Unannounced Care Inspection Report
8 November 2016

Rathowen

Type of Service: Nursing Home
Address: 118 Portadown Road, Tandragee, Craigavon, BT62 2JX
Tel no: 028 3884 0226
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Rathowen took place on 8 November from 09.30 to 16.30 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?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies, staff training and development and the management of patients' accidents within the home. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. A general inspection of the home confirmed that the premises and grounds were well maintained. Areas for improvement were identified in relation to the recruitment and selection processes; the frequency with which nurses' registrations with the NMC are checked; record keeping in relation to environmental cleaning; the format of the falls risk assessment tool; and the need for shelving in the sluice room to be replaced. One requirement and four recommendations have been made.

Is care effective?

A review of care records confirmed that a range of risk assessments were completed. Care plans were created to prescribe care. There were arrangements in place to monitor and review the effectiveness of care delivery. We examined the systems in place to promote effective communication between staff, patients and relatives and were assured that these systems were effective. Areas for improvement were identified in relation to the need for the assessment of the patient's needs to be revised in relation to changes in the patients' condition; fluid intake management; the need for care plans to include the specific consistency of prescribed modified diets; the process for involving patients and/or their representatives in care plan development; and record keeping in relation to personal care delivery. Two requirements and three recommendations have been made.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully. Staff were also observed to be taking time to reassure patients as was required from time to time. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding issues affecting them. Patients spoken with commented positively in regard to the care they received. An area of improvement was identified in relation to the records around the provision of activities. One recommendation has been made.

Is the service well led?

There was a clear organisational structure evidenced within Rathowen and staff were aware of their roles and responsibilities. Staff spoken with were knowledgeable regarding the line management structure and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Areas for improvement were identified in relation to the home's categories of care; the auditing processes in relation to care records and cleaning records; and the completion and content of the monthly quality monitoring visits, undertaken in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. Two requirements and two recommendations have been made.

Following the inspection, discussions were held with senior management in RQIA in relation to the home accommodating one more patient than they were registered for, under the 'residential' category. The responsible person was requested to submit a variation application to temporarily vary the categories of care for which the home is registered. This was submitted to RQIA on 14 November 2016.

The term 'patients' is used to describe those living in Rathowen 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	5	*12

*The total number of requirements and recommendations above includes two recommendations that have been stated for the second time. Details of the Quality Improvement Plan (QIP) within this report were discussed with Alison Wylie, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Following the inspection, concerns in relation to the home's breach of their categories of care were discussed with senior management in RQIA. The responsible person was requested to submit a variation application to temporarily vary the categories of care for which the home is registered.

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 estates inspection undertaken on 19 April 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: Mr Desmond Joseph Watt	**Registered manager:** Mrs Alison Wylie
Person in charge of the home at the time of inspection: Mrs Alison Wylie	**Date manager registered:** 25 April 2016
Categories of care: RC-I, NH-I A maximum of 5 residents in category RC-I.	**Number of registered places:** 19

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. Questionnaires were distributed to patients, relatives and staff. We also met with four patients, two care staff, one registered nurse, four patients' representatives and one visiting professional.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training records for 2015/2016
- audits in relation to falls
- one staff recruitment and selection record
- complaints received since the previous care inspection
- a selection of policies and procedures.
- 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
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- accident and incident records.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 19 April 2016

The most recent inspection of the home was an announced estates inspection. The completed QIP was returned and approved by the estates inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next estates inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 01 February 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 20 (c) (i) **Stated:** Second time	The registered person must ensure that staff receives mandatory training and other training appropriate to the work they are to perform. A copy of the training matrix for the home which illustrates compliance with all areas of mandatory training should be submitted to RQIA with the return of the QIP. A record of all training completed must be retained as evidence.	**Met**
	Action taken as confirmed during the inspection: 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.	

