Unannounced Care Inspection Report
18 May 2017

Faith House

Type of service: Nursing Home
Address: 25 Orpen Park, Belfast BT10 0BN
Tel No: 02890612318
Inspector: Sharon McKnight and Priscilla Clayton

1.0 Summary

An unannounced inspection of Faith House took place on 18 May 2017 from 09:30 to 16:45.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies, staff training and development and the environment. Observation of the delivery of care and discussion with patents and staff evidenced that patients' needs were met by the levels and skill mix of staff on duty.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. We were assured that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice.

Concerns were identified in relation to the appropriate assessment of patients by a registered nurse following accidents; a requirement was made. A recommendation was made to review the seating in one identified lounge to ensure it is suitable to meet the needs of the patients.

Compliance with these requirements and recommendation will further drive improvements in this domain.

Is care effective?

A review of seven patients' care records evidenced that a range of validated risk assessments were completed as part of the admission process. There was evidence that risk assessments informed the care planning process. Care records contained good details of patients' individual needs and preferences. Supplementary care charts such as repositioning charts and food and fluid intake records were maintained for identified patients. One area for improvement was identified in relation to the care plans and a recommendation was made.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. There was evidence within the care records of regular, ongoing communication with relatives.

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

Patients, relatives and staff consulted with confirmed that if they had any concerns, they could raise these with the nurse in charge, deputy manager or the registered manager. Patients and relatives' meetings were held regularly and a record maintained of the issues discussed. One relative spoken with was supportive of the relatives' meetings; they explained that it provided an opportunity to raise any ideas/issues regarding the general running of the home. They also commented that the meetings kept them informed of events in the home.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with fifteen patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Examples of comments provided by patients are included in the main body of the report.

We reviewed the provision of activities and observed that the weekly activity programme was displayed at the reception area, with copies available throughout the home. Patients spoken with were well informed of the activity programme, which include art, crafts and recreational games. There were also daily and weekly events to support patients' religious and spiritual needs.

Questionnaires were issued by RQIA to patients, relatives and staff. All of the respondents were either very satisfied or satisfied with the care provided across the four domains. Comments with regard to staffing were shared with the registered manager. A number of comments provided in the questionnaires are included in the report.

There were no areas for improvement identified in this domain.

Is the service well led?

Discussion with the registered manager and observation of patients evidenced that the home was operating within its' registered categories of care. The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them contact as required. The registered manager was supported in her role by a deputy manager whose hours and responsibilities were divided between their dual role of nursing and management. The registered manager was also supported by an administration team who were well informed of the day to day operation of the home. The deputy manager and administration team provided good support throughout the inspection.

Review of records evidenced that unannounced quality monitoring visits were completed on a monthly basis on behalf of the responsible person. An action plan was included within the report to address any areas for improvement. The action plan was reviewed at the next visit. A copy of the quality monitoring reports were available in the home.

During the inspection we were informed that structural work had been completed in one identified bedroom. RQIA had not been notified of the proposed changes prior to them taking place. No application to vary the registration of the home had been submitted to RQIA. A requirement was made that the responsible person and registered manager must identify any gaps in their knowledge of the application of relevant legislation, and take appropriate action to rectify. They must demonstrate a clear understanding of the process to vary the registration of the home, including timescales and action. The full details of this issue are discussed in section 1.1 and 4.6 of this report.

The term 'patients' is used to describe those living in Faith House which provides both nursing and residential care.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**2**	**2**

Details of the Quality Improvement Plan (QIP) within this report were discussed with Jane Moore, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

An issue was identified during this inspection when we were informed that one existing bedroom had been structurally altered as part of the building work. RQIA had not been notified of the proposed changes prior to them taking place. No application to vary the registration of the home had been submitted to RQIA with regard to this bedroom. The bedroom was unoccupied at the time of the inspection. Following the inspection a meeting with RQIA senior management was held to discuss this breach in The Nursing Homes Regulations (Northern Ireland) 2015. An application was requested from the registered persons and received by RQIA on 22 May 2017. This application to vary registration has been assessed by the estates inspector for the home and the bedroom was found to comply with the care standards. It was agreed that a meeting would be held with the registered manager to discuss our concerns, clarify the understanding of the registered manager in relation to the legislation and to seek assurances that an application to vary registration would be submitted to RQIA prior to the commencement of any future refurbishment work. This meeting has been scheduled to take place on Friday 16 June 2017. This issue is further discussed in section 4.3 of this report.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection.

