5 **Ref**: Standard 41.1 **Stated:** First time	The registered manager should review the work practices on the morning shift, taking into account the dependency levels of the patients accommodated in the home. This refers specifically to the period in the morning, when the registered nurse is administering medicines.	**Not Met**
	Action taken as confirmed during the inspection: A review of the staff duty roster and observations on the day of the inspection confirmed that the dependency levels of the patients had not been taken into account. This recommendation was not met. **A requirement has now been stated in this regard. Refer to section 4.3.**	

4.3 Is care safe?

There were safe systems in place for the recruitment and selection of staff. A review of two personnel files evidenced that these were reviewed by the registered manager and checked for possible issues. Where nurses and carers were employed, their pin numbers were checked with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), to ensure that they were suitable for employment. Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. The review of recruitment records evidence that enhanced criminal records checks were completed with AccessNI and the reference number and date received had been recorded.

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

There was evidence that new staff completed an induction programme to ensure they developed their required knowledge to meet the patients' needs. Staff consulted confirmed that they received induction; and shadowed experienced staff until they felt confident to care for the patients unsupervised. This ensured that they had the basic knowledge needed to begin work.

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. Training had also been provided for staff about managing the behaviour of patients which challenge.

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

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adults safeguarding. The complaints and safeguarding records provided evidence of incidents. A review of the records identified that concerns had been logged appropriately. A review of documentation confirmed that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. However, a review of the staffing rota evidenced that the planned staffing levels were not consistently adhered to, specifically in the nursing dementia unit. Due to some patients' care requirements, two members of staff were required to assist them. This meant that when two staff were busy attending to patients in their bedrooms, there was no staff available to supervise and meet the needs of the remaining patients. The registered manager outlined how three staff members were meant to be assigned to work on the dementia nursing unit, from 08.00 hours to 10.30 hours. However, the review of the staff duty roster commencing 16 May 2016 evidenced that there had only been two staff members on duty on three out of the seven days. There was also evidence that care staff had been re-deployed from caring duties to assist in the kitchen. As discussed in section 4.2, a recommendation had previously been stated to ensure that the work practices on the morning shift were reviewed, taking into account the dependency levels of the patients accommodated in the home. This was discussed with the registered manager who provided assurances that five new care staff had recently been recruited and were awaiting all the necessary checks before they could commence work. Although the registered manager confirmed that an additional staff member had been assigned to the dementia unit, following the inspection, a requirement has still been made in this regard.

Although all staff consulted were aware how to identify who was in charge of the home, in the absence of the registered manager, this was not recorded on the duty roster. The duty roster also did not accurately record the hours worked by the activities coordinator, in relation to the hours worked in that role and the hours worked, delivering care to the patients. A recommendation has been made in this regard.

A range of risk assessments were completed as part of the admission process and were reviewed as required. The assessments included where patients may require the use of a hoist or assistance with their mobility and their risk of falling; the use of bedrails, if appropriate; regular repositioning due to a risk of developing pressure damage and wound assessment, if appropriate; assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties. The risk assessments generally informed the care planning process.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident, care management and patients' representatives were notified appropriately. However observation of the care practices evidenced that a number of patients were seated in the lounges, with lap belts loosely fastened. This posed a potential risk of entrapment. The staff consulted with stated that the lap belts were used to prevent the patients falling out of their chairs. They did not recognise the use of lap belts as a form of restraint. Although there was evidence of regular release and repositioning of the lap belts, a review of the care records did not evidence that risk assessments had been completed or consent obtained, in respect of the use of the restraint.

There was no evidence of multi-disciplinary consultation in the decision making processes in relation to the use of these devices. A requirement has been made in this regard.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

The staffing provision on the dementia unit must be reviewed to ensure that the staffing levels are in such numbers as are appropriate for the health and welfare of the patients. A requirement has been made in this regard.