Requirement 2 **Ref:** Regulation 18 (2) (j) **Stated:** First time	The registered person must ensure that the floor coverings in the two identified bedrooms are replaced to ensure that the malodours are effectively eliminated. **Action taken as confirmed during the inspection**: The identified floor coverings had been replaced and there were no malodours detected during the inspection.	**Met**
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 36 **Stated:** Second time **To be Completed by:** 1 April 2016	It is recommended that a policy and procedure is developed and should reflect current guidelines for each of the following areas; • Communicating effectively including the Breaking of Bad news • Palliative and end of life care • Death and dying. **Ref Section: 5.2** **Action taken as confirmed during the inspection**: Although the breaking bad news policy and the policy on palliative and end of life care had been reviewed in line with best practice, the death and dying policy had not been updated to include the management of shared rooms, when a patient is nearing end of life care. One element of the recommendation has been stated for the second time.	**Partially Met**
Recommendation 2 **Ref**: Standard 4 Criteria (1)(7) **Stated:** First time	It is recommended that continence assessments and care plans are reviewed to include all aspects of continence management for example; the type of continence products being used, bowel patterns and type. **Action taken as confirmed during the inspection**: A review of continence assessments evidenced that although new continence assessments had been developed, they had not been reviewed since March 2016 and did not consistently include information on bowel patterns and type.	**Not Met**

Recommendation 3 **Ref**: Standard 36 **Stated:** First time	It is recommended that a system is developed to ensure staff are knowledgeable of the reviewed policies and procedure regarding continence management and that they are embedded into practice.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and a review of records confirmed that staff were knowledgeable regarding best practice guidance on continence care.	
Recommendation 4 **Ref**: Standard 21 Criteria (6) **Stated:** First time	It is recommended that a pain assessment should be completed for all patients on admission and care plans are developed in line with the outcomes of such risk assessments. Assessments and care plans should be reviewed and evaluated accordingly.	**Met**
	Action taken as confirmed during the inspection: A review of patient care records confirmed that patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.	
Recommendation 5 **Ref**: Standard 4 Criteria (1)(7) **Stated:** First time	It is recommended that an individual care plan is developed which provides the basis for care to be delivered and is re-evaluated in response to the patient's changing needs. This is in particular reference to patients receiving treatment and care for the management of distressed reactions. The care plan should clearly define the parameters of care and interventions required.	**Met**
	Action taken as confirmed during the inspection: A review of one patient's care record confirmed that a care plan had been developed with regard to challenging behaviour. The care plan included the triggers for the behaviours and effective interventions to deescalate the behaviour.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to review to ensure the assessed needs of the patients were met. A review of the staffing rota for the week commencing 14 October 2016 evidenced that the planned staffing levels were not consistently adhered to. However, there was evidence that the registered manager assisted in delivering patient care on the days the home was short staffed.

No concerns were raised during the inspection, regarding the staffing levels. Staff were observed assisting patients in a timely and unhurried way. 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 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.

As discussed in section 4.2, 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 training 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 safeguarding.

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 and completed annual appraisals. Review of two records confirmed that a competency and capability assessment was completed with all registered nurses who were given the responsibility of being in charge of the home.

There were systems in place for the recruitment and selection of staff. A review of one personnel file evidenced that these were reviewed by the registered manager and checked for possible issues; however, areas for improvement were identified in relation to the recruitment and selection procedures in the home. For example, there were unexplained gaps in the applicant's application form and a review of the interview notes did not evidence that the reasons for the gaps in employment had been explored. Although the staff consulted with stated that they had only commenced employment once all the relevant checks had been completed, the ACCESSNI reference number and date received were not retained in the home. Therefore we were unable to establish if the checks had been completed at pre-employment stage. Following the inspection, the responsible person confirmed the relevant information to RQIA by email. A recommendation has been made in this regard.

Although there was a system in place to check the PIN numbers of nurses and carers with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), the checking system was not sufficiently robust, to ensure that all staff had renewed their registrations. For example, one nurse's registration had not been checked until 24 days following their renewal date. This was discussed with the registered manager. A requirement has been made in this regard.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. There had been no safeguarding incidents reported since the last inspection. The registered manager was able to describe the reporting procedure and a flowchart was available, for all staff, in accordance with the regional safeguarding protocols.

Validated risk assessments were completed as part of the admission process and were reviewed as required. These risk assessments informed the care planning process.

Although a review of the accident and incident records confirmed that the falls risk assessments and care plans were generally completed following each incident; and that care management and patients' representatives were notified appropriately, the format of the falls risk assessment did not identify the patients' level of risk. A recommendation has been made in this regard. 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.

