Unannounced Care Inspection Report
6 & 8 July 2019

Valley Nursing Home

Type of Service: Nursing Home
Address: 8 Tullybroom Road, Clogher, BT76 0UW
Tel No: 028 8554 8048
Inspectors: Kate Maguire, James Laverty and Laura O'Hanlon

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

1.0 What we look for

2.0 Profile of service

This is a nursing home which is registered to provide nursing care and residential care for up to 96 persons. Patients' bedrooms are located within two buildings. The 'Main House' comprises three distinct units: one unit providing care for people requiring frail elderly nursing care, one unit for people living with dementia and one unit for people living with a brain injury. The adjacent building (Tullybroom House) provides care for people living with dementia.

3.0 Service details

Organisation/Registered Provider: Valley Nursing Home (MPS) Ltd **Responsible Individual:** Paul Warren-Gray	**Registered Manager and date registered:** No registered manager in place – see section 6.3 for further details
Person in charge at the time of inspection: There was no designated nurse in charge of the home at the time of the inspection. The deputy manager was contacted by staff following our arrival and chose to attend the inspection.	**Number of registered places:** 96
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. MP – Mental disorder excluding learning disability or dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 85 A maximum number of 58 patients in category NH-DE, in addition 2 persons may receive care on a day basis only in Tullybroom House and 2 persons who do not require bath/shower facilities may receive care on a day basis only in the Dementia Unit (Main House). There shall be a maximum of 4 named residents receiving residential care in category RC-DE and 4 named residents receiving residential care in category RC-A

4.0 Inspection summary

An unannounced inspection took place on 6 July 2019 and 8 July 2019.

This inspection was undertaken following information received via the RQIA duty desk. The issues highlighted raised concerns relating to some aspects of care delivery to patients, the quality of the internal environment and staff practices.

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.

Significant concerns were identified with regard to the provision of person centred care to patients; the internal environment; infection prevention and control (IPC) practices; governance and management oversight within the home, the dining experience of patients, and the provision of activities / social stimulation for patients.

As a consequence, a meeting was held on 10 July 2019 in RQIA with the intention of issuing nine failure to comply notices under The Nursing Homes Regulations (Northern Ireland) 2005, in relation to:

- Regulation 8 (1) (a) relating to managerial arrangements
- Regulation 12 (1) (a)(b) relating to the dining experience of patients
- Regulation 13 (1) (a)(b) relating to care delivery to patients
- Regulation 13 (7) relating to infection prevention and control practices
- Regulation 18 (2) (n)(i) relating to the provision of activities/social stimulation to patients
- Regulation 15 (1) (e) relating to care delivery for one identified patient
- Regulation 20 (1) (a) relating to staffing arrangements
- Regulation 27 (1) (2) (b)(c)(d)(m) relating to the internal environment
- Regulation 29 (1) relating to governance oversight/monthly monitoring visits

The meeting was attended via teleconference by Mr Paul Warren-Gray, Responsible Individual, the deputy manager and other members of the nursing home's senior management team.

At the meeting the home's representatives were given an opportunity to submit any actions or plans they had implemented since the inspection. RQIA received some assurance that actions had been taken regarding some of the deficits highlighted. It was decided that failure to comply notices would not be served under Regulations 15 (1) (e) and 20 (1) (a).

However, during the meeting RQIA did not receive the necessary assurance required in relation to the other areas requiring improvement. It was therefore decided that one failure to comply notice would be issued under Regulation 8 (1) (a), with the date of compliance to be achieved by 30 July 2019. A second failure to comply notice under Regulation 13 (7) would be issued, with the date of compliance to be achieved by 30 July 2019. A further five failure to comply notices would also be issued under Regulations 12 (1) (a)(b), 13 (1) (a)(b), 18 (2) (n)(i), 27 (1) (2) (b)(c)(d)(m) and 29 (1), with the date of compliance to be achieved by 16 September 2019.