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 7 June 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

However, since this previous inspection an email was received by RQIA on 11 April 2017 in which the responsible person advised that building work for eleven new bedrooms was well advanced and there were plans was to move patients from the first floor to the new ground floor rooms to allow further refurbishment. RQIA were concerned that at that time an application to vary the registration of the home has not been submitted despite this matter being raised with the responsible person via emails on a number of occasions. In view of our concerns a serious concerns meeting and subsequent intention to serve a notice of proposal meeting were held with the responsible person on 27 April 2017.

At the serious concerns meeting it was acknowledged that an application to vary the registration of the home was received by RQIA on 26 April 2017. The responsible person provided a full account of the present building work undertaken and gave assurances that the newly built rooms would not be used until they have been inspected and registered by RQIA.

An intention to serve a Notice of Proposal meeting was also held on 26 April 2017 to consider placing conditions on the registration of the home to ensure the newly built rooms would not be used prior to registration. However, the responsible person voluntarily agreed to a condition being placed on the registration of Faith House. Therefore enforcement action was not required at that time. A condition was placed on the registration of Faith house on 27 April 2017 which states that the new 11 bed extension was not to be used for the purposes of the registered nursing home until RQIA have granted the variation.

2.0 Service details

Registered organisation/registered person: Board of Trustees – Faith House Mervyn Wishart	**Registered manager:** Jane Moore
Person in charge of the home at the time of inspection: Jane Moore	**Date manager registered:** 9 January 2015
Categories of care: RC-I, NH-I, NH-PH, NH-TI A maximum of 31 residents in category RC-I. The new 11 bed extension is not to be used for the purposes of the registered nursing home until RQIA have granted the variation.	**Number of registered places:** 65

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection we met with 15 patients individually, two senior carers, four care staff, number staff, two housekeeping staff and the relatives of two patients.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspectors.

Questionnaires were also left in the home to facilitate feedback from relatives and staff not on duty. Six patient questionnaires and sixteen staff and patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- duty rota for all staff for the week of the inspection
- records confirming registration of staff with the Nursing and Midwifery Council (NMC)and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment files
- competency and capability assessments of nurses
- staff register
- six patient care records
- record of staff meetings
- patient register
- complaints record
- record of audits
- RQIA registration certificate
- certificate of public liability insurance
- monthly monitoring reports

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 13 April 2017

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector.

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

4.2 Review of requirements and recommendations from the last care inspection dated 19 May 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 4.8 **Stated:** First time	Care records should be updated following an accident to reflect any identified risks.	**Met**
	Action taken as confirmed during the inspection: A review of accident reports and care records evidenced that this recommendation has been met.	
Recommendation 2 **Ref**: Standard 4 **Stated:** First time	It is recommended that the registered manager review which risk assessments are required for patients in receipt of residential care.	**Met**
	Action taken as confirmed during the inspection: A review of care records for patients in receipt of residential care evidenced that the risk assessments in place were appropriate. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 16.11 **Stated:** First time	It is recommended that the recording of complaints is further developed to include whether or not the complainant was satisfied with the outcome and how this level of satisfaction was determined.	**Met**
	Action taken as confirmed during the inspection: The complaints records reviewed included whether or not the complainant was satisfied with the outcome and how this level of satisfaction had been determined. This recommendation has been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that staffing was subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for week commencing 15 May 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily. Staff were employed to delivery activities. Observation of the delivery of care and discussion with patients evidenced that their needs were met by the levels and skill mix of staff on duty.

Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; ten were returned following the inspection. Eight of the respondents answered 'yes' to the question "Are there sufficient staff to meet the needs of the patients?" Two staff commented that due to the current needs of patients more staff were required. One respondent from the residential area of the home explained that management were aware of the increased workload and that plans were in place to increase the staffing in the mornings. The registered manager had informed us of this planned increase during the inspection.

Patients spoken with during the inspection commented positively regarding the staff and care delivery. Patients were satisfied that when they required assistance staff attended to them in timely manner. We sought patients' opinion on staffing via questionnaires; five were returned from residential patients. No issues were raised regarding the provision of staffing. One patient commended that "all staff are pleasant and kind and caring."

We sought relatives' opinion on staffing via questionnaires; seven were returned in time for inclusion in this report. All of the relatives were either very satisfied or satisfied with staffing. One relative commented "Plenty of staff who are efficient and professional."

A nurse was identified to take charge of the home when the registered manager was off duty. The nurse in charge was clearly identified on a separate sheet at the front of the nursing and residential duty roster. A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the registered manager. The assessments were signed by the registered manager to confirm that the assessment process had been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home.

A review of two staff recruitment records evidenced that they were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records confirmed that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work.

A record of staff including their name, address, contact number, position held, contracted hours, date of receipt of Access NI certificate, date commenced and date position was terminated (where applicable) was maintained electronically and provided an overview of all staff employed in the home. This additional detail supplemented the information contained in the staff recruitment files as required in accordance with regulation 19(2), schedule 4(6) of The Nursing Homes Regulations (Northern Ireland) 2005.