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. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. Infection prevention and control measures were adhered to and equipment was stored appropriately. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout.

A review of the cleaning records identified inconsistencies in the completion of cleaning records. For example, the commode cleaning records had not been completed between December 2015 and May 2016; bed rail and bedrail cover cleaning records had not been completed since January 2016. The review of the daily cleaning records did not specify the individual area that had been cleaned and there were also inconsistencies in the completion of the monthly cleaning records. Although RQIA acknowledges that the home was clean and free from odours, systems and protocols must be established to ensure compliance with best practice in infection prevention and control within the home. A recommendation has been made in this regard.

Shelving in the downstairs sluice room was also observed to have the edging missing, exposing the wood underneath. This meant that the shelving could not have been effectively cleaned. A recommendation has been made in this regard.

Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

A recommendation has been made that the recruitment and selection processes are reviewed, to ensure that any gaps in employment are explored and the reasons documented. A record should also be maintained of the Access NI reference numbers and the date received.

A requirement has been made that nurses' registrations with the NMC are checked on a regular basis

A recommendation has been made that the cleaning records are further developed to ensure traceability in terms of the specific areas cleaned. The registered manager should also have oversight of the cleaning records, to ensure compliance with best practice in infection prevention and control.

A recommendation has been made that the shelving in the ground floor sluice room is repaired or replaced to ensure that it can be cleaned effectively.

A recommendation has been made that the format of the falls risk assessment is further developed, to ensure that the level of risk is clearly identified.

Number of requirements	1	**Number of recommendations**	4

4.4 Is care effective?

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. Whilst the majority of assessments were reviewed on a regular basis, the review identified deficits in the completion of assessments in relation to changes in the patients' condition. For example, where one identified patient had developed a pressure ulcer, neither the risk assessment, or the care plan, had been updated to reflect the change to the patient's condition. The patient's risk of poor nutrition was assessed using a recognised Malnutrition Universal Screening Tool (MUST); however this assessment tool had also not been updated in response to recent poor oral intake and the most recent entry in the care plan evaluation included that the patient 'continued to eat well'. This was discussed with the registered manager. A requirement has been made in this regard.

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. However, a review of one identified patient's food and fluid intake chart identified that the patient had taken a poor fluid intake on two consecutive days. The daily food and fluid intake charts had not been totalled on these days and a review of the daily progress notes did not evidence any action taken by registered nurses. For example, registered nurses recorded that the patient was 'eating and drinking fairly well' when the patient's actual recorded intake had only been 530mls. This posed a risk of dehydration. A requirement has been made in this regard.

Although patients who were identified as requiring a modified diet, had the relevant choke risk and malnutrition risk assessments completed, the care plan had not been updated to include the consistency of the prescribed diet. A recommendation has been made in this regard.

Patients and or their representatives had been involved in the development of care plans when they were first formatted; however, the system to ensure input into subsequent care plans was not effective. For example, the review of patient care records evidenced that one care plan had not been discussed with the patient's representative since December 2014. A recommendation has been made in this regard.

Personal care records were reviewed. These records evidence the assistance provided to patients in relation to the assistance provided with washing and dressing; and the checking of skin areas at risk of pressure damage. A review of personal care records evidenced gaps in completion. For example, in one patient's personal care record, assistance with washing and dressing had not been recorded on 14 out of 28 days. Where assistance with washing and dressing was provided by the night staff, the entries of the personal care records only indicated 'night staff' therefore there was no indication of what specific care intervention had been delivered. The section entitled 'residents pressure areas checked' did not identify which areas had been checked and had also been inconsistently completed. Where personal care had been delivered by the night staff, there was also no evidence that the staff had checked the patients' skin, throughout the day. RQIA acknowledges that the patients were well groomed and presented on the day of the inspection; and whilst consultation with patients and their representatives confirmed that the patients' hygiene needs were always met, a recommendation has been made to address the improvements required in relation to record keeping.

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.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The most recent staff meeting was held on 15 September 2016. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities.

