Unannounced Follow Up Care Inspection Report
16 and 17 December 2019

Valley Nursing Home

Type of Service: Nursing Home
Address: 8 Tullybroom Road, Clogher, BT76 0UW
Tel No: 028 8554 8048
Inspectors: James Laverty, Karen Scarlett, Dermot Walsh Jane Laird and Dermot Parsons

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 from their responsibility for maintaining compliance with legislation, standards and best practice.

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.

1.0 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 (the Valley unit), one unit for people living with dementia (the Lane unit) and one unit for people living with a brain injury (the Amadeus unit). 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:** Gary Foley Interim manager - no registration required
Person in charge at the time of inspection: Gary Foley	**Number of registered places:** 96 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
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:** 75

4.0 Inspection summary

An unannounced inspection took place on 16 December 2019 from 09.40 hours to 18.02 hours, and 17 December 2019 from 12.16 hours to 14.30 hours. Following a previous inspection on 31 October 2019, a meeting was held in RQIA on 4 November 2019 with the intention of issuing and Notice of Proposal to Cancel the Registration of the Responsible Individual in respect of Valley Nursing Home (MPS Ltd). At this meeting an action plan was presented and ongoing monitoring arrangements were agreed. As a result the notice was not issued. This inspection forms part of ongoing monitoring arrangements agreed during this meeting.

We also assessed progress with areas for improvement identified since the previous care inspections in order to determine if the home was delivering safe, effective and compassionate care and if the service was well led. Any areas for improvement not reviewed during this inspection have been carried forward for review at a future care inspection.

Significant concerns were identified with regard to: the internal environment; infection prevention and control (IPC); fire safety practices; Control of Substances Hazardous to Health (COSHH) compliance; care delivery; care records; staff interaction with patients; managerial oversight and governance. Following the inspection, a meeting was held on 20 December 2019 in RQIA with the intention of cancelling the registration of Paul Warren-Gray, the Responsible Individual for the Valley Nursing Home (MPS Ltd.), in respect of the Valley Nursing Home under Article 15 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, (the 2003 Order).

The meeting was attended by Paul Warren-Gray, Responsible Individual, Joel Gray, Chief Executive, Vanessa Davis, Director of Care, Quality and Compliance, and Valerie Atcheson, Management Consultant. RQIA was advised during the meeting of some actions which had been taken immediately and others which were being proposed in relation to the deficits highlighted during this inspection. However, during the meeting RQIA did not receive the necessary assurance required. RQIA decided to issue a Notice of Proposal (NOP) to Cancel the Registration of the Responsible Individual (MPS Ltd) in respect of Valley Nursing Home.

RQIA informed relevant stakeholders including the Trusts, Health and Social Care Board and the Department of Health following the inspection and continue to liaise with them during this process.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	23*	10*

*The total number of areas for improvement under Regulations includes one which has been carried forward for review; five which have been stated for a third time and six which have been stated for a second time. The total number of areas for improvement under the Standards includes two which have been carried forward for review; one which has been stated for a third time and three which have been stated for a second time. Three areas for improvement previously made under the standards have been subsumed into new areas for improvement under the Regulations.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Gary Foley, Manager, Valerie Atcheson, Management Consultant, and Mark Laight, Operations Director, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action resulted from the findings of this inspection. Following the inspection, a meeting was held on 20 December 2019 in RQIA with the intention of Cancelling the Registration of Paul Warren-Gray, the Responsible Individual for the Valley Nursing Home (MPS Ltd.), in respect of the Valley Nursing Home under Article 15 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, (the 2003 Order).

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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.

4.2 Action/enforcement taken following the most recent inspection dated 3 December 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 3 December 2019. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action is ongoing in respect of the home.

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, and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients, 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:

- duty rota for all staff from 9 to 22 December 2019
- staff training records
- staff supervision/appraisal records
- staff induction records
- incident and accident records
- thirteen patients' care records
- supplementary repositioning charts/wound care records
- a sample of quality assurance audits

- complaints records
- records of staffs' registration with their professional bodies
- a sample of monthly monitoring reports
- adult safeguarding records
- three staff recruitment files

Some areas for improvement identified at the last inspection were reviewed and assessment of compliance recorded as either met, partially met, or not met.

The findings of the inspection were provided to the interim manager, management consultant and operations director at the conclusion of the inspection.

6.0 The inspection

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

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 27 (4) (b) **Stated:** Third and final time	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.	**Carried forward to the next care inspection**
	Action taken as confirmed during the inspection: We observed that some gaps were still evident under bedroom doors in identified areas. This matter has been referred to the RQIA estates team to discuss further with the responsible individual**.** This will be reviewed at a future care inspection.	

Area for improvement 2 **Ref:** Regulation 20 (1) (c) (iii) **Stated:** Second time	The registered person shall ensure that persons employed to work at the nursing home receive training relevant to their role. With specific reference to: • the management of wounds • first aid • dementia awareness • behaviours which are challenging • training in the use of Person Centred Software	**Not met**
	Action taken as confirmed during the inspection: Training records were reviewed and discussed with the manager. This is referenced further in section 6.2. This area for improvement has not been met and has been stated for a third and final time.	
Area for improvement 3 **Ref:** Regulation 27 (2) (b) **Stated:** Second time	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.	**Not met**
	Action taken as confirmed during the inspection: Observation of this identified area evidenced that the surface remained uneven and continued to pose a hazard to patients. This area for improvement has not been met and has been stated for a third and final time.	
Area for improvement 4 **Ref:** Regulation 18 (2) (c) **Stated:** First time	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.	**Partially Met**

	Action taken as confirmed during the inspection: An action plan had been submitted as requested and the foliage had been addressed. However, there were ongoing deficits identified in relation to the provision of suitable furniture and the overall standard of décor. This area for improvement has been partially met and has been stated for a second time.	
Area for improvement 5 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall review the systems in place for the management of oxygen to ensure that signage is in place, the location of oxygen is detailed in the fire plan and a policy for the use of oxygen in an emergency is available.	**Not met**
	Action taken as confirmed during the inspection: Oxygen management was reviewed and discussed with the manager. This is discussed further in section 6.2. This area for improvement has not been met and has been stated for a second time.	
Area for improvement 6 **Ref:** Regulation 13 (1) (a) (b) **Stated:** Second time	The registered person shall promote and make proper provision for the nursing, health and welfare of patients as follows: • Care plans must be written in a comprehensive and person centred manner; they must also be reflective of multiprofessional recommendations, as appropriate, and regularly reviewed by staff. • Patients' wound care need must be consistently met in keeping with their prescribed care and best practice standards.	**Not met**
	Action taken as confirmed during the inspection: The regular review of care plans and the delivery of wound care is referenced further in section 6.2. This area for improvement was not met and has been stated for a third and final time.	