The duty roster should accurately record the hours worked by the activities coordinator, in relation to the hours worked in that role and the hours worked, delivering care to the patients. A recommendation has been stated in this regard.

The registered person 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. A requirement has been made in this regard.

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

4.4 Is care effective?

The home used an electronic system for assessing, planning and recording patients' care needs and a review of five patient care records evidenced that risks to patients were generally assessed on a regular basis. The home used an electronic system for assessing, planning and recording patients' care needs and a review of five patient care records evidenced that risks to patients were generally assessed on a regular basis. These assessments included assessments in moving and handling, falls, wounds/pressure ulcers, nutrition, bed rails and choking. The 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) or dieticians. Registered nurses consulted with were aware of the local arrangements and referral process to access other multidisciplinary professionals.

The review of care records evidenced that risk assessments were completed as part of the admission process and were reviewed as required. There was also evidence that risk assessments informed the care planning process. For example, 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. A review of the daily progress notes, evidenced that the dressing had been changed according to the care plan. Patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

However, as discussed as discussed in section 4.3, a number of patients were observed to have lap belts fastened, whilst seated in specialist/recliner chairs. A review of the care records evidenced that risk assessments and care plans had not been completed for the use of the lap belts. There was also no evidence of multidisciplinary consultation in the decision making

processes in relation to the use of these devices and there was no evidence that consent had been obtained from the patients and/or their representatives. A requirement has been made in this regard.

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.

There was evidence of regular communication with patient representatives within the care records, regarding changes in the patients' condition. Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and it provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective. Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff, patients and patients' representatives consulted with expressed their confidence in raising concerns with the home's staff/ management. Discussion with the registered manager and review of records evidenced that relatives meetings were held on a regular basis and records were maintained. Plans were in place to hold a patients meeting.

Areas for improvement

Risk assessments and care plans must be completed for each patient who requires the use of a lap belt. Formal consent must be obtained for their use and evidence of consultation with multidisciplinary professionals must be retained within the care record. A requirement has been made in this regard.

Number of requirements	**1**	**Number of recommendations**:	**0**

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that they were afforded choice, privacy, dignity and respect. 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. Patients consulted with stated that they knew how to use their call bells and stated that staff usually responded to their needs in a timely manner. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. 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. Discussion with patients and staff also evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

The serving of the mid-day meal was observed. Although the meal-time experience on the ground floor was observed to have the menu displayed and the tables appropriately set, in advance of the patients being seated, the dining room on the dementia nursing did not. This was brought to the attention of the registered manager. A recommendation has been made, to ensure that the mealtime experience is reviewed to address the deficits identified during this inspection.

In the dementia nursing unit, there were few signs or other types of support for patients who were living with dementia and may require help to recognise their surroundings. The bedrooms had not been personalised. Bathrooms and toilets were not clearly marked with pictures. There was no other signage or pictures at their bedrooms to show the patients that the room was theirs. Bedroom doors held only room numbers. This would make it difficult for patients to identify their bedrooms. Six patients were seated in the lounge area, the majority of whom were observed to be either sleeping or to have their heads down. There was little stimulation observed and there was no evidence of any activities provided. This was discussed with the registered manager and a recommendation has been made to ensure that an audit of the dementia care environment is conducted.

Although there was evidence that activities had been provided on the ground floor on the day of the inspection, we did not see any activities provided to the patients who were living in the dementia nursing unit. Patients on the dementia nursing unit were dependent on staff to mobilise and only moved when going to the toilet, or having their meals. This demonstrated that patients were at risk of social isolation. There was little evidence of meaningful activities and patients were sat around but disengaged. Discussion with staff and a review of the staff duty roster identified that the activities coordinator was often re-deployed to caring duties, due to staff shortages. This had occurred three times in the week preceding the inspection. There was also no formal list displayed regarding what activities had been planned. A review of the care records evidenced that social care plans had been developed and there was evidence that the patient's preferences had been identified. However, there was no evidence recorded in regards to the level of engagement/enjoyment involved and there was also little evidence that activities had been provided to patients who could not partake in group activities. This was discussed with the registered manager. A recommendation has been made in this regard.