Discussion with the registered manager and review of records evidenced that patients and/or relatives meetings were held on a regular basis and records were maintained. The most recent patients' meeting was held on 26 August 2016 and a relatives' meeting was held on 30 May 2016. Minutes of the meetings held were reviewed and confirmed attendance and the detail of the issues discussed.

A notice board displaying information for relatives was provided in each floor, which included. the 'Charter of Patients' Rights' and the home's complaints procedure. All those consulted with expressed their confidence in raising concerns with the home's staff/ management.

Areas for improvement

A requirement has been made that the assessment of the patient's needs is kept under review and revised at any time when it is necessary to do so having regard to any change of circumstances.

A requirement has been made that patients' total fluid intake are recorded in the daily progress notes, to evidence validation by registered nurses and to identify any action taken in response to identified deficits.

A recommendation has been made that the consistency of patients who require a modified diet is specified in the patients' care plan.

A recommendation has been made that the process for discussing care plans with patients and/or their representatives is reviewed to ensure that they are facilitated to participate in all aspects of reviewing outcomes of care, on a regular basis.

A recommendation has been made that the systems for recording personal care delivery, which includes bathing and skin checks, are reviewed to ensure that the contemporaneous records of all nursing interventions are maintained within the patient care record.

Number of requirements	2	**Number of recommendations**	3

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 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 who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Patients stated that they were involved in decision making about their own care. 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.

One patient was identified as having a visual impairment. Consultation with the staff confirmed that they felt they had the necessary skills to communicate effectively with the patient and that if additional support was required; they would get this from the registered manager. One staff member explained to the inspector how she described the taste, texture and temperature of all the meals being served and how she explained to the patient the way in which the food was presented on the plate.

Menus were displayed clearly throughout the building. A review of the menu confirmed that meals were generally provided, as per the planned menu; however, on the day of the inspection, an alternate meal was being trialled. Advice was given to the registered manager in relation to the need to record the reasons for any changes to the planned menu.

We observed the lunch time meal being served in two day rooms. Discussion with patients confirmed that they were content having their meals in these rooms and stated that they would not want to move to a designated dining room. The atmosphere was tranquil and patients were encouraged to eat their food. The lunch served in both rooms appeared very appetising and patients spoken with stated that it was always very nice.

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.

There were various photographs displayed around the home of patients' participation in recent activities. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

We saw a list of activities on the ground and first floors that included manicure and makeup sessions; baking; musicians and newspaper reading. The registered manager explained that the activities coordinator engaged patients, as appropriate, in various activities, over three days in the week. Discussion with care staff confirmed that they provided activities, on the other days; however, there were no records available in relation to the activities provided, or the level of patient participation or enjoyment. One relative also commented to the inspector, in relation to the lack of stimulation provided to patients. This was discussed with the registered manager. A recommendation has been made in this regard.

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 and that the returned questionnaires were in the process of being reviewed. This will be followed up at future inspection..

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 cards, there was evidence that the staff cared for the patients and the relatives in a kindly manner.

During the inspection, we met with four patients, two care staff, one registered nurse, four patients' representatives and one visiting professional. Some comments received are detailed below:

Staff

"The care is very good. Everyone is so caring, it is just like family."
"It is very good here. We go above and beyond for the patients, whatever they want, they get."
"The standard of care is pretty good, the staff genuinely care. I would place my own relative here, without a doubt."

Patients

"I love every last one of them here, the nurses, carers and the other patients too."
"I couldn't say a word against them here."
"They are very nice and polite and I get more than what I need."

Patients' representatives

"It is very happy place, always clean."
"I was delighted to get my mother in here."
"They are all very good here. The way they looked after my mother was unreal."
"They are no activities. The place is clean, but not as clean as it should be."

Visiting professional

"I have no concerns, this is one of the better nursing homes."

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. Two relatives had returned their questionnaires, within the timeframe for inclusion in this report. No other questionnaires were returned. Both returned questionnaires reflected that the respondents were 'very satisfied' in the four domains examined. No written comments were provided.

Areas for improvement

A recommendation has been made that a record is maintained to evidence the decision making process regarding the provision of activities and events for patients accommodated in the nursing home. This record should include the level of participation and enjoyment and the activities provided to patients who cannot or do not wish to partake in group activities.