Due to the focus of the inspection, the majority of the areas for improvement arising from the previous care inspection on 7 June 2019 were not reviewed and have been carried forward to the next inspection. Two areas for improvement from the previous care inspection have been subsumed into relevant failure to comply notices.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	*4	*4

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

Details of the Quality Improvement Plan (QIP) was discussed with Louise Hughes-McKenna, Deputy Manager, as part of the inspection process on 6 July 2019. Feedback was further provided to Louise Hughes-McKenna, Deputy Manager and Kim Truscott, Regional Manager,

as part of the inspection process on 8 July 2019. The timescales for completion commence from the date of inspection.

Enforcement action resulted from the findings of this care inspection. Seven failure to comply notices were issued under The Nursing Homes Regulations (Northern Ireland) 2005 as follows:

FTC Ref: FTC000063 with respect to Regulation 27(1)(2)(b)(c)(d)(m)
FTC Ref: FTC000064 with respect to Regulation 8 (1)(a)
FTC Ref: FTC000065 with respect to Regulation 12(1)(a)(b)
FTC Ref: FTC000066 with respect to Regulation 13(1)(a)(b)
FTC Ref: FTC000067 with respect to Regulation 13(7)
FTC Ref: FTC000068 with respect to Regulation 18 (2)(n)(i)
FTC Ref: FTC000069 with respect to Regulation 29(1)

The enforcement policies and procedures are available on the RQIA website.
https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information, previous management arrangements, and any other written or verbal information received.

During our inspection we:

- where possible, speak with residents, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

The following records were examined and/or discussed during the inspection:

- care records for one patient
- supplementary repositioning records for one patient

During the inspection, inspectors met with both patients and staff. We observed practice and interactions between staff and patients. We walked through the nursing home including bedrooms, lounges, dining areas and bathrooms. We also observed the provision of meal and snack times.

The findings of the inspection were provided to the deputy manager of the home who attended on 6 July 2019. On 8 July feedback was provided to the deputy manager, Louise Hughes-McKenna and Kim Truscott, Regional Manager.

6.0 The inspection

6.1 Review of outstanding areas for improvement from previous inspection(s)

Due to the specific focus of this inspection which was in response to concerns received by RQIA on 5 July 2019, the majority of areas for improvement identified at the previous care inspection have not been reviewed during this inspection. These will be reviewed at a future care inspection and are included in the QIP at the back of this report.

However, two areas for improvement arising from the previous care inspection, were reviewed as part of this inspection and not met. These areas for improvement have been subsumed into the relevant Failure to Comply Notices issued by RQIA on 16 July 2019.

6.2 Inspection findings

6.3.1 Managerial arrangements

On arrival to the home on Saturday 6 July 2019 we were granted access by a member of the nursing team who was identified as the nurse in charge of the unit providing care to those patients living with dementia. Discussion with nursing staff during the inspection highlighted that while there were nurses in charge of the individual units throughout the home, there was no designated nurse in charge of the entire home. Staff also informed us that a senior manager, who was based in England, was providing on-call support if needed. However, feedback from staff highlighted that there was no clear process in place to determine which nurse on duty had overall responsibility for contacting the on-call manager, if required.

Following our arrival, the deputy manager arrived and advised us that at present, there was no appointed manager for the home. The deputy manager advised us that in the absence of a manager, she was responsible from some aspects of managerial oversight and governance within the home in addition to her clinical duties as the deputy manager. However, given the scope and range of governance oversight required to ensure the effective care delivery to patients, these managerial arrangements were considered to be inadequate. Discussion with the deputy manager further highlighted that while she was aware of some of the deficits highlighted, such as the poor internal environment, she was unaware of any robust measures to address these failings. It is essential for robust management arrangements that a manager is identified for the home and appointed in a supernumerary capacity to allow them to drive the necessary improvements required.

In view of the insufficient managerial arrangements noted during the inspection, a Failure to Comply Notice was served.