Area for improvement 7 **Ref:** Regulation 14 (2) (a) (b) and (c) **Stated:** Second time	The registered person shall ensure that cleaning chemicals are suitably labelled and stored in accordance with COSHH regulations.	**Not met**
	Action taken as confirmed during the inspection: Review of the environment highlighted that COSHH regulations were not effectively complied with in two areas. This was brought to the attention of the manager for action as appropriate. This area for improvement has not been met and has been stated for a third and final time.	
Area for improvement 8 **Ref:** Regulation 20 (3) **Stated:** First time	The registered person shall ensure that the competency and capability assessments are completed and regularly updated, for any nurse who is given the responsibility of being in charge of the home for any period of time in the absence of the registered manager. Records should be retained and available for inspection.	**Not met**
	Action taken as confirmed during the inspection: The review of competency and capability assessments is discussed in section 6.2. This area for improvement was not met and has been stated for a second time.	
Area for improvement 9 **Ref:** Regulation 21 **Stated:** First time	The registered person shall ensure that all persons are recruited in accordance with best practice and legislation and that the efficacy of this is present in staff recruitment and selection files prior to commencing employment. This refers specifically to documentary evidence of pre-employment vetting by completion of the AccessNI process.	**Met**
	Action taken as confirmed during the inspection: No concerns were identified in regard to the AccessNI status of staff. However, other deficits were noted in relation to the recruitment process and another area for improvement has been made.	

Area for improvement 10 **Ref:** Regulation 30 (d) **Stated:** First time	The registered person shall give notice to the Regulation and Improvement Authority without delay of the occurrence of any event in the nursing home which adversely affects the wellbeing or safety of any patient.	**Met**
	Action taken as confirmed during the inspection: Review of records relating to notifiable incidents evidenced no concerns. This area for improvement has been met.	
Area for improvement 11 **Ref:** Regulation 27 (2) (t) **Stated:** First time	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 and updated when necessary. With specific reference to: • storage of toiletries • use of electric heaters within patient areas	**Partially met**
	Action taken as confirmed during the inspection: Observation of the environment and discussion with the manager highlighted no concerns in regard to the management of patients' toiletries. However, there were no available risk assessments relating to the use of electric heaters which were noted to be in use in a part of the home. This area for improvement was partially met and has been stated for a second time.	
Area for improvement 12 **Ref:** Regulation 27 (4) (b) **Stated:** First time	The registered person shall take adequate precautions against the risk of fire. With specific reference to ensuring that fire doors are not wedged open.	**Not met**
	Action taken as confirmed during the inspection: Observation of the environment highlighted three fire doors which were inappropriately wedged open. This was brought to the attention of the manager for action as appropriate. This area for improvement was not met and	

	has been stated for a second time.	
Area for improvement 13 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk of spread of infection.	**Not met**
	Action taken as confirmed during the inspection: IPC practices/observations are discussed in section 6.2. This area for improvement was not met and has been stated for a second time.	
Area for improvement 14 **Ref:** Regulation 14 (4) **Stated:** First time	The registered person shall ensure that there is a robust system in place which ensures/demonstrates that patients are not placed at risk of harm or abuse. All governance records relating to the management of adult safeguarding matters should be maintained in an effective manner at all times.	**Not met**
	Action taken as confirmed during the inspection: The management of adult safeguarding is discussed in section 6.2. This area for improvement was not met and is stated for a second time.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 41 **Stated:** Second time	The registered person shall ensure that the nurse in charge of the home in the absence of the manager is clearly identified for each shift on the staffing rota and communicated to staff.	**Met**
	Action taken as confirmed during the inspection: Review of the staffing rota confirmed that this area for improvement was met.	

Area for improvement 2 **Ref:** Standard 39 **Stated:** Second time	The registered person shall ensure that newly appointed staff and agency staff complete a structured orientation and induction and records are retained.	**Not met**
	Action taken as confirmed during the inspection: On discussion with the administrator responsible for the management of staff recruitment records and review of a sample of induction records it was evidenced that the induction process was being carried out over a six month period instead of three months as per care standards. Induction paper work for two employees was not available during inspection. This area for improvement was not met and has been stated for a third and final time.	
Area for improvement 3 **Ref:** Standard 6 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Observation of staffs' practice confirmed that this area for improvement was met.	
Area for improvement 4 **Ref:** Standard 30 **Stated:** First time	The registered person shall review and revise the management of insulin. Insulin pens should be individually labelled and marked with the date of opening. In-use insulin pens should be stored at room temperature.	**Partially met**
	Action taken as confirmed during the inspection: Two insulin pens were observed. One insulin pen was not labelled or marked with the date of opening and the other was. This area for improvement has been partially met and has been stated for a second time.	

Area for improvement 5 **Ref:** Standard 18 **Stated:** First time	The registered person shall review and revise the management of distressed reactions. Detailed care plans should be in place. The reason for and outcome of administration should be recorded.	**Not met**
	Action taken as confirmed during the inspection: The management of distressed reactions is considered further in section 6.2. This area for improvement was not met and has been subsumed into a new area for improvement under regulation.	
Area for improvement 6 **Ref:** Standard 18 **Stated:** First time	The registered person shall ensure that the level, nature and type of any restraint is proportionate to the risk it is attempting to address and that relevant documentation is maintained including evidence of consultation with the patient (where appropriate), their next of kin and care manager. This is with specific reference to the locking of bedroom doors within the identified unit of the home.	**Carried forward to the next care inspection**
	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 7 **Ref:** Standard 28 **Stated:** First time	The registered person shall ensure that records of staff medicines management training and competency assessments are available for inspection.	**Not met**
	Action taken as confirmed during the inspection: This information was requested by inspectors but was not made available during the inspection. This area for improvement was not met and has been stated for a second time.	

Area for improvement 8 **Ref:** Standard 35 **Stated:** First time	The registered person shall ensure that a robust system of audits is implemented and maintained to promote and make proper provision for the nursing, health and welfare of patients. Such governance audits shall be completed in accordance with legislative requirements, minimum standards and best practice. This includes but is not limited to: • IPC • Wound care • Accidents/incidents • Care records	**Not met**
	Action taken as confirmed during the inspection: Governance audits are discussed further in section 6.2. This area for improvement was not met and has been subsumed into a new area for improvement under the regulations.	
Area for improvement 9 **Ref:** Standard 4 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that patients' care plans and risk assessments are reviewed in an effective and timely manner.	**Not met**
	Action taken as confirmed during the inspection: On review of care records for two patients it was identified that several risk assessments and care plans had not been updated in over two months. One patient's care plans were not fully transferred over onto the PCS/electronic record system and on review of the hard copy the care plans were last reviewed on 15 October 2019. This area for improvement was not met and has been subsumed into a new area for improvement under the Regulations.	

