Unannounced Care Inspection Report
30 September 2016

Apple Blossom Lodge

Type of Service: Nursing Home
Address: Apple Blossom Lodge, 62 Drumilly Road, Armagh, BT61 8RH
Tel no: 02838891202
Inspector: Sharon Mc Knight

1.0 Summary

An unannounced inspection of Apple Blossom Lodge took place on 30 September 2016 from 10 00 hours to 17 40 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, staff registration status with their professional bodies and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. The safe disposal of shapes was not managed in accordance with best practice. A requirement was made.

Areas for improvement where also identified with the recording of Access NI records and the registered managers oversight of competency and capability assessments for nurses who were given the responsibility of being in charge of the home in the absence of the registered manager. Two recommendations were made.

Is care effective?

We reviewed the systems and processes in place which support effective care delivery.

Following a review of care records areas for improvement were identified; three recommendations were made.

We examined the systems in place to promote effective communication and were assured that these systems were robust. Staff and patients spoken with explained that a meeting was held every morning with patients and staff. The routine for the day was agreed at this meeting and which patients, supported by staff, would undertake which tasks in the home. Patients reported that they look forward to the daily meeting.

Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly supporting patients' in their daily routine. Patients spoken with commented positively in regard to the care and support they received. We spoke with the relatives of two patient; both were very satisfied with the standard of care and communication in the home. There were no weaknesses or areas for improvement identified in the delivery of compassionate care.

Is the service well led?

There was a clear organisational structure and staff were aware of their roles and responsibilities. A review of care confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide.

The registered manager explained that they had regular, daily contact with the patients and visitors and were available, throughout the day, to meet with both on a one to one basis if needed. Patients spoken with confirmed that the registered manager was approachable and regularly available in the home to speak with. 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 acting manager was off duty.

We reviewed the governance arrangements and the systems in place to monitor and report on the delivery of nursing and other services. Two requirements were made with regard to the auditing of care records and the completion of the unannounced monthly monitoring visits required in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

An area for improvement was identified with the recording of complaints. A recommendation was made.

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	**3**	**7**

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Heather Maxwell, 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 premises inspection

The most recent inspection of the home was an announced estates inspection undertaken on 7 June 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: Christopher Walsh	**Registered manager:** Heather Joan Maxwell
Person in charge of the home at the time of inspection: Heather Maxwell	**Date manager registered:** 29 January 2015
Categories of care: NH-DE, NH-MP, NH-MP(E)	**Number of registered places:** 37

3.0 Methods/processes

Prior to inspection we analysed the following records:

- notifiable events 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 plan (QIP) from the previous care inspection
- the previous care inspection report.

During the inspection we met with the majority of patients generally, two registered nurses, four care, the activity therapist and two patients' relatives.

Ten questionnaires were also issued to relatives and staff with a request that they were returned within one week from the date of this inspection.

The following information was examined during the inspection:

- three patient care records
- staff duty roster for the week commencing 26 September 2016
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- complaints and compliments records
- incident and accident records
- records of audit
- records of staff meetings
- reports of monthly quality monitoring visits.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 7 June 2016.

The most recent inspection of the home was an unannounced 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 28 January 2016.

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 32.1 **Stated:** Second time **To be Completed by:** 10 March 2016	It is recommended that end of life arrangements for patients are discussed and documented as appropriate, and includes patients' wishes in relation to their religious, spiritual and cultural needs.	**Met**
	Action taken as confirmed during the inspection: A Palliative care register was in place which evidenced discussion with patients/relatives regarding end of life wishes, for example preferred place of death and spiritual requests. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 44.14 **Stated:** First time **To be Completed by:** 10 March 2016	It is recommended that arrangements for ventilation in the smoking room are reviewed, and upgraded if necessary, to ensure there is adequate ventilation in the smoking room and to prevent contamination of adjacent communal areas and rooms with smoke.	**Met**
	Action taken as confirmed during the inspection: The staff member employed to oversee the day to day maintenance of the home confirmed that modifications to the extractor fans had been completed. Staff reported an improvement in the ventilation of the smoke room. There was no smell of smoke in the adjacent areas. This recommendation has been met.	