6.3.2 Internal environment

During our inspection of the 'main building' on 6 July 2019 and of Tullybroom House on 8 July 2019, we observed that the décor in several areas was tired, neglected and unclean. The following deficits were noted within patient areas:

- exposed electrical wiring which was partially and ineffectively covered within a corridor area
- items of patient furniture were visibly and notably worn in some areas, for example, chairs in communal lounges were worn and frayed within the dementia unit, and a sample of bedroom furniture such as bed frames and/or chests of drawers were chipped and/or in disrepair across all three units of the 'main building'
- carpets within two identified communal lounges within the 'main building' were dirty, stained and had a fusty malodour
- carpets on two identified stairwells within the dementia unit were significantly worn and stained. Feedback from domestic staff highlighted that these carpets had been in this condition for several years despite repeated and unsuccessful attempts by domestic staff to clean them to a satisfactory standard
- a strong and persistent malodour of urine was noted within one identified communal bathroom within the brain injury unit
- flooring within one identified communal bathroom was visibly stained and in poor condition within the brain injury unit. Fixtures and fittings within this bathroom were also noted to be broken and/or missing
- corridors and communal lounges within the brain injury unit and dementia unit were noted to be bare in appearance and lacked adequate stimulation and orientation for patients
- internal damage was noted to the wall of one communal lounge being used by patients within the brain injury unit
- safety checks concerning the securing of wardrobes was incomplete and out of date in one bedroom within the dementia unit
- two quantities of foul smelling and rancid fruit were found by inspectors within one patient's bedroom. Staff were unaware of the presence of this fruit despite the strong malodour caused by the rancid fruit
- one wall mounted soap dispenser was found to be broken and unclean
- three patients' bedrooms within the dementia unit had a duvet cover in place with no duvet. Staff who were spoken with about this were unable to explain why duvets were not in place
- in relation to the brain injury unit, one dresser within a communal lounge was in disrepair while a dresser within another communal lounge, was unclean and used to store crumpled up papers
- a number of bedrail protectors were found to be stained and/or torn

We also noted that bed linen within a patient's bedroom located in the dementia unit was unclean. In addition, a fitted sheet within the frail elderly unit was being used by staff on a patient's bed despite being significantly torn; further ripped bed linen was also noted on a patient's bed within Tullybroom House on 8 July 2019. Furthermore, during our visit on 6 July 2019, one patient's bed linen was heavily stained with urine and faeces; feedback provided from care staff provided no assurances that they were aware of this or would proactively monitor the condition of patients' bed linen throughout the day.

Due to these deficits, a Failure to Comply Notice was served in relation to the cleanliness and quality of the internal environment.

6.3.3 The dining experience of patients

During the inspection of the main building on 6 July 2019, a member of staff was asked to describe the dining routine for the patients and in doing so used the term “feeders” three times when referring to patients. Another member of staff also used the term ‘feeding time’ with inspectors when describing meal times for patients. It was noted during this visit that clothes protectors were placed on the majority of patients within the dementia unit at the commencement of lunch as a matter of routine rather than in a timely and person centred manner prior to patients being individually served. This resulted in the majority of patients within this unit standing and/or sitting within the communal lounge wearing clothes protectors despite not having been served their meal. While care staff were observed assisting individual patients with their lunch within this unit, this was necessarily time consuming due to the complex needs of patients. As a result, several patients within the dementia unit had to wait an unduly long period of time before being served and adequately assisted with their lunch. The majority of patients remained seated in the same part of the communal lounge throughout the serving of lunch while two or three other patients walked in and out of a small dining area adjacent to the kitchen entrance. Inspectors were therefore not assured that patients within the dementia unit were being served lunch in a person centred and timely manner or in such a way as to promote a meaningful dining experience which involves social interaction throughout their meal.

Observation of the serving of lunch to patients living within Tullybroom House on 8 July 2019 also highlighted that their dining experience was inadequate. For instance, there was insufficient provision of seating for patients within the dining room if all patients wished to dine together. As a consequence a number of patients were receiving their main meal within the communal day room area. This meant that these patients remained in the same room throughout the day including during mealtimes. All patients were observed to be prepared for their meal with clothing protectors in place. The dining experience was noted to be protracted as staff initially attended to a limited number of patients before becoming available to support other patients requiring assistance with eating and drinking. This resulted in some patients waiting for a lengthy period of time before being able to enjoy their meal in a communal atmosphere with other patients. It was observed that some patients were watching other patients being assisted with their meal and in one instance this was causing a patient to become restless. Feedback from staff did not provide assurance that patients within this part of the home were being assisted with their lunch in a person centred and timely manner. Two patients were also observed being served their lunch at approximately 13.45 despite the serving of meals commencing at 12.30.