Area for improvement 10 **Ref:** Standard 4 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all patients have a named nurse who has responsibility for discussing, planning and agreeing the nursing interventions necessary to meet patients' assessed needs. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this has been be carried forward to the next care inspection.**	**Carried forward to the next care inspection**
Area for improvement 11 **Ref:** Standard 12 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the dining experience of patients is promoted and maintained in keeping with best practice standards at all times. **Action taken as confirmed during the inspection:** The dining experience of patients is considered further in section 6.2. This area for improvement was not met and has been stated for a second time.	**Not met**

6.2 Inspection findings

The internal environment.

Observation of the internal environment evidenced that while some progress had been made with regard to the refurbishment plan, this remained incomplete. For instance, several bedrooms still required refurbishment; skirting boards and architraves were found to be in poor condition in some areas. Also, significant plaster damage remained evident within one identified unit. An area for improvement has been stated for a second time.

We also noted that the internal décor across several parts of the home continues to remain sterile in appearance and lacking adequate stimulation. This was discussed with the manager and we agreed that there is a need for ongoing refurbishment throughout the home so as to ensure a homely and comfortable environment.

In regard to Tullybroom House we noted that several walls required refurbishment/painting and floor covering was lifting in the lounge which presented as a potential trip hazard.

Infection prevention and control.

Observation of the internal environment evidenced that posters were displayed to promote hand hygiene practices throughout the home. However, as with previous care inspections, there was a variance in the information displayed. As highlighted to the senior management team during previous inspections, this information is inconsistent and potentially confusing for staff. We also observed staff practices in regard to IPC and found compliance to be inconsistent, for example, in the use of Personal Protective Equipment (PPE).

In one bathroom a toilet seat had broken off and was left lying behind the toilet cistern. In another bathroom a toilet roll holder was broken; a shower chair was found to be soiled underneath and cracked, which had the potential to cause injury. The toilet pedestal had been crudely repaired with filler and could not be effectively cleaned. The handle bar beside the toilet was heavily contaminated with what appeared to be plaster dust. In another communal toilet there was leakage noted under the toilet on to the floor, the bath panel was cracked and filler had been used to repair the bath enamel. One pedal bin was not working properly. A standing hoist was observed and a sticker was visible saying that it had last been cleaned on 9 December and last serviced in March 2019. We were concerned that the ongoing cleaning and maintenance of such equipment is not being effectively achieved. Also, a strip of fly paper was observed hanging from the ceiling in the lounge which was full of dead flies and required replacing. These deficits in regard to IPC were shared with the manager and an area for improvement was stated for a second time.

We also observed that cleaning schedules on display had been inconsistently completed by staff. The shower drain within one communal shower room was also observed to be unclean.

Fire safety

A bedroom door was identified as not being able to close which would render that door ineffective in the event of a fire and raised a significant risk to the welfare of patients. When first identified this was immediately brought to the attention of the nurse in charge of the unit who agreed to communicate this with the maintenance personnel. Prior to the completion of the inspection the bedroom door was repaired. Gaps under bedroom doors is discussed in section 6.1.

Oxygen management

Two registered nurses spoken with stated that all the emergency oxygen cylinders had been removed from the home. The only oxygen in the home was prescribed for specific patients. They cited a recent occasion when the general unit rang staff within the Amadeus unit to enquire if they had oxygen to manage a patient in an emergency but none was available. The staff were therefore unable to offer appropriate care as they awaited an ambulance. This was discussed with the manager on the evening of the 16 December 2019 and he confirmed that this was ordered the next day.

Care delivery and Patient Dignity

Review of care records for one patient who required ongoing wound care evidenced that nursing staff had liaised with the podiatrist and tissue viability nurse. A relevant care plan was also in place. However, while feedback from nursing staff indicated that the patient's wound was healing, supplementary wound care records evidenced that staff compliance with the patient's prescribed wound care regimen was inconsistent. Nursing staff also told us that some agency nursing staff do not know how or where to record the delivery of wound care using the PCS system.

One further patient's care record was reviewed in relation to wound care. The electronic record showed multiple wound sites, some of which the nurse explained had healed, but which they did not know how to archive. The registered nurse was concerned that care staff were not always reporting reddened areas or bruises and they tried to check all patients herself. It could not be

ascertained what wounds were current or if there was an up to date care plan to manage any wounds. An area for improvement was stated for a third and final time.

We also considered repositioning care delivery for the same patient. The patient's care plans provided contradictory information as to how frequently such care should be provided. In addition, review of supplementary repositioning records highlighted that staff did not consistently reposition the patient in a timely manner. It was also noted that staff did not effectively vary the position of the patient consistently. The repositioning records for a second patient were also reviewed; we found that a relevant care plan provided no detail as to how frequently the patient required such assistance. Also, PCS records relating to repositioning care were noted to be repetitive and unclear as to when the care was actually carried out by staff.

Repositioning records for a further patient also evidenced inconsistent information regarding the recommended frequency of repositioning and significant gaps of up to 12 hours within the charts where the patient had not been repositioned as per the recommended frequency within their care plans. Referrals were made to the adult safeguarding team within the Southern Health and Social Care Trust (SHSCT) regarding the above findings. An area for improvement was made.

Care delivery for one patient who was nursed in bed was reviewed. The patient's care plan stated that the patient was able to make use of their nurse call button. However, observation of this patient highlighted that staff had not ensured that the nurse call button was within reach. Inspectors were therefore not assured that staff were effectively supervising the patient and/or ensuring that the patient could summon help using the nurse call system if needed. An area for improvement was made.

We also reviewed care delivery to patients who may present with behaviours which staff find challenging. One patient's care records did provide detailed information as to how staff could manage the patient's physical and/or verbal aggression if such a situation occurred. However, observation of the patient evidenced that staff did not effectively or proactively engage with the patient in keeping with such recommendations. Review of daily care records also highlighted inaccuracies concerning the patient's routine on the day of inspection which was noted to be inadequate and not person centred. An area for improvement was made.

The provision of enteral care to patients was also considered. Review of supplementary care records for one patient requiring enteral feeding evidenced that daily checks of the enteral site was documented inconsistently. The need to ensure that the patency and condition of the enteral site is checked in a timely and consistent manner was stressed. An area for improvement was made.