Recommendation 3 **Ref**: Standard 3.2 **Stated:** First time **To be Completed by:** 25 February 2016	It is recommended that for any patient, who continually refuse nursing or medical intervention staff in the home should request a capacity assessment to be completed by a relevant healthcare professional. **Action taken as confirmed during the inspection**: The registered manager and clinical lead confirmed that for any patient who continually refuse nursing or medical intervention they would request a capacity assessment to be completed by a relevant healthcare professional.	**Met**
Recommendation 4 **Ref**: Standard 21.1 **Stated:** First time **To be Completed by:** 25 February 2016	It is recommended that when prescribed care is refused on an ongoing basis, for example, medications, that the registered nurses regularly update the relevant healthcare professional of the patients continued non-compliance. **Action taken as confirmed during the inspection**: Registered nurses spoken with were knowledgeable regarding the importance of informing the relevant healthcare professionals if patients are continually non-compliant with care. A review of one patient's care records evidenced that the GP had been informed of the patient's refusal. This recommendation has been met.	**Met**
Recommendation 5 **Ref**: Standard 12 **Stated:** First time **To be Completed by:** 25 February 2016	It is recommended that the dining experience is reviewed to ensure that it is a positive experience for patients. This review should include the environment of the dining rooms. **Action taken as confirmed during the inspection**: We observed the serving of lunch. The tables were set prior to the serving of lunch and a range of condiments were provided. The dining room on the ground floor had been decluttered and there was no inappropriate storage of furniture. There was a relaxed atmosphere and the patients were satisfied with the meals served. This recommendation has been met.	**Met**

4.3 Is care safe?

The registered manager confirmed the current occupancy of the home and the planned daily staffing levels. They advised that these levels were subject to regular review to ensure the assessed needs of the patients were met. The registered manager provided examples of the indicators used to evidence that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for week commencing 26 September 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff, staffing rosters confirmed that administrative, catering, domestic, laundry and maintenance staff were on duty daily. There was also an occupational therapist (OT) to support patients with individual life skills, in keeping with the recovery model within the home. They also provided structured activities for other patients. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Patients commented positively regarding the staff and care delivery.

We also sought patient and relative opinion on staffing via questionnaires; four patients returned their questionnaires in time for inclusion in this report. Two patients indicated that there was sufficient staff available, one patient commented that they would like to see more staff. Patients provided comments related to their individual experience of staff. All of the comments provided were shared with the registered manager who agreed to examine the issues further.

Two staff questionnaires were returned in time for inclusion in this report. One agreed that there were sufficient staff to meet the needs of the patients; the other commented that due to staff sickness some shifts were not covered. This comment was also shared with the registered manager who confirmed that action would be taken to attempt to replace staff who reported sick at short notice but it was not always possible to cover the shift.

Staff spoken with were aware that a nurse was identified to be in charge of the home when the registered manager was off duty. The nurse in charge of the home was clearly identified on the staffing roster.

A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the registered manager. The assessments were completed and signed by the clinical lead. When the process has been completed the registered manager should review the assessment to satisfy themselves that the nurse was competent to take charge of the home. A recommendation was made.

We reviewed two personnel files. One file contained the date and the unique certificate number of the Access Ni check; there was nothing recorded on the other file. This was discussed with the registered manager who confirmed that Access NI checks were arranged and maintained by the Human Resources (HR) officer for Care Circle. Prior to commencement of employment they would confirm with the administrator in the home that the outcome of the Access NI check had been received and if employee was ready to commence employment. No records were provided to the home. We spoke with the HR officer who confirmed that this was the current practice. Written confirmation of the outcome of the Access NI check and the date received should be provided to the registered manager and recorded in the recruitment records to evidence that the process has been completed prior to the candidate commencing employment. A recommendation was made.

The arrangements in place to confirm and monitor the registration status of registered nurses with the Nursing and Midwifery council (NMC) and care staff registration with the Northern Ireland Social Care Council (NISCC) were discussed with the registered manager. A review of records evidenced that the arrangements for monitoring the registration status of registered nurses were appropriately managed. The date of the registration expiry was recorded for each nurse.