With regard to use of appropriate, compassionate and respectful language when describing patients, it was also concerning that a staff member described one patient as ‘deaf and dumb.’ This referred to a patient who was unable to clearly communicate their needs. Inspectors highlighted to staff that the patient was calling out and asked if they knew what the patient required help with. Inspectors were concerned as to how staff communicated with this patient which was not in keeping with best practice. During discussions with staff, inspectors were told that they didn’t feel that British Sign Language (BSL) would be appropriate for the patient. Other communication strategies such as pictorial prompts to help the patient communicate their needs were suggested by inspectors. While staff told us that they would consider these options, discussions with staff and observation of their interactions with this patient, did not assure us that all potential methods to facilitate effective communication were being proactively explored. This had the potential to negatively impact on the patient’s quality of life, including their daily dining experience.

We also observed staff interactions with a patient within the dementia unit during the serving of lunch. Staff introduced inspectors to the patient and advised that the patient was being served lunch in their bedroom rather than the dining room due to a history of exhibiting loud and disruptive behaviours, which could potentially disturb other patients. Discussion with staff highlighted that their decision to preclude the patient from dining with other patients had been taken on the day of the inspection before the patient exhibited behaviours which may be challenging or disruptive to others. Discussion with staff further highlighted that this approach to care delivery had not resulted from any form of multiprofessional discussion focused on the best way to manage the patient's emotional and psychosocial needs. Staff feedback also highlighted that they had not yet made any referral to the multiprofessional team in respect of assessing and managing the patient's behaviours.

Due to these deficits, a Failure to Comply Notice was served in relation to the dining experience of patients.

6.3.4 Care delivery to patients

During the inspection of the 'main building' on 6 July 2019, one patient was observed being assisted to their bedroom to watch television. From staff feedback and in discussion with the patient, we found that they had significant sight loss. While the deputy manager stated that staff would closely monitor this patient while in their bedroom, feedback from staff on duty within that unit highlighted that they were unaware of the need to do so. Given that the patient was unable to use the nurse call bell independently and the bedroom was a significant distance from where staff were typically located, the safety and wellbeing of the patient could not be consistently maintained.

We also observed one patient who remained in bed until approximately 15.45 and we asked nursing staff to provide an explanation for this. While staff stated that this was the patient's preferred routine, we found no care plan or nursing entries in place to evidence this. One of the patient's care plans referred to them having a "vulnerable sacrum" when describing the condition of their skin. Despite this assessed risk for potential skin breakdown, there was no care plan to direct staff as to when the patient should be assisted into/out of bed or how staff should manage the patient's skin when they express a preference to remain in bed throughout the day. This patient told the inspectors that getting out of bed was "hit and miss" and expressed a desire to be assisted out of bed to inspectors. The patient also stated that they had to "shout for a nurse" if one was needed given their inability to use the nurse call lead. The patient's comments to inspectors were highlighted to staff within the unit and they immediately assisted the patient with getting out of bed. We stressed the need to ensure that person centred care plans are in place which clearly outline patients' preferred rising/retiring routines. It was also highlighted that any deviation from such routines should be clearly evidenced within daily care records and an appropriate explanation provided.