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 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.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. All comments on the returned questionnaires were positive. Some comments received are detailed below:

Staff

'It is a good home'
'I like it here. It is a great home, when fully staffed'.

Three staff members commented regarding the impact of staff shortages on patient care, in particular on the nursing dementia unit. Staff consulted with stated that they had raised their concerns to management. Staff also commented that they were being consistently phoned on their days off work, to cover shifts. This was discussed with the registered manager during feedback and a requirement has been made to address the matter. Refer to section 4.3 for further detail.

Patients

'It is spotless here, I have no concerns'.
'The staff are lovely, although there is not much to do here'.
'more staff are required for early mornings to help with washing, dressing etc.'

Patients' representatives

'the shortage of staff results in (patients) waiting to go to the toilet'.
'I have no concerns, the care is good'.
'Sometimes the girls can be very busy'.

Areas for improvement

The dining experience in the dementia unit should be reviewed, with regard to patient choice and consider the introduction of pictorial menus to assist patients in making their choice of meal. A recommendation has been made in this regard.

A dementia audit should be 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. A recommendation has been made in this regard.

The provision of activities on the dementia unit should be 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. A recommendation has been made in this regard.

Number of requirements	**0**	**Number of recommendations**:	**3**

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. All staff were aware who would be in charge of the home, in the absence of the registered manager. Staff, patients and patients' representatives all commented positively regarding the way in which the home was led. One relative described the registered manager as being 'excellent in every way'.

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

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. 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 who had sanctions imposed on their employment by professional bodies.

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

Discussion with the registered manager 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. However, there was no evidence that an annual quality assurance report had been completed for 2015. A requirement has been made in this regard.

Discussion with the manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, the registered manager outlined how the following audits were completed in accordance with best practice guidance:

- falls
- wound management
- medicines management
- care records
- infection prevention and control
- environment audits
- health and safety
- bedrails
- restraint
- dining experience audits
- human resource audits
- complaints

An audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis.

Given that deficits were identified in the safe and effective domains the audits of care records were reviewed. Although there was evidence that audits had been completed, via the 'key checks' electronic system every three months, there was no evidence of any action taken to address identified deficits. There was also no evidence that the hard copy records, which supplement the electronic patient records, had been reviewed. Therefore we were not assured about the effectiveness of the audits. A recommendation has been stated in this regard.

As discussed in section 4.2, there was no evidence that the Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, monitoring visit had been completed in April 2015. A requirement has been stated for the second time in this regard.

Areas for improvement

An annual quality audit report must be completed to ensure that the quality of nursing and other service provision is reviewed. This report must also provide for consultation with patients and their representatives. A requirement has been made in this regard.

A process for auditing patients' care records is further developed to include a review of the supplementary documentation, in addition to the patients' electronic care records. Records of key checks (audits) completed should be retained and should evidence action taken in response to identified deficits. A recommendation has been made in this regard.