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the registered manager. A review of the records of NMC registrations evidenced that all of the nurses on the duty rota for the week of the inspection were included in the NMC check. The record of the checks of care staff registration included the expiry date of their registration with NISCC.

The registered manager confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. A review of two completed induction programmes evidenced that these were completed within a meaningful timeframe.

We discussed the provision of mandatory training with staff and reviewed the training records for 2016/2017. The registered manager explained that they were currently piloting an e-learning programme for the delivery of training. Training records evidenced good compliance; for example from January 2017 85% of staff had completed fire safety training, 96% first aid and 97% had completed the theory element of moving and handling. The registered manager confirmed that they had systems in place to facilitate compliance monitoring.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. The registered manager attended training on the role of the safeguarding champion in February 2017 and confirmed that a champion had been identified.

Review of six patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

A review of accidents and incident records since January 2017 confirmed that RQIA were appropriately notified of events in the home. The review of completed accident reports identified that patients in residential care were not always assessed by a registered nurse at the time of an accident. To ensure that there is proper provision for the health and welfare of patients the registered nurse in charge of the building must assess each patient following an accident to ensure that all treatment required is delivered. In the event of a suspected head injury central nervous system (CNS) observation must be completed. A requirement was made.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Patients spoken with were complimentary in respect of the home's environment. We observed a number of armchairs in the residential lounge which were low to the ground and not conducive to safe moving and handling practices. It is recommended that the seating in the identified lounge is reviewed to ensure it is suitable to meet the needs of the patients. Staff should be able to assist patients to sit and rise from these chairs in accordance with safe manual handling practices. Any chair identified as compromising safe moving and handling practices should be replaced.

Building work to an extension to the home was ongoing. Staff, patients and relatives reported that there had been minimal disruption to the daily routine of the home and that noise had been kept to a minimum. As previously discussed in section 1.1 of this report one existing bedroom had been structurally altered as part of the building work. RQIA had not been notified of the proposed changes prior to them taking place. No application to vary the registration of the home had been submitted to RQIA. In accordance with regulation the registered person must inform RQIA in writing if it is proposed that the premises of the nursing home are to be significantly altered. A completed application was received by RQIA on 22 May 2017. This issue and the action taken by RQIA is further discussed in section 4.5 of this report.

Infection prevention and control measures were adhered to. We spoke with the house keeper and one member of housekeeping staff; both were knowledgeable regarding the National Patient Safety Agency (NPSA) national colour coding scheme for equipment such as mops, buckets and cloths. Sluice rooms and bathroom/toilets were observed to be clutter free and

well organised. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately.

We discussed the management of fire safety with the registered manager who confirmed that fire checks were completed weekly. Records were available to confirm the checks had been completed. Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas for improvement

The nurse in charge of the home must ensure that all patients are assessed by a registered nurse following an accident and that any treatment required is delivered.

The seating in the identified lounge should be reviewed to ensure it is suitable to meet the needs of the patients. Any chair identified as compromising safe moving and handling practices should be replaced.

Number of requirements	1	Number of recommendations	1

4.4 Is care effective?

A review of seven patients care records evidenced that a range of validated risk assessments were completed as part of the admission process. There was evidence that risk assessments informed the care planning process. Assessments and care records were reviewed as required and at minimum monthly. Care plan evaluations included an overview of the patients' condition. Care plans for patients at risk of falling referenced any fall since the previous evaluation. Care records contained good details of patients' individual needs and preferences. We observed a small number of records which had not been signed by the person completing them; the deputy manager explained that they had identified this during a recent audit and hi-lighted this to staff. They confirmed that this area will continue to be monitored through the auditing processes in the home.

We reviewed the management of wound care for one patient. An assessment of the wound was recorded after each dressing change. A review of wound care records for the period 15 April to 16 May 2017 evidenced that the wound dressing was regularly changed, consistent with the regimens recorded in the wound assessment chart. A range of care plans were in place; however there was no care plan in place for wound care. A recommendation was made.

Patients who had been identified as being at risk of losing weight had their weight regularly monitored. This ensured that any weight loss was identified and appropriate action taken in a timely manner.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients

admission was held in a patient register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Supplementary care charts such as repositioning charts and food and fluid intake records were maintained for identified patients. Staff were knowledgeable regarding the importance of ensuring prescribed care, for example the frequency with which patients were required to be repositioned, was delivered and that records were maintained to evidence care delivery.