On Saturday 6 July 2019, we observed in all three units within the 'main building' that the majority of patients within communal lounges were seated around the edges of these rooms. The layout of these lounges and the limited interaction by staff with patients did not promote the emotional and/or social stimulation of patients. Several staff who were spoken with demonstrated limited awareness of practical ways in which they could promote a sense of communal interaction between patients. We noted that several patients within one part of the home displayed loud and repetitive behaviours. Feedback from patients and staff within the unit highlighted that other patients found this distressing at times. We were concerned that when

some patients displayed these behaviours within one communal lounge, staff made no attempt to positively manage the situation for either the patient or other patients seated nearby. These repetitive behaviours were observed to continue unaddressed by staff for long periods of time. This was discussed with care staff within the unit who did not employ any appropriate diversional techniques in order to effectively manage the patients' behaviours and emotional needs. Feedback from staff highlighted that they possessed a limited understanding of ways in which such a situation could be effectively managed in the best interests of patients.

We also considered the timely repositioning of patients. While feedback from staff advised that one patient had been repositioned as needed, it was noted that electronic care records did not corroborate this. We discussed this with the nurse who advised that the care records would be suitably updated later in the day. We were concerned that such an approach to documentation means that care delivery is not recorded in a timely manner.

It was noted that staff are provided with electronic handheld devices for documenting various aspects of care delivery to patients. While RQIA welcomes the introduction of any system which allows for accurate and timely recording of care, the need to ensure that it does so in a patient centred manner was highlighted.

The moving and handling of patients was also considered. We observed a patient being transferred from a wheelchair back into a lounge chair within the dementia unit. The battery of the hoist was noted to insufficiently charged in order to allow staff to complete the transfer without delay or interruption. As a result, one of the staff members assisting with the transfer had to walk into another unit in the home to locate a sufficiently charged hoist battery, midway through the procedure. This resulted in the patient having to remain in the hoist sling while staff attempted to replace the required hoist battery. The patient presented as distressed and fearful of what was happening to them; at no stage did either attending staff member explain what was happening or suitably comfort the patient until the inspector asked them to do so.

We saw another patient being assisted from the dining room back to the lounge in a wheelchair despite this patient being ambulant. When staff were asked why they were using the wheelchair, they explained that the patient preferred it. The need for staff to promote patients' physical independence at all times was stressed.

We spoke with one patient within their bedroom. It was noted that the patient had no personal clothing or belongings in their room apart from old greeting cards scattered within their chest of drawers. Inspectors found a foul smell within the bedroom and upon further inspection, located two quantities of rancid fruit. Staff stated that they had been unaware of the rancid fruit and that it was probably brought into the home by the patient's family. Staff also stated that the patient's clothing was located elsewhere due to certain behaviours of the patient which required this arrangement. We were concerned as to the lack of personalisation or stimulation within the patient's bedroom and that staff remained unaware of the unpleasant presence of the rancid fruit despite the strong malodour. In view of the fact that the patient chose to relax within their room during the inspection, staff were asked to address the patient's environment and to remain vigilant regarding the comfort of patients, including those who choose to rest within their bedrooms throughout the day.

Due to these deficits regarding patient care, a Failure to Comply Notice was served.

6.3.5 Infection prevention and control (IPC) practices

On both days of the inspection, a number of significant infection prevention and control deficits were noted throughout the home. A wall mounted hand sanitiser was found to be broken and extensively stained. Patient equipment was incorrectly stored and was unclean; this included items such as commodes and shower chairs. We believe that cross contamination could occur as used and unused bags of clinical waste were stored beside each other.

There were broken and/or chipped fixtures and fittings in several identified patients' bedrooms, making these impossible to clean. Single use medicine cups had been cleaned by nursing staff and were left to dry on a wall radiator. Poor hand washing practices by staff were also noted throughout the home. As referenced in section 6.3.2, rancid fruit was located within one patient's bedroom. Review of the environment also highlighted that several patients' toiletries were stored within a walk in wardrobe located in the bedroom of another patient.

We also observed one instance of nursing staff not employing effective IPC principles when attending to a minor cut sustained by a patient. Furthermore, feedback from care staff highlighted that a communal bathroom within the brain injury unit would not always be consistently cleaned. One such bathroom was found to have a pungent smell of urine and the flooring was visibly stained. This was highlighted to a carer who told us that when domestic staff aren't on duty, "nine times out of 10 this bathroom won't be cleaned if it smells." When stained and soiled bed linen within one patient's bedroom was brought to the attention of staff, a carer stated that they check patients' bedrooms "only if we have time." We were therefore not assured that IPC standards were being effectively maintained.