An unsafe moving and handling practice was noted to be undertaken by two care assistants and directed by the nurse. The practice was not only unsafe but undignified for the patient. This was reported to the manager and to the Trust adult safeguarding team following the inspection. An area for improvement was made.

Further concerns were identified in relation to the delivery of care to protect patients' dignity. The majority of patients were noted to be wearing tracksuit bottoms with formal shirts and jumpers. A number of patients' jumpers were soiled with food waste following breakfast. Two patients were noted to be wearing jeans which were evidently too big for them and the patients had to hold up their trousers as they walked. It was noted that labels were displayed on patients' doors with QR codes. Whilst it was appreciated that it was to facilitate the electronic

record system it presented as dehumanising. Concerns were noted in the manner of address of one staff member to patients. This is discussed in more detail in relation to the dining experience. An area for improvement was made.

The care records for two patients were reviewed in relation to the delivery of personal care. We found that the provision of oral care, fingernail care and hair washing was inconsistently referenced and did not assure us that this was being provided to patients in an effective manner. One patient was noted to have very long and dirty nails. There was also poor recognition and delivery of care in regards to an identified patient's eye care and relevant staff were requested to attend to the patients' needs by the inspector. An area for improvement was made.

Care records

An electronic record system (PCS) was in use in the home. Staff were in the process of transferring paper records to the electronic system. One registered nurse spoken with stated that they were 'self taught' on the PCS electronic care record system. They were not fully conversant with how the system worked. They had some training and had been given training materials and told to update themselves at break and lunch times. A second registered nurse was not sufficiently familiar with PCS and therefore unable to retrieve information requested by the inspector; this nurse had to seek assistance from nursing staff in another part of the home to retrieve the information being requested.

Records specific to fluid intake were reviewed on a sample of patients over a four day period which evidenced that the daily set fluid target as per the care plan had not been maintained on most occasions and there was no reference within the daily progress notes of any action taken if a deficit was noted. On review of one patient's dietary intake records there was no record that the patient had had any breakfast or anything to drink from the previous day. This was discussed with the registered nurse who agreed to liaise with the patient's GP regarding the patient's reduced appetite. An area for improvement was made.

The care record of one patient with a urinary catheter was reviewed. The date it had last been changed was recorded as 28 September 2019 but there was no planned date for the next change. The registered nurse stated that they would wait until it 'blocked' and then change it. This would not be in accordance with good practice in catheter care and could be potentially uncomfortable and undignified for the patients. They noted that the catheter site was bleeding and sore that morning and swabs had been taken. An area for improvement was made.

This patient also required insulin and a review of their recorded blood glucose readings evidenced these to be consistently above normal range. The registered nurse was unsure if this had been followed up with the GP or diabetic nurse. This potentially placed the patient at unnecessary risk of diabetic complications. This was fed back to the manager on the evening of the 16 December 2019 and it was confirmed that a referral had been made to the diabetic specialist nurse the next morning. An area for improvement was made.

This patient also required a modified diet but there were inconsistencies in the care plan as to the level of modification for food. We asked the registered nurse how they knew what diet patients were on. They replied that some of the care assistants knew and directed us to a list of patients' dietary requirements which they knew to be out of date. The list also referred to the old dietary modification terminology and did not use the new International Dysphagia Diet Standardisation Initiative (IDDSI) terminology. We asked how the kitchen staff would be updated following a Speech and Language Therapy (SALT) visit, for example. They stated that

the kitchen staff should be told but admitted that with agency staff, this may not be happening consistently. The patient we reviewed was served a meal not consistent with either of the levels stipulated in the care plan placing them at potential risk of choking. The care deficits identified were reported to Trust Adult Safeguarding team following the inspection. An area for improvement was made.

Two care plans were reviewed in relation to the management of distressed reactions with medication. A care plan was in place for one patient but not the other. An area for improvement on the QIP has been stated for a second time.

Two patients' records were reviewed in relation to weights and these evidenced that weights were done regularly and there had been no recent weight loss.

Confidential patient information was easily accessible at a nurse's station where the computer had been left unattended. Folders belonging to patients were also easily accessed at the nurses' station. This was discussed with the manager and an area for improvement was identified. An area for improvement was made.

Patients' dining experience

The lunch service was observed in Amadeus. Some patients chose to go to the dining room for lunch whilst others remained in the lounge or in their own rooms. It was unclear if this was the patients' choice or not. There were no menus on display. One care assistant stated that they assisted patients to choose their lunch in the morning. The food looked and smelled appetising; however, given that the patient group was mainly younger men, the portion sizes may not have been adequate. One patient asked a nurse if he could finish someone else's dinner, stating: 'I'm hungry!' The nurse responded by stating 'you've had your dinner and dessert and that's it!'

We asked him if he was still hungry and he responded that he was "starving." Staff when asked about this claimed that he was "always like this" and didn't know when he had had enough to eat. However, it was noted that his jeans were loose and he had to hold them up when walking. We observed the registered nurse speaking to patients as if they were children, using a firm and intimidating tone of voice. One patient asked for a drink and was told to 'Sit down! Then I'll get you a drink.' On another occasion they were heard to tell a patient off for talking with their mouth full. This behaviour was also witnessed by the manager who did not challenge at the time but acknowledged that he had witnessed this during feedback on the 16 December 2019. It was confirmed that the registered nurse had been spoken with by the manager once we left. As previously stated an area for improvement was made in relation to the provision of dignified care.

Meals were also served in the lounge on occasional tables. The meals and desserts were placed on an unheated trolley. The desserts were intended to be served hot but were going cold on the trolley as the main meal was served. There were a selection of drinks available and three care assistants were assisting with the meals. Patients spoken with were enjoying their lunch. An area for improvement was stated for a second time in relation to the dining experience of patients.

Managerial Oversight and Governance Arrangements.

Review of adult safeguarding records and discussion with the manger evidenced that related governance records were poorly maintained. It was noted that a monthly analysis of all safeguarding incidents in the home was not completed for October 2019 and November 2019. In addition, several monthly safeguarding analyses which were available, showed no evidence of any review by the manager. Review of records relating to previously implemented safeguarding arrangements, specifically unannounced night checks by senior staff, evidenced that these records were either incomplete or not available. Feedback from the manager highlighted that such checks were not ongoing to the best of his knowledge and that he had not yet addressed this. An area for improvement was stated for a second time.