The record of staff registered with the NISCC included the staff name and individual certificate registration number; there were no expiry dates recorded. A copy of each staff member's registration, downloaded from the NISCC website was held. The administrator explained that an alert e mails were received from the NISCC when someone was due to pay their annual fee or renewal their registration. The dates staff are due to renew their registration with the NISCC, and pay their annual fee, should be maintained in the home to allow the registered manager to be proactive in supporting staff to renew their registration. A recommendation was made.

Discussion with the registered manager and staff and a 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 programme included a written record of the areas completed and the signature of the person supporting the new employee. We discussed the importance of the registered manager signing the completed induction programme to evidence oversight of the induction process.

Mandatory training was provided by the home in classroom based sessions. Systems were in place to monitor staff attendance and compliance with training. Training opportunities were also provided by the local health and social care trust. The registered manager confirmed that when they receive notification of training from the Trust the dates would be displayed in the home and staff would be encouraged to attend. Staff spoken with confirmed that they were provided with a range of training. Staff spoken with were of the opinion that the training provided was relevant to their role and responsibilities within the home. In one returned questionnaire a staff member commented that the training could be improved in relation to care delivery. This comment was shared with the registered manager.

Review of three patients' care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk.

The registered manager and staff clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. The registered nurses and care staff were aware of whom to report concerns to within the home. Annual refresher training was considered mandatory by the home.

A review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The home was fresh smelling, clean and appropriately heated. Both of the staff responses we received in the returned staff questionnaires confirmed that this was normal for the home. We observed in one nursing office a box for the safe disposal of sharps. The closure on the box was not engaged and the box had been overfilled with items, mainly used disposable razors, which were protruding from the top of the box. Safe arrangements for the disposal of sharps must be adhered to by staff. A requirement was made. We reviewed the storage of the sharps box in another location and observed that the box was stored closed and was appropriately filled.

Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas for improvement

Completed competency and capability assessment for any nurse who is given the responsibility of being in charge of the home in the absence of the registered manager should be signed by the registered manage to confirm that they are satisfied that the nurse is competent to take charge of the home.

Written confirmation of the outcome of the Access NI check and the date received should be provided to the registered manager and recorded in the recruitment records to evidence that the process has been completed prior to the candidate commencing employment.

The dates staff are due to renew their registration with the NISCC, and pay their annual fee, should be maintained in the home to allow the registered manager to be proactive in supporting staff to renew their registration.

Safe arrangements for the disposal of sharps must be adhered to by staff.

Number of requirements	1	Number of recommendations	3

4.4 Is care effective?

We reviewed one patient's care records with regard to the prevention of pressure ulcers and the repositioning of patients. A risk assessment was completed and identified the level of risk for this patient as moderate. There were no care plans in place to prescribe the care required to minimise the risk of the patient developing pressure ulcers. Where a patient is assessed as at risk of pressure damage, a documented pressure damage prevention and treatment care plan must be drawn up. A recommendation was made. The patient had a range of risk assessments and care plans in place to meet other identified needs

We reviewed the management of wound care for another patient. A care plan was in place to direct the care required. An open wound assessment chart to record an assessment of the wound at each dressing change was also in place. This chart however had not been completed at each dressing renewal. Some dressing renewals were recorded in the daily evaluation notes and contained less information in regard to the condition of the wound. The dimensions of the wound were not consistently recorded across the records.

The repositioning charts completed for both these patients did not evidence regular repositioning.

Contemporaneous records should be maintained of all nursing interventions carried out with each patient. The following improvements in care records are recommended:

- the recording of wound care should be reviewed to ensure information is consistently recorded
- repositioning charts must be completed to evidence that patients are being repositioned regularly.

The recorded evaluation of care plans varied between the two care records; some staff commented on the patient's condition since the previous evaluation and others recorded "no change to care plan." The need to ensure that evaluations contain a meaningful statement of the patient's condition since the previous review was discussed and a recommendation was made.