Number of requirements	0	Number of recommendations	1

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

The registration certificate was displayed appropriately. A certificate of public liability insurance was also current and displayed.

Discussion with the registered manager confirmed that on the day of the inspection, there were 11 patients accommodated under the 'nursing' category and six accommodated under the 'residential' categories. Given that the home is only registered to accommodate a maximum of five patients under the residential category, it was concerning that the home was operating outside its registered categories of care. This was discussed with the registered manager who explained that a patient who had been admitted for respite care, had extended their admission period and that this culminated in the home accommodating one additional patient under the 'residential' category. A review of the monthly quality monitoring reports confirmed that responsible person had been aware of the additional patient. The report specifically included a statement that home was 'operating within its statement of purpose and categories of care, as indicated on the registration certificate'. Following the inspection, the responsible person was requested to submit an application to temporarily vary the categories of care, for which the home is registered. This was received on 14 November 2016. A requirement has been made in this regard.

The registered manager explained that she had been attempting to update the home's policies and procedures and that plans were in place to employ an external provider to systematically review all the policies on a three yearly basis. Staff confirmed that they had access to the home's policies and procedures.

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 and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided; however, given the weaknesses identified during this inspection in relation to record keeping, we were not assured that the auditing processes were effective. A recommendation has been made in this regard.

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 that had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were not consistently completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. For example, the last recorded quality monitoring visit had taken place on 30 September 2016. This was discussed with the registered manager. A requirement has been made in this regard.

The review of the monthly quality monitoring reports also evidenced inconsistencies in the completion of all sections. This related particularly to the sections pertaining to the numbers of patients/residents accommodated in the home on the day of the visit; and to the section which detailed staff comments, in relation to the quality of the care provided. One report reviewed stated that 'the quality and compliance of records monitored were satisfactory'; however, there was no traceability in relation to which specific records had been reviewed during the visit. An action plan was generated to address predominantly refurbishment matters. A recommendation has been made in this regard.

Areas for improvement

A requirement has been made that the home only accommodates patients within the category of care for whom they are registered.

A recommendation has been made that robust systems are in place to discharge, monitor and report on the delivery of nursing care, in particular, the auditing processes in relation to care records; personal care records; and cleaning records.

A requirement has been made that the monthly quality monitoring visits are undertaken in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

A recommendation has been made that the regulation 29 monthly quality monitoring report is further developed to ensure that there is traceability in regards to the specific records that were examined and include the comments made by staff in relation to the quality of care provided.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Alison Wylie, 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 20 (1) (c) (ii) **Stated:** First time **To be completed by:** 06 January 2016	The registered persons must ensure that nurses' registrations with the NMC are checked on a regular basis. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: NMC registrations are checked 1st day of each month and a copy of registration is printed out to verify registration
Requirement 2 **Ref:** Regulation 15 (2) (a) **Stated:** First time **To be completed by:** 06 January 2016	The registered persons must ensure that the assessment of the patient's needs is kept under review and revised at any time when it is necessary to do so having regard to any change of circumstances. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: The registered manager spoke with nurses about updating care plans with regard to any changes in residents circumstances, care plans are also reviewed through the auditing process
Requirement 3 **Ref:** Regulation 13 (1) (a) **Stated:** First time **To be completed by:** 06 January 2016	The registered persons must ensure that patients' total fluid intake are recorded in the daily progress notes, to evidence validation by registered nurses and to identify any action taken in response to identified deficits. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Fluid balance charts have been put in place and are totalled over a 24 hour period and documented in individual daily evaluation notes, any identified deficits are reported to the nurse receiving hand over report and actioned accordingly
Requirement 4 **Ref:** Regulation 15 (e) **Stated:** First time **To be completed by:** 06 January 2016	The registered persons must ensure that the home only accommodates patients within the category of care for whom they are registered. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: Temporary registration has been applied for to accommodate residents within the category of care