We looked at staff supervision and appraisal records. While individual records were available, there was no system in place to provide the manager with effective oversight in regard to this aspect of staff management. We were therefore unable to determine overall compliance in relation to staff supervision/appraisal. An area for improvement was made.

There were no competency and capability assessments completed for nurses who were left in charge of the home in the absence of the manager. The manager confirmed this to be the case but stated he had undertaken some supervision with registered nurses in this regard. An area for improvement was stated for a second time.

The records for the checks of staffs' registration with the Northern Ireland Social Care Council (NISCC) or the Nursing and Midwifery Council (NMC) were reviewed. The NMC check was carried out on the day of inspection and all staff were appropriately registered. However, the previous check had not been done since May 2019. There was no system of regular checks evident which would help to prevent any nurse working in the home unregistered. The NISCC checks had been done on 4 December 2019 and this could not evidence that all staff were appropriately registered. The home management had sent out letters to 13 staff asking them to provide proof of NISCC registration. There was no discernible system for regular checking. An area for improvement was made.

Recruitment records for three members of staff evidenced that there were deficits in the recruitment process. A second reference was unavailable for one employee and another employee had no health check or gaps in employment explored. An area for improvement was made.

The complaints record was reviewed and the last complaint recorded was in February 2019. We discussed this with the manager, given the size of the home, we were concerned that complaints may not have been appropriately documented. Discussion with staff prior to this inspection confirmed that they were aware of a relative's dissatisfaction with care delivery which should have been recorded as a complaint. An area for improvement was made.

Some audits had been carried out in relation to nutrition, falls and IPC but a number of these had not been fully completed nor dated or signed. When actions had been identified there was no evidence that these had been effectively addressed and they had failed to identify the issues found on inspection. There was confusion amongst the management team as to who was to carry these out and when.

In addition, there was a schedule for audits but this had not been adhered too. A nutritional audit had been started on 12 December 2019 but had not been fully completed and was not signed. The audit had a section for modified diets but failed to identify the issues found in the Amadeus unit with conflicting information in care records and the failure to use up to date terminology.

A nutritional audit had also been carried out on 13 November 2019 and actions generated. However, these actions had been carried forward into the December audit and included the need for first aid training for choking. A falls audit had been done for August 2019 and for September 2019. This identified no trends but we found a clear pattern of falls occurring between 08.00 and 12.00 hours.

No audits were evident for care records, pressure ulcers, restrictive practice or weights. An IPC audit had been stared but not completed, with no date and no action plan having been generated. These shortfalls relating to governance audits were highlighted to the manager and an area for improvement was stated for a second time.

A review of training records was undertaken. It was extremely difficult to establish if staff had undertaken relevant training or how to ascertain who still had to complete training. There was no overview of this. Recent training in relation to dementia awareness and wound care had not been captured. There were obvious gaps in the first aid training; staff spoken with had not had first aid training. An area for improvement in relation to training had to be stated for a second time. The manager explained that they were moving to a new system the next week which would enable them to generate percentage compliance with training and would alert staff when training was due.

We discussed the overall lack of robust governance processes with the manager and senior management team. The registered person must ensure that systems are in place and maintained to allow for effective review of the quality of nursing and other service provision, including audits. An area for improvement was made in this regard.

An additional area for improvement was made in relation to the oversight of the manager, particularly in relation to their overview of training, induction, staff competencies, staff supervision/appraisal and audit systems.

Staff arrangements

The planned staffing arrangements for the Amadeus unit were two registered nurses and five care assistants with one patient being given one to one support. One care assistant had been redeployed to another unit on 16 December 2019 in the home and the one to one was not provided over and above the existing staff complement, effectively leaving three care assistants. One registered nurse spoken with stated that there were plans to reduce staffing to only one registered nurse which they would find challenging. They reported that the management regularly ‘took staff from them to cover other units’ but they were of the opinion that they needed all their staff to meet the needs of the patients. Discussion with the manager on 16 December 2019 evidenced that the manager had limited awareness of actions taken by staff during the morning to address the instance of short staffing. An area for improvement was made.

A review of the duty rota from 9 to 22 December 2019 evidenced that the required one to one had not been provided over and above the existing staff complement. There was evidence that there were deficits in the planned staffing levels, particularly in the Amadeus and Valley units. Staff did comment to inspectors that staffing levels can be affected by short notice absenteeism.

The registered nurse in the Amadeus unit knew who was in charge of the home and directed us to a white board which was updated per shift. The nurse in charge was also reflected on the rota. A previous area for improvement in this regard had been met.

Staff spoken with confirmed that an activity leader was on leave and there were no arrangements in place to cover whilst they were off. A movie was planned to be shown in one of the other units in the afternoon and some of the patients were able to attend, though not all. There were no activities for the other residents who could not attend and interactions with staff were purely perfunctory. The need to have effective arrangements in place in the absence of activities staff was stressed, to ensure that patients have something to look forward to and are able to experience a sense of achievement and well-being. It could not be evidenced that patients had a voice and appeared to have little control of their day to day lives. An area for improvement was made.

Staff feedback

We spoke with one care assistant who started four months previously. They reported having had an induction where they were shown around and shown how to wash the patients. They recalled having training in dementia and manual handling but not in first aid. They knew the manager but felt he was too busy so they would go to the Nurse in Charge or the Deputy with any concerns. They reported that staffing levels were inconsistent with three care assistants on one day and five the next so you were never sure who would be on shift. They commented that activities were on some days but not others.

We spoke with one staff member and they were never sure where they would spend the working day or in what capacity. They stated that when they come into work there may be staff on sick leave. They reported that short notice sick leave was an issue particularly at the weekends and Mondays which they described as ‘a nightmare’. Otherwise they reported that they enjoyed working in the home and confirmed that they had had training and induction.

Two registered nurses spoken with referenced issues with the working relationship with the local GP surgery. They stated that management were aware of this. However, as a result the staff tended to misuse the out of hours service or directly call an ambulance if patients were ill. The manager stated that they were trying to arrange a meeting with the GP practice. It was disappointing that despite recommending that the Responsible Individual raise this matter directly with the relevant GP practice, no progress had yet been achieved to resolve the matter in the interests of the patients.

We spoke with one care assistant who had been there for three months. They stated that they had received an induction and thought the staff team were ‘great’. They recalled having training in manual handling and infection control but no first aid. They confirmed that often there were four care assistants and not the planned five so ‘you just have to adapt.’

Areas of good practice

Individual staff members were observed to be delivering care in a compassionate manner.

Areas for improvement

Areas for improvement were highlighted in regard to: the internal environment; infection prevention and control; fire safety practices; Control of Substances Hazardous to Health compliance; care delivery; care records; staff interaction with patients; managerial oversight and several governance processes.