A general review of a third care record evidenced that a comprehensive, holistic assessment of patients' nursing needs was completed and contained good detail of the patient's individual needs. A range of care plans were generated to the meet the individual needs of the patient. As previously discussed a range of validated risk assessments were also completed as part of the admission process. Care records were regularly reviewed and updated, as required.

All of the care records reviewed reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), podiatry and dieticians. Staff demonstrated an awareness of the importance of patient confidentiality in relation to the storage of records.

There was evidence within the care records of ongoing communication with relatives. Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Discussion with the registered manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Observations evidenced that patients' needs were responded to promptly and those requesting assistance in the lounge areas or their bedrooms were responded to appropriately. Staff and patients spoken with explained that a meeting was held every morning with patients and staff. The routine for the day was agreed at this meeting and which patients, supported by staff, would undertake which tasks in the home. Patients reported that they look forward to the daily meeting.

The registered manager confirmed that staff meetings were held regularly with staff. The most recently recorded meeting was a meeting with the registered nurses held on 22 September 2016. Prior to this, a general staff meeting took place on 11 August 2016. Minutes of these meetings, detailing who had attended and the areas discussed, were available. In one returned questionnaire the staff member answered "no" to the questions "are there regular team meetings?" and indicated that the issues and actions agreed were not shared if they were unable to attend the meeting. This opinion was shared with the registered manager.

Staff advised that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff confirmed that if they had any concerns, they would raise these with the registered manager or clinical lead.

Areas for improvement

Where a patient is assessed as at risk of pressure damage, a documented pressure damage prevention and treatment care plan should be drawn up.

Contemporaneous records should be maintained of all nursing interventions carried out with each patient.

Care plan evaluations should contain a meaningful statement of the patient's condition since the previous review.

Number of requirements	0	Number of recommendations	3

4.5 Is care compassionate?

Observations throughout the inspection evidenced that staff strived to maintain a calm, consistent atmosphere in the home. Staff were observed responding to patients' needs and requests promptly and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding patients' likes and dislikes and individual preferences. Staff also demonstrated a sound knowledge of potential triggers for unsettled behaviour for a number of patients.

Patients spoken with were generally satisfied with the support they were receiving. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. The staff confirmed that whilst socialisation between patients was promoted, each had a choice as to how they spent their day and where they preferred to sit throughout the day. Staff were knowledgeable of the potential for friction between identified patients and provided examples of action they could take to minimise the risk of incidents.

We spoke with the relatives of two patients who confirmed that they were made to feel welcome into the home by all staff. They were confident that if they raised a concern or query with the registered manager or staff, their concern would be addressed appropriately.

Thank you cards and compliments had been received from relatives and friends of former patients. The following comment was recorded in a thank you card received:

"We would like to thank you all from the bottom of our heart for looking after …and making his last few days as comfortable as possible."

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. The registered manager has regular, daily contact with the patients and visitors and was available, throughout the day, to meet with both on a one to one basis if needed. Patients spoken with confirmed that they knew who the registered manager was and that she was regularly available in the home to speak with. As previously discussed meeting took place each morning with patients, supported by staff, where patients were encouraged to discuss their goals for the day and the daily routine.

We met with one patient who explained that each morning staff agreed a daily timetable of his day with him. The timetable was written on a board in the patient's bedroom. The time table included any activities the patient wanted to participate in that day, tasks to be undertaken and any trips out. We discussed the benefits of the timetable with the patient who explained that it provided him with a structure for the day and reduced the risk of him becoming agitated as he

knew what he would be doing and, more importantly, when he would be doing it. Staff also explained that the timetable could act as a motivational tool encouraging patients to undertake tasks, for example their laundry, prior to completing task that they enjoyed more. Staff were knowledgeable of the necessity for patients to participate with the initiative on a voluntary basis.

We met with the OT who explained that they facilitated both group and individual activity sessions based around the patients' current needs, hobbies and previous past times. An initial assessment was completed on admission and identified areas the patients required support with, communication needs, interests and the goals they wanted to achieve. The OT explained that these assessments would be reviewed with the patients a minimum of six monthly.