Requirement 5 **Ref:** Regulation 29 (2)(3) **Stated:** First time **To be completed by:** 06 January 2016	The registered persons must ensure that the monthly quality monitoring visits are undertaken in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: Registered provider is carrying out regulation 29 visits at beginning of each month and discusses this with the registered manager at time of visit
Recommendations	
Recommendation 1 **Ref**: Standard 36 **Stated:** Second time **To be completed by:** 06 January 2016	It is recommended that a policy and procedure is developed and should reflect current guidelines for each of the following areas; • Death and dying. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Death and dying policy has been reviewed and amended to include shared rooms
Recommendation 2 **Ref**: Standard 4 Criteria (1)(7) **Stated:** Second time **To be completed by:** 06 January 2016	It is recommended that continence assessments and care plans are reviewed to include all aspects of continence management for example; the type of continence products being use, bowel patterns and type. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: All residents continence assessments and care plans have been reviewed and updated to include all aspects of continence management
Recommendation 3 **Ref**: Standard 38.1 **Stated:** First time **To be completed by:** 06 January 2016	The registered persons should ensure that the recruitment and selection processes are reviewed, to ensure that any gaps in employment are explored and the reasons documented. A record should also be maintained of the Access NI reference numbers and the date received. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Recruitment and selection processes have been reviewed and application forms have been amended to include employment gaps and starter checklists has been amended to include access ni numbers and date received

Recommendation 4 **Ref**: Standard 46.2 **Stated:** First time **To be completed by:** 06 January 2016	The registered persons should ensure that that the cleaning records are further developed to ensure traceability in terms of the specific areas cleaned. The registered manager should also have oversight of the cleaning records, to ensure compliance with best practice in infection prevention and control. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Cleaning records have been reviewed and updated and are reviewed in the monthly auditing process
Recommendation 5 **Ref**: Standard 44.1 **Stated:** First time **To be completed by:** 06 January 2016	The registered persons should ensure that the shelving in the ground floor sluice room is repaired or replaced to ensure that it can be cleaned effectively. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The shelving has been replaced
Recommendation 6 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 06 January 2016	The registered persons should ensure that the format of the falls risk assessment is further developed, to ensure that the level of risk is clearly identified. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The falls auditing process has been reviewed and amended to include a falls risk assessment tool to include low, medium or high risk
Recommendation 7 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 06 January 2016	The registered persons should ensure that the consistency of patients who require a modified diet is specified in the patients' care plan. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Care records have been reviewed and updated to include modified diets and is included in the auditing process
Recommendation 8	The registered persons should ensure that the process for discussing

Ref: Standard 4.1 **Stated:** First time **To be completed by:** 06 January 2016	care plans with patients and/or their representatives is reviewed to ensure that they are facilitated to participate in all aspects of reviewing outcomes of care, on a regular basis. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Allocation of residents have been reviewed and staff nurses are to discuss care records with residents / relatives on a monthly basis

Recommendation 9 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 06 January 2016	The registered persons should ensure that the systems for recording personal care delivery, which includes bathing and skin checks, are reviewed to ensure that the contemporaneous records of all nursing interventions are maintained within the patient care record. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Personal care register is in place for each individual resident and this is monitored daily by the nurse in charge
Recommendation 10 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 06 January 2016	The registered persons should ensure that a record is maintained to evidence the decision making process regarding the provision of activities and events for patients accommodated in the nursing home. This record should include the level of participation and enjoyment and the activities provided to patients who cannot or do not wish to partake in group activities. **Ref: Section 4.5**
	Response by registered provider detailing the actions taken: Activity records have been reviewed and updated to include the level of participation and enjoyment and the activity provided to residents who cannot or do not wish to partake in group activity.
Recommendation 11 **Ref**: Standard 35.4 **Stated:** First time **To be completed by:** 06 January 2016	The registered persons should ensure that robust systems are in place to discharge, monitor and report on the delivery of nursing care, in particular, the auditing processes in relation to care records; personal care records; and cleaning records. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: Auditing documentation has been amended to include care records, cleaning records personal care records
Recommendation 12	The registered persons should ensure that the regulation 29 monthly

Ref: Standard 35 **Stated:** First time **To be completed by:** 06 January 2016	quality monitoring report is further developed to ensure that there is traceability in regards to the specific records that were examined and include the comments made by staff in relation to the quality of care provided. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: Regulation 29 has been reviewed and amended to include traceability in specific records that were examined and includes comments made by staff in relation to the quality of care provided.

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