	Regulations	Standards
Total number of areas for improvement	11	4

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Gary Foley, Manager, Valerie Atcheson, Management Consultant, and Mark Laight, Operations Director, as part of the inspection process. The timescales 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 13 (4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall review the systems in place for the management of oxygen to ensure that signage is in place, the location of oxygen is detailed in the fire plan and a policy for the use of oxygen in an emergency is available. Ref: 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:** Third and final 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: 6.1 and 6.2
	Response by registered person detailing the actions taken: .. The specifics of this works are, fire strips have been fitted to the bottoms of the doors that were highlighted as being of concern. On the Estates Inspection that took place on the 25/11/2019 and the Home was compliant. On 15th January 2020, the NI Fire and Rescue Service attended site and issued to the home a statement saying that the home was broadly compliant, there were no recommendation or requirements from this visit.
Area for improvement 3 **Ref:** Regulation 20 (1) (c) (iii) **Stated:** Third and final time **To be completed by:** 31 December 2019	The registered person shall ensure that persons employed to work at the nursing home receive training relevant to their role. With specific reference to: • the management of wounds • first aid • dementia awareness • behaviours which are challenging • training in the use of Person Centred Software Ref: 6.1 and 6.2

	Response by registered person detailing the actions taken: The Training Matrix is monitored by the Home Manager, with a governance overview provided by th Deputy Home Mananger-Non-Clinical, as they have experience in relation to Human Resources, including what training needs staff have. *These bulleted points are all adressed in the Training Matrix, other than PCS, as this system is no longer in use.
Area for improvement 4 **Ref**: Regulation 27 (2) (b) **Stated:** Third and final 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: 6.1
	Response by registered person detailing the actions taken: The uneven section of the surface of the outdoor patient smoking area within the Valley Suite has been addressed by way of re-tarmacing the area, this area has been scheduled for complete resurfacing as soon as the winter weather subsides. As part of the Home Manager's on-going monitoring, as identified in the Daily Walkaround in Section 5, 6, 7 and under 'External Grounds', these enable the Home Manager to identify any issues and take and record appropriate actions to address these. Maintenance Sheets are in situ, in each area of the home, which help to identify any maintenance issues that are picked up on a daily basis, and these are checked twice daily.
Area for improvement 5 **Ref:** Regulation 13 (1) (a) (b) **Stated:** Third and final time **To be completed by:** With Immediate effect	The registered person shall promote and make proper provision for the nursing, health and welfare of patients as follows: • Care plans must be written in a comprehensive and person centred manner; they must also be reflective of multiprofessional recommendations, as appropriate, and regularly reviewed by staff. • Patients' wound care need must be consistently met in keeping with their prescribed care and best practice standards. Ref: 6.1 and 6.2
	Response by registered person detailing the actions taken: Named nurses are currently reverting care plans back to paper format, the deadline for completion of this 01/05/2020. In line with the nursing process the assessment planning and implementation of care is an ongoing process. Assessments and individual care plans have undergone both internal and external audit. Areas of improvement have been highlighted and forwarded to the relevant staff nurses to ensure that they meet the needs of the patients and that they promote and make proper provision for the nursing,

	health and welfare of patients. Patients' wound care needs have been audited and staff liaise with the Tissue Viability Nurses on an on-going basis-they visited the home on the 15/01/2020, and gave positive verbal feedback, there were no negative comments. We have revisted the wound care tool and a revised tool has been put into place to ensure that wound care needs are being reviewed. The first audit took place on 13/01/2020. After auditing, the Audit Form is left in the front of each patient care file and the Named Nurse responsible for thet file uses it as a point of reference to update the file. These files are then re-audited monthly.
Area for improvement 6 Regulation 14 (2) (a) (b) and (c) **Stated:** Third and final time **To be completed by:** Immediate effect	The registered person shall ensure that cleaning chemicals are suitably labelled and stored in accordance with COSHH regulations. Ref: 6.1
	Response by registered person detailing the actions taken: Cleaning chemicals have been inspected and are now suitably labelled and stored in accordance with COSHH regulations-this has now been audited by the home's provider (Beaucare.) on the 20/01/2020.
Area for improvement 7 **Ref:** Regulation 18 (2) (c) **Stated:** Second 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. Ref: 6.1
	Response by registered person detailing the actions taken: All bedding has been inspected by the management of the home and any damaged or worn bedding has been replaced. Adequeate replacement stock has been purchased to avoid any further issues should bedding become damaged or worn. Any furniture identified during the daily walkaround, that has been found to be damaged or worn beyond acceptable infection control standards will continue to be removed and replaced. Furniture is continually assesed for damage or wear and tear and staff have been instructed to report any defficiencies via the maintenance report sheet, which forms part of the daily reporting in the stand up meeting held by the manager or nurse in charge of the home. Bedding is checked under 'The Bedrooms and Communal Areas' Section of the Daily Walkaround.

Area for improvement 8 **Ref**: Regulation 20 (3) **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that the competency and capability assessments are completed and regularly updated, for any nurse who is given the responsibility of being in charge of the home for any period of time in the absence of the registered manager. Records should be retained and available for inspection. Ref: 6.1
	Response by registered person detailing the actions taken: The Competency and Capability Assessments were all completed between May 2019 and January 2020 and these are retained for inspection in the Home Manager's Office. These will be reviewed annually by the Home Manager. However, if the Home Manager identifies concerns with any individuals, these will be completed more regularly, as deemed appropriate by the Home Manager.
Area for improvement 9 **Ref**: Regulation 27 (2) (t) **Stated:** Second time **To be completed by:** With immediate effect	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 and updated when necessary. With specific reference to: • use of electric heaters within patient areas Ref: 6.1
	Response by registered person detailing the actions taken: All electric heaters within patient areas have been disabled with immediate effect.Electric heater guards are being sourced and once done will be ordered appropriatley. Health and Safety Audits will be carried out by the Home Manager every month.
Area for improvement 10 **Ref:** Regulation 27 (4) (b) **Stated:** Second time **To be completed by:** With Immediate effect	The registered person shall take adequate precautions against the risk of fire. With specific reference to ensuring that fire doors are not wedged open. Ref: 6.1 and 6.2
	Response by registered person detailing the actions taken: Doors are no longer being wedged open and this is checked on the Home Manager's Daily Walkaround-this is captured in the 'Are Fire Exits Free From Obstruction' section. This was also addressed with staff during fire training which took place on 27/11/2019 and will be reinforced in subsequent training sessions. Seven fire wardens were trained on the 18 October 2019 and appointed to assist with on-going monitoring and all matters relating to fire training and procedures.