It was also noted that the corresponding care plan for one patient who had an indwelling urinary catheter lacked sufficient information as to the provision of daily catheter care and/or regular changing of the catheter itself. This lack of effective care planning did not assure us that IPC best practice principles were being maintained with regard to urinary catheter care.

Due to these shortfalls, a Failure to Comply Notice was served.

6.3.6 The provision of activities/social stimulation to patients

During our visit on 6 July 2019, we observed deficits in regard to the consistent and meaningful provision of activities and social stimulation for patients. While it was noted that an activities programme was in place, and displayed within some parts of the home, there was no evidence that staff were implementing any of these formal/informal aspects of care on the day of inspection. Activity signage informed patients and visitors as to the range of scheduled activities which were available from Monday to Friday, although they did not contain information for patients with regard to any such activities at the weekend.

One staff member stated: "There needs to be more activities … (a) few (patients) are taken out a lot more than others … some would love to get out like (patient name)…"

Staff interaction with patients located across all three units of the 'main building' on 6 July 2019 was observed to be largely task focused and limited. One such staff member was observed standing in a communal lounge watching television and showed no initiative in talking with patients who were also seated within the same lounge. This staff member told us that they were unaware of any planned formal/informal activities for the patients during their shift.

One staff member was also overheard abruptly reprimanding a patient for using foul language within a communal area. The inspectors spoke to this patient who enthusiastically shared their life story and was effectively distracted by inspectors from becoming increasingly upset. It was disappointing that staff failed to meaningfully engage with this patient in a manner which would sufficiently stimulate and involve the patient. A staff member in the brain injury unit was also overheard speaking sharply to a patient who had stood up by telling them to "Sit back down." The patient immediately responded in a submissive manner.

On 8 July 2019 one patient was being cared for within a part of the home which was separate from other patients within that unit. The patient was observed by the inspector to be wearing clothing which was in disrepair. Feedback from staff also failed to provide sufficient assurance that the social and emotional needs of the patient were being closely and proactively managed. This was discussed with the responsible individual following the inspection who stated that urgent discussion with the local Health and Social Care Trust was required in regard to the patient's ongoing care needs. The responsible individual agreed to keep RQIA informed of this matter.

We observed staff interactions with patients in communal lounges throughout the home. We saw several instances of staff failing to provide adequate and/or person centred stimulation of patients within these areas. Observation of and feedback from staff within the brain injury unit highlighted that it was not untypical for staff to observe patients from a standing position at the lounge entrance rather than coming alongside seated patients and meaningfully engaging with them. The staff members who were observed watching patients from the lounge entrance were not engaged in any other activity at the time and displayed limited interaction with patients - despite the majority of the patients being seated with no obvious social or emotional stimulation taking place. While a television was switched on within this lounge, the volume was so low as to be inaudible. We spoke to patients within this lounge and while we recognise that they presented with complex care needs, the patients were noted to spontaneously communicate with inspectors. One staff member stated "The lounge today is how it is … staff don't have time …" Another staff member told inspectors "This place would depress me let alone the residents."

On the day of the inspection we noticed that that few patients were involved in any form of informal activities. Through the four hours of the inspection on 6 July 2019, patients were either sitting in the communal lounges with the television on or sitting in their bedrooms. We witnessed the provision of no group activities to patients on 6 July 2019 and feedback from staff highlighted that none were planned by staff for that day.

Within the brain injury unit we were informed by staff that 'Saturday was like any other day' and that the majority of patients would spend most of their day sitting in the communal lounge.

Observation of the internal environment, particularly the dementia and brain injury units, highlighted a lack of adequate stimulation. The décor of these areas was notably bare in character and provided little by way of a homely atmosphere or adequate orientation considering the nature of the assessed needs of the patients who live there. There was also no evidence of consistent personalisation throughout patients' bedrooms within these units.

Due to these shortfalls, a Failure to Comply Notice was served.