Staff and patients continued to value the presence of the animals; pigs, goats, ducks and chickens were accommodated in the fields at the front of the home. Staff reported that over the summer the patients and staff had undertaken a project to improve the habitat of the ducks.

Ten patient questionnaires were issues; four were returned. Three of the patients responded that they were satisfied with the care they were receiving; one patient indicated that his needs were not met promptly and stated that he was unsatisfied with the delivery of effective care. All of the respondents included comments of their opinion of their care. The comments were individual to each patients situation. All of the comments were shared with the registered manager who agreed to review the comments and action as appropriate.

Ten relative questionnaires were issued; none were returned within the timescale for inclusion in this report.

Ten questionnaires were issued to staff; two were returned within the timescale for inclusion in this report. Both staff were of the opinion that the delivery of safe, effective and compassionate was either excellent or good. One comments provided re staffing is discussed in section 4.3.

Areas for improvement

No areas for improvement with the delivery of compassionate care were identified during the inspection.

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

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the home. Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home.

Staff spoken with were knowledgeable regarding the line management arrangements and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty.

The registered manager explained that they had regular, daily contact with the patients and visitors and were available, throughout the day, to meet with both on a one to one basis if needed. It was obvious as the registered manager showed us around the home that the patients were familiar with her.

Patients spoken with confirmed that the registered manager was approachable and regularly available in the home to speak with. We also sought patient, relative and staff opinion on leadership in the home via questionnaires. As previously discussed in section 4.5; no completed relative questionnaires were received. The four patients who completed questionnaires indicated that they were satisfied that the home was well led. Individual comments regarding the availability of the manager were shared with the registered manager.

We discussed the management of complaints with the registered manager who explained that any issues are investigated and a response provided to the patient. There were no recorded complaints in the complaints record. This was discussed with the registered manager who explained that if a record of a complaint was made this would be in the patient's care record. No system was in place to provide an oversight of the minor issues/complaints raised. We discussed at length with the registered manager the definition of a complaint and what is required to be recorded in keeping with standard 16 of the DHSSP Care Standards for Nursing Homes, April 2015. A recommendation was made.

There were arrangements in place to receive and act on health and safety information, urgent communications, safety alerts and notices; for example from the Northern Ireland Adverse Incident Centre (NIAIC).

The registered manager discussed the systems in place to monitor the quality of the services delivered. A programme of audits was completed on a monthly basis. Areas for audit included medications and the occurrence of accidents and incidents. Given the issues identified with the care records we discussed the auditing arrangements. The registered manager explained that the clinical leads in each unit were responsible for the auditing care records. We discussed the auditing arrangements with the other clinical lead who explained that they did not complete formal audit but as they used the care records daily they would identify any deficits on a day to day basis. There were no issues identified with care records this clinical lead had responsibility for. One of the two clinical lead posts was vacant at the time of the inspection. Due to the issues with care records in the identified unit it was agreed that the registered manager would undertake regular audits to ensure care records are maintained in accordance with best practice. The audit process must include a re-audit of the identified areas for improvement to check compliance has been achieved. A requirement was made.

A review of the arrangements for the unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 evidenced that for the period April – September 2016 no visits had been completed in April or July. A report, with an action plan was received by the registered manager following the visits. There was evidence in the reports of review of the previous month's action plan. Staff spoken with informed us that sometimes they received prior notice of the visits. The registered provider must ensure that an unannounced visit is undertaken monthly to monitor the quality of services provided. A requirement was made.

Areas for improvement

Records of all complaints should be maintained in accordance with the DHSSPS Care Standards for Nursing Homes, April 2015, standard 16.

Regular audits must be undertaken to ensure care records are maintained in accordance with best practice. The audit process must include a re-audit of the identified areas for improvement to check compliance has been achieved.

An unannounced visit must be undertaken monthly to monitor the quality of services provided.