Area for improvement 11 **Ref**: Regulation 13 (7) **Stated:** Second time **To be completed by:** With Immediate effect	The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk of spread of infection. Ref: 6.1 and 6.2
	Response by registered person detailing the actions taken: Signage appropriate to the area for both hand hygeine via washing at wash hand basins or using appropriate alchohol gel have been reinstated post the ongoing redecoration within the home, particular regard has been given to this and the maintenance team have been instructed to ensure the signage has been replaced once the decoration has been completed, this is checked on the Daily Walkaround to ensure compliance and good practise is taking place. Infection contol training has been completed both internally and externally sourced providers. All other areas of infection control concern have been identified and addressed via an action plan and ongoing monitoring is taking place through maintenance checks, maintenance log and Daily Walkaround by the Home Manager. Infection Control Audits are completed monthly, and there are Daily and Nightly Cleaning Schedules in all areas of the home. Equipment is cleaned by night staff on a daily basis and between use throughout the day and labelled as having been cleaned.
Area for improvement 12 **Ref:** Regulation 14 (4) **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that there is a robust system in place which ensures/demonstrates that patients are not placed at risk of harm or abuse. All governance records relating to the management of adult safeguarding matters should be maintained in an effective manner at all times. Ref: 6.1 and 6.2
	Response by registered person detailing the actions taken: All governance records relating to adult safeguarding are held in a central file in the Managers office. All APP1's are recorded on a safeguarding log within the file, which records ongoing actions to be taken and outcomes. The registered person shall maintain this system so that robust monitoring of safeguarding matters continues within the home.The Home Manager will be checking these records daily, to ensure good governance.

Area for improvement 13 **Ref**: Regulation 14 (3) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that staff patients are assisted with their moving and handling needs by staff in a safe and effective manner at all times. Ref: 6.2
	Response by registered person detailing the actions taken: Patient's moving and handling needs have been updated within their relevant support plans. Staff training in Moving and Handling is ongoing and allocation dates have been given for moving and handling training for staff who need updates. Staff training in moving and handling from a theoretical point of view is delivered by online training methods, practical training is delivered by in house train the trainers, which there are 6 in total.
Area for improvement 14 **Ref**: Regulation 12 (4) (a)(b)(c)(d) & (e) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the effective measures are in place to ensure that the dietary needs of patients requiring a modified diet are safely and effectively met at all times. Ref: 6.2
	Response by registered person detailing the actions taken: The home now has a SALT File in place-this is kept centrally, and there are separate files on each Unit and in the Kitchen, relevant to their specific areas. This file contains information regarding Resident's Food and Fluid Monitoring, Diet Notification Forms, Referral Forms and Advice Received. There is now an area of reference within the kitchen where staff can refer to in relation to any specific SALT requirements. Care plans are being updated to ensure that they highlight current SALT recommendations.
Area for improvement 15 **Ref**: Regulation 13 (8) (a) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall make suitable arrangements to ensure that the nursing home is conducted in a manner which respects the privacy and dignity of patients. Ref: 6.2
	Response by registered person detailing the actions taken: New documentation has been implemented in relation to patients daily care, which includes clothing and overall appearance. However, patient choice is paramount, subject to safety, and patients wishes are always sought as to their preference regarding clothing. Where a patients desire is to wear what may not be the most visually asthetic clothing, patients wishes and choices are respected at all times. This is clearly identified within the new documentation. Where patients have been in need of alternative clothing, due to miss sizing or wear and tear, this has been addressed by way of purchase of new clothing and in line with the patients personal preferences. Further training in dignity and respect has been provided by Jan Gilbert - specialised training services on 4th and 5th of January 2020.

	The Home Manager/Deputy Home Manager - clinical during their daily walk round will continue to monitor that patients dignity is being maintained. QR codes for the former PCS system are now removed.
Area for improvement 16 **Ref**: Regulation 15 (2) (a) and (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the needs of patients who present with behaviours which may challenge staff are assessed appropriately and their needs kept under review. Ref: 6.2
	Response by registered person detailing the actions taken: Patients who present with behaviours that challenge have been recently re assessed by both the home and the relevant trusts and patients needs have been determined as part of this reassessment. Patients whom present with behaviours that challenge, that the home finds it is having difficulty in meeting the needs of, have been referred to the relevant trusts for the trust to find suitable alternative placements. Further training took place with Jan Gilbert - specialist trainer, on 5th Jan focusing on how to manage behaviours that challenge for the general client group. The Southern Trust has offered to assist the home in the provision of behaviours that challenge specific training as despite numerous enquiries the home has been unable to source courses within NI within a suitable timescale and the trusts belive that they can assist in this matter.
Area for improvement 17 **Ref**: Regulation 12 (1) (a) and (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person must ensure that the personal hygiene needs of patients are met in an effective and timely manner. The delivery of this care must be documented appropriately particularly in relation to hair, nail and eye care. Ref: 6.2
	Response by registered person detailing the actions taken: New documentation has been implemented and is in use within all areas of the home which documents patients individual care delivery in relation to personal hygeine. This is checked randomly for appropriate delivery of care on a daily basis by the homes management. This is also checked as part of the Daily Walkaround.

Area for improvement 18 **Ref**: Regulation 12 (2); 27 (2) (c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that equipment is properly maintained and suitable for use by patients. Ref: 6.2
	Response by registered person detailing the actions taken: Maintenance checks have been reviewed and updated to encoporate a more thorough level of monitoring and this is being overseen by the non-clinical Deputy Home Manager. Maintenance report sheets are present in all units and these are checking twice daily and all maintenance concerns are dealt with in a timely manner.
Area for improvement 19 **Ref**: Regulation 16 (1); (2) (b)(c) & (d) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that care plans are in place to meet the needs of patients and that these are kept under regular review. The registered person shall also ensure that patients' care plans and risk assessments are reviewed in an effective and timely manner. This should include but is not limited to: • care of enteral sites • insulin management • daily fluid intake • pressure relief/repositioning needs • urinary catheter care • management of distressed reactions Ref: 6.2
	Response by registered person detailing the actions taken: Named nurses are currently reverting care plans back to paper format, the deadline for completion of this is 01/05/2020. In line with the nursing process the assessment planning and implementation of care is an ongoing process. Assessments and individual care plans have undergone both internal and external audit. Areas of improvement have been highlighted and forwarded to the relevant staff nurses to ensure that they meet the needs of the patients and that they promote and make proper provision for the nursing, health and welfare of patients. Daily care charts have been devised and implemented, which include monitoring for daily fluid intake, pressure relief and reposition charts, management of distressed reaction, these have been implemented where there has been an assessed need identified. The nurses will refer to the Care Plan Audits, as highlighted in 5.If there are any individual concerns with any nurses, these are reviewed through performance and capability policies, in line with HR policies and utilising the support of the company's HR Department.