Number of requirements	**1**	**Number of recommendations**:	**1**

5.0 Quality improvement plan

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

The registered person/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 person/manager 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 the 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 person/s meets legislative requirements based on Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to Nursing.Team@rqia.org.uk and assessed 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 person/manager 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 person/manager 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 29 (5) (a) **Stated:** Second time **To be completed by:** 21 July 2016	A copy of the regulation 29 monitoring reports must be retained in the home and available for inspection. **Ref: Section 4.2**
	Response by registered person detailing the actions taken: Spoke with Trevor Gage who is responsible for completing Monthly Monitoring Visits. All monthly reports are now in place.
Requirement 2 **Ref**: Regulation 20 (1) (a) **Stated:** First time **To be completed by:** 21 July 2016	The registered persons must ensure that at all times staffing levels in the dementia unit are in such numbers as are appropriate for the health and welfare of the patients. **Ref: Section 4.3**
	Response by registered person detailing the actions taken: An additional Care Assistant 8 - 2 has been allocated to Dementia Unit.
Requirement 3 **Ref**: Regulation 14 (5) **Stated:** First time **To be completed by:** 21 July 2016	The registered person 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. **Ref Section 4.3**
	Response by registered person detailing the actions taken: Make nurses aware for residents/patients who use lapbelts that a discussion of same must take place at each care review between patient/resident/next of kin and keyworker and the outcome will be documented. Memo outlining same for Staff Nurses in place in each Treatment Room.
Requirement 4 **Ref:** Regulation 15 (2) (a) **Stated:** First time **To be completed by:** 21 July 2016	The registered person must ensure that risk assessments and care plans are completed for each patient who requires the use of a lap belt. Formal consent must be obtained for their use and evidence of consultation with multidisciplinary professionals must be retained within the care record. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: We are in the process of having a lapbelt risk assessment installed on the computer system and will then be completed for each patient/resident using same.

Requirement 5 **Ref:** Regulation 17 (1) **Stated:** First time **To be completed by:** 21 July 2016	The registered persons must ensure that an annual quality audit report is completed to ensure that the quality of nursing and other service provision is reviewed. This report must also provide for consultation with patients and their representatives. **Ref: Section 4.6**
	Response by registered person detailing the actions taken: A questionaire is being sourced and will be completed by residents/patients and from this questionaire an annual quality audit report will be developed and outcome will be displayed.
Recommendations	
Recommendation 1 **Ref**: Standard 32.1 **Stated:** Second time **To be completed by:** 21 July 2016	All policies and procedures should be reviewed to ensure that they are subject to a three yearly review. • A policy on palliative and end of life care should be further developed in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines* and should include the procedure for managing an unexpected death. The policies and guidance documents listed above, should be made readily available to staff. **Ref: Section 4.2**
	Response by registered person detailing the actions taken: A policy on Managing an Unexpected Death is now available for all staff. All policies and procedures will continue to be reviewed and updated.
Recommendation 2 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 21 July 2016	The registered person should ensure that the staff duty roster accurately records the hours worked by the activities coordinator, in relation to the hours worked in that role and the hours worked, delivering care to the patients. **Ref: Section 4.3**
	Response by registered person detailing the actions taken: This has been put in place from date of last inspection.
Recommendation 3 **Ref**: Standard 12.6 **Stated:** First time **To be completed by:** 21 July 2016	The registered person should review the dining experience in the dementia unit with regard to patient choice and consider the introduction of pictorial menus to assist patients in making their choice of meal. **Ref: Section 4.5**
	Response by registered person detailing the actions taken: Since last inspection two cooks have attended a Dysphagia Catering Workshop which included presentation of specialised diets. Prior to the Inspection a book of pictorial menus and choices was in place and located in the Dementia Unit.

Recommendation 4 **Ref**: Standard 25.3 **Stated:** First time **To be completed by:** 21 July 2016	The registered person 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. **Ref: Section 4.5**
	Response by registered person detailing the actions taken: This is currently being addressed and will be ongoing.
Recommendation 5 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 21 July 2016	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. **Ref: Section 4.5**
	Response by registered person detailing the actions taken: Activity Therapist is reviewing daily activities within Dementia Unit at present to faciliate all patients' interests. Records are being kept within each patient's care record.
Recommendation 6 **Ref**: Standard 35.4 **Stated:** First time **To be completed by:** 21 July 2016	The registered persons should ensure that a process for auditing patients' care records is further developed to include a review of the supplementary documentation, in addition to the patients' electronic care records. Records of key checks (audits) completed should be maintained and should evidence action taken in response to identified deficits. **Ref: Section 4.5**
	Response by registered person detailing the actions taken: A process is in place for auditing patients' care records and has been kept up to date, however this will be developed to include level of engagement and enjoyment by each patient/resident.

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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