Care management reviews for patients receiving long term care were arranged by the relevant health and social care trust. These reviews could be held in response to a change to patient need and as a minimum annually. They could also be requested at any time by the patient, their family or the home. There was evidence within the care records of regular, ongoing communication with relatives.

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

The registered manager confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed. The most recent staff meeting held was with all staff on 28 April 2017 with the housekeeping staff.

Patients, relatives and staff consulted with confirmed that if they had any concerns, they could raise these with the nurse in charge, deputy manager or the registered manager. Patients and relatives' meeting were held regularly and a record maintained of the issues discussed. The most recent patients' meeting took place on 3 May 2017. The most recent relatives' meeting was held on 4 May 2017. One relative spoken with confirmed that a copy of the minutes of the meetings was sent to all relatives who were unable to attend. The relative was supportive of the relatives' meetings; they explained that it provided an opportunity to raise any ideas/issues regarding the general running of the home. They also commented that the meetings kept them informed of events in the home.

Areas for improvement

It is recommended that care plans should be in place to direct wound care.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with 15 patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Discussion with patients individually and with others in smaller groups, confirmed that

living in Faith House was a positive experience. The following are examples of comments provided by patients:

"It's a nice place and always so clean."
"Very nice place everyone is so helpful."
"You get everything you need when you need it."
"I like it here, they are nice staff, always available."

We reviewed the provision of activities and observed that the weekly activity programme was displayed at the reception area, with copies available throughout the home. One relative commented that having the weekly planner displayed allowed them to plan their visiting around the activities that their mum would not be interested in. Patients spoken with were well informed of the activity programme which included art, crafts and recreational games. There were also daily and weekly events to support patients' religious and spiritual needs. A few patients commented that whilst they didn't join in with all of the activities there were certain events they enjoyed and it was good to know when these were planned.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives on the running of the home. A satisfaction survey was conducted annually by the home; the most recent survey was conducted in May 2017. The results were displayed on the relatives' notice board. The survey sought relatives' opinion on the quality of the service, visiting arrangements, communication, staff and laundry services. The majority of responses were excellent or very good.

Six questionnaires were issued to patients receiving residential care; five were returned. All of the patients were either very satisfied or satisfied with the care they were receiving. The following are examples of some comments provided:

"You are always kept up to date and there are regular residents and relatives meetings."
"You are made to feel loved and your life is important, even if you can't do much for yourself."
"Staff keep your business private and work at your pace and listen to you."

As the majority of patients receiving nursing care were spoken with there were no questionnaires issued.

Two patients commented that at times, especially in the morning, they would like staff to respond to them more quickly; the registered manager was aware of this and was in the process of increasing the number of staff for the residential patients in the morning.

Sixteen relative questionnaires were issued; seven were returned within the timescale for inclusion in this report. All of the relatives was very satisfied or satisfied with the care provided across the four domains. The following are some examples of comments provided:

"We are very impressed that staff are monitoring various aspects of her condition and providing us with detailed reports when we visit."
"…. is unable to make decisions on her own, but as her relatives we are fully involved in any decisions taken."
"…I like that there is continuity of staff. The staff seem happy to work here which I think is important"
"We as relatives are frequently updated by texts, mail and family meetings."
"…is content. Looks and feels much better under the watchful eye of Faith House."
"Management and staff are always approachable. Importance is given to spiritual and pastoral care."

We issued sixteen questionnaires to nursing, care and ancillary staff; ten were returned prior to the issue of this report. Staff were either very satisfied or satisfied with the care provided across the four domains.

Any comments from relatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Areas for improvement

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

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Discussion with the registered manager and observation of patients evidenced that the home was operating within its' registered categories of care. The most recent certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. In discussion patients and relatives were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

The registered manager's hours were clearly recorded in the home. Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them contact as required. The registered manager was supported in her role by a deputy manager whose hours and responsibilities were divided between the role of nursing and management. The registered manager was also supported by an administration team who were well informed of the day to day operation of the home. The deputy manager and administration team provided good support throughout the inspection.

Discussion with the registered manager and review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. The complaints record was well maintained with information of the action taken in response to complaints and a detailed response to the complainant.

The registered manager confirmed that monthly audits were completed, for example care records. The records of audit evidenced that any identified areas for improvement had been reviewed to check compliance and drive improvement.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

Review of records evidenced that unannounced quality monitoring visits were completed on a monthly basis by the responsible person. An action plan was included within the report to address any areas for improvement. The action plan was reviewed at the next visit. A copy of the quality monitoring reports were available in the home.

As previously discussed in section 1.1 and 4.2 one bedroom had been structurally altered without notification to RQIA prior to the proposed work being completed. A requirement was made that the responsible person and registered manager must identify any gaps in their knowledge of the application of relevant legislation, and take appropriate action to