6.3.7 Governance oversight/monthly monitoring visits

We were informed by the deputy manager that concerns regarding to the quality of the internal environment had been reported to her senior management team several times although had not yet been addressed. A review of monthly monitoring reports which were submitted to RQIA following the inspection on 8 July 2019 highlighted that while some environmental concerns had been highlighted, they lacked a robust action plan to ensure that the deficits were appropriately remedied. A number of these shortfalls were still unresolved by the time of our inspection on 6 and 8 July 2019.

Staff feedback received during the inspection also highlighted that staff were extremely frustrated with a number of deficits relating to the environment and felt that these had gone unaddressed despite being reported to senior staff. One staff member told inspectors "We're just not valued here as staff … staff (are) totally undervalued."

The monthly monitoring reports also failed to evidence robust quality assurance of other aspects of patient care and service delivery such as: infection prevention and control practices; managerial arrangements within the home; the dining experience of patients; the provision of safe, effective and compassionate care delivery to patients and the provision of activities to patients.

In addition, feedback from the deputy manager highlighted that a number of adult safeguarding investigations remain ongoing within the home. These investigations require the home to comply with a number of measures required by relevant adult safeguarding teams so as to ensure the safety and wellbeing of identified patients. While the monthly monitoring reports viewed did reference these investigations, the information was limited and did not provide assurance that the person conducting the monthly monitoring visit had robustly reviewed ongoing safeguarding arrangements for these identified patients.

Due to these deficits, a Failure to Comply Notice was served.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Louise Hughes-McKenna, Deputy Manager, as part of the inspection process. The findings were also discussed with the responsible individual and his senior management team as referenced in section 4.0. The timescales for improvement commence from the date of inspection.

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

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

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 27 (2) (b) **Stated:** Second time **To be completed by:** 31 August 2019	The registered person shall ensure that the premises both internally and externally are kept in good state of repair. This relates to the uneven surface of the outdoor patient smoking area within the Valley suite. Ref: 4.0 & 6.1
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 2 **Ref:** Regulation 27 (4) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall take adequate precautions against the risk of fire. This is with specific reference to the gaps identified to fire resistant doors. Ref: 4.0 & 6.1
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 3 **Ref**: Regulation 27(2)(t) **Stated:** First Time **To be completed by:** 7 July 2019	The registered person shall, having regard to the number and needs of the patients, ensure that a risk assessment to manage health and safety is carried out on all potential ligature risk points. This is specific to window blinds and curtain tie backs. Ref: 4.0 & 6.1
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.

Area for improvement 4 **Ref:** Regulation 18 (2) (c) **Stated:** First time **To be completed by:** 7 July 2019	The registered person shall having regard to the size of the nursing home and the number of patients provide adequate furniture, bedding and other furnishings suitable to meet the needs of the patients. Overgrown foliage from the window view of identified patient bedrooms must also be removed. An action plan detailing the time frame for completion of these works must be submitted separately when returning the QIP. Ref: 4.0 & 6.1
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Action required to ensure compliance with the applicable Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 4 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that all nursing interventions are appropriate to the individual patients needs and supported by current evidence and best practice guidelines. Specific reference to fluid and repositioning recording charts: • Fluid target should be recorded on daily intake chart over 24 hours. • Frequency of repositioning to be recorded on individual charts. Ref: 4.0 & 6.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 2 **Ref**: Standard 38 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that before making an offer of employment a pre-employment health assessment is obtained in line with guidance and best practice. Ref: 4.0 & 6.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.

Area for improvement 3 **Ref**: Standard 6 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that patients are treated with respect and their right to privacy is upheld. With specific reference to knocking on a patient's bedroom door before entering and establishing if the patient agrees for them to enter. Ref: 4.0 & 6.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 4 **Ref**: Standard 7 **Stated:** First time **To be completed by:** 7 August 2019	The registered person must ensure that each patient in the identified unit has the name and contact details of their care manager located in their bedroom. Ref: 4.0 & 6.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.

Please ensure this document is completed in full and returned via Web Portal

The Regulation and Quality Improvement Authority

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