Area for improvement 20 **Ref**: Regulation 17 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall introduce and ensure systems are maintained for reviewing at appropriate intervals the quality of nursing and other service provision in or for the purposes of the nursing home. Ref: 6.2
	Response by registered person detailing the actions taken: A new auditing schedule has been in place in the care home since January 2020, and the Home Manager uses these audits to ensure systems are maintained for reviewing the quality of the service provision. The registered individual/person within the reg 29 report overviews the audit file system to ensure that there is oversight and governance of the audit system.
Area for improvement 21 **Ref**: Regulation 24 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that complaints are recorded and managed appropriately. Ref: 6.2
	Response by registered person detailing the actions taken: All complaints are recorded and managed appropriately and the quarterley return is completed for the trusts. Complaint documentation is now being used correctly.
Area for improvement 22 **Ref**: Regulation 21(1)(b)(c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all persons are recruited in accordance with best practice and legislation and that the efficacy of this is present in staff recruitment and selection files prior to commencing employment. This relates specifically to ensuring that health checks for staff are completed and that gaps in previous employment are effectively reviewed. Ref: 6.2
	Response by registered person detailing the actions taken: The recruitment application form was reviewed and considered inapt. A new application has been revised to fully comply with legislation, which includes new health checks and Gaps in employment history. HR audit checks in place for best practice and efficiency that all staff recruitment checks have been completed.

Area for improvement 23 **Ref**: Regulation 10 (1) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that having regard to the size of the nursing home, the statement of purpose, and the number and needs of the patients, carry on or manage the nursing home (as the case may be) with sufficient care, competence and skill. This includes but is not limited to the management of staff sickness/absences, overview of training, induction, staff competencies, staff supervision/appraisal and audit systems. Ref: 6.2
	Response by registered person detailing the actions taken: The statement of purpose has been updated as a result of the new acting manager, and this includes all the items listed above.
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 16 October 2019	The registered person shall ensure that the level, nature and type of any restraint is proportionate to the risk it is attempting to address and that relevant documentation is maintained including evidence of consultation with the patient (where appropriate), their next of kin and care manager. This is with specific reference to the locking of bedroom doors within the identified unit of the home. Ref: 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 4 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all patients have a named nurse who has responsibility for discussing, planning and agreeing the nursing interventions necessary to meet patients' assessed needs. Ref: 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 39 **Stated:** Third and final time **To be completed by:** With immediate effect	The registered person shall ensure that newly appointed staff and agency staff complete a structured orientation and induction and records are retained. Ref: 6.1
	Response by registered person detailing the actions taken: Induction records are in place for newly appointed staff and agency staff. These have been reviewed and updated to enhance the level of induction.
Area for improvement 4 **Ref**: Standard 30 **Stated:** Second time **To be completed by:** 20 September 2019	The registered person shall review and revise the management of insulin. Insulin pens should be individually labelled and marked with the date of opening. In-use insulin pens should be stored at room temperature. Ref: 6.1
	Response by registered person detailing the actions taken: All staff nurses have received, between September 2019 and Jan 2020, further diabetes management training, courses have been held by Judith Pike - Diabetes specialist nurse and Jan Gilbert - specialist nurse trainer. Staff have been trained that when opening a new insulin pen a label should be in situ, clearly showing the date of opening and in use insulin pens are stored on our medicine trolleys, alongside patients in use medications. This will be monitored through medication audits. Notices giving staff reminders, which will enable embeddedment of practise of positioned appropriately in nurse treatment rooms.
Area for improvement 5 **Ref**: Standard 28 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that records of staff medicines management training and competency assessments are available for inspection. Ref: 6.1
	Response by registered person detailing the actions taken: Medication management competency assessments have been completed for all registered nurses and records of this are held in the managers office. There is further training scheduled to be provided on Friday 23 Janaury 2020. Medications management training will be completed by the end of January 2020.

Area for improvement 6 **Ref**: Standard 12 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that the dining experience of patients is promoted and maintained in keeping with best practice standards at all times. Ref: 6.1 and 6.2
	Response by registered person detailing the actions taken: The Registered Person monitors the dining experience as part of their daily walkaround to ensure that best practise standards are maintained. The dining experience has been re-evaluated and steps have been taken to imporove this, for example, the dining room layout has been changed, new seating has been provided, furnishings have been purchased to enhance the environment, patient choice is taken into consideration at all times and individual needs are catered for.
Area for improvement 7 **Ref**: Standard 43 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that patients have effective access to the nurse call system at all times, as appropriate. Ref: 6.2
	Response by registered person detailing the actions taken: The Registered person conducts a daily walkaround and this incorporates monitoring that patients have effective access to the nurse call system. The staff are reminded on a daily basis that they are accountable for ensuring that patients have access to the nurse call system, random checks are also undertaken at varying times of the day and night by the senior staff members in charge to ensure this is complied with. This is recorded in the office diary.
Area for improvement 8 **Ref**: Standard 29 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the confidentiality of patients' care records is effectively maintained at all times. Ref: 6.2
	Response by registered person detailing the actions taken: PCS is no longer in use and new filing cabinets have been purchased with a locking mechanism.

Area for improvement 9 **Ref**: Standard 35 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that that an effective system is implemented and monitored for managing the professional registration of nursing and care staff at all times. Ref: 6.2 **Response by registered person detailing the actions taken:** NMC PIN checks and NISCC checks are completed at the point of employment of staff in the home, and PIN checks are carried out on a monthly basis and records of these checks are maintained in the office for viewing.We have experienced delays with the NISCC registrastion process, ongoing liaison with the NISCC registration manager in relation to this.
Area for improvement 10 **Ref**: Standard 18 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that effective arrangements are in place to ensure that person centred activities are provided to patients in the absence of activities staff being on duty. Ref: 6.2 **Response by registered person detailing the actions taken:** Activities coordinators have begun to develop life stories to create a profile to ensure that activities are person centred. Actitivies are left accessible within each area of the nursing home at all times and staff are encouraged to engage with residents with meaningful activities. Further training was completed on 5th January 2020 with Jan Gilbert, looking at engagement techinques.

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

The Regulation and Quality Improvement Authority

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