Number of requirements	2	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Heather Maxwell, 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 nursing.team@rqia.org.uk 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 13(4) **Stated:** First time **To be completed by:** 28 October 2016	The registered provider must ensure that safe arrangements for the disposal of sharps are adhered to by staff. **Ref section 4.3**
	Response by registered provider detailing the actions taken: Clinical areas are checked daily. All staff aware of safe disposal arrangements and in particular the non overfilling of sharps boxes. Separate sharps disposal boxes are currently being arranged for the disposal of all razors
Requirement 2 **Ref:** Regulation 12(1)(b) **Stated:** First time **To be completed by:** 28 October 2016	The registered provider must ensure that regular audits are undertaken to ensure care records are maintained in accordance with best practice. The audit process must include a re-audit of the identified areas for improvement to check compliance has been achieved. **Ref section 4.6**
	Response by registered provider detailing the actions taken: Regular audits are undertaken. Paper evidence of this is now in place
Requirement 3 **Ref:** Regulation 29(3) **Stated:** First time **To be completed by:** 28 October 2016	The registered provider must ensure that an unannounced visit is undertaken monthly to monitor the quality of services provided. **Ref section 4.6**
	Response by registered provider detailing the actions taken: Provider visits had been inadvertantly announced. These are now unanounced and monthly
Recommendations	
Recommendation 1 **Ref**: Standard 41.7 **Stated:** First time **To be completed by:** 28 October 2016	It is recommended that the completed competency and capability assessment for any nurse who is given the responsibility of being in charge of the home in the absence of the registered manager should be signed by the registered manage to confirm that they are satisfied that the nurse is competent to take charge of the home. **Ref section 4.3**
	Response by registered provider detailing the actions taken: All Nurses in charge of the home had a competency assessment in place. Senior Nurses (Clinical Leads) were signed by the Registered Manager. Staff Nurses by Clinical Leads. They had beed checked and filed in the Managers office by the Manager. The Manager has now signed all competenies

Recommendation 2 **Ref**: Standard 38 **Stated:** First time **To be completed by:** 29 October 2016	It is recommended that written confirmation of the outcome of the Access NI check and the date received are provided to the registered manager and recorded in the recruitment records to evidence that the process has been completed prior to the candidate commencing employment. **Ref section 4.3**
	Response by registered provider detailing the actions taken: Written confirmation of the outcome od Access NI checks are now received by the Manager and retained at a local level within the personell file
Recommendation 3 **Ref**: Standard 35.6 **Stated:** First time **To be completed by:** 29 October 2016	It is recommended that the date staff are due to renew their registration with the NISCC, and pay their annual fee, should be maintained in the home. **Ref section 4.3**
	Response by registered provider detailing the actions taken: Documentation has been reviewed to include the date staff are due to renew their registration.
Recommendation 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 28 October 2016	It is recommended that where a patient is assessed as at risk of pressure damage, a documented pressure damage prevention and treatment care plan should be drawn up. **Ref section 4.4**
	Response by registered provider detailing the actions taken: Where a patient is assessed as at risk of pressure damage, care plans are in place. On the day of the inspection the care plan did not include advice from the TVN. All careplans now clearly reflect advice from other professionals involved in their care.
Recommendation 5 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 28 October 2016	It is recommended that contemporaneous records are maintained of all nursing interventions: • The recording of wound care should be reviewed to ensure information is consistently recorded. • Repositioning charts should be completed to evidence that patients are being repositioned regularly. **Ref section 4.4**
	Response by registered provider detailing the actions taken: All staff are aware of record keeping requirements. Dopcumentation is checked on a daily basis

Recommendation 6 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 28 October 2016	It is recommended that review of prescribed care interventions should include a meaningful statement of the patient's condition since the previous review. **Ref section 4.4**
	Response by registered provider detailing the actions taken: All reviews now include a meaningful statement of the residents condition including an outcomes based assessment of the effectiveness of the intervention.
Recommendation 7 **Ref**: Standard 16.11 **Stated:** First time **To be completed by:** 28 October 2016	It is recommended that records of all complaints are maintained in accordance with the DHSSPS Care Standards for Nursing Homes, April 2015, standard 16. **Ref section 4.6**
	Response by registered provider detailing the actions taken: Records of all complaints are maintained in accordance with DHSSPS Care Standards for Nursing Homes 2015 Standard 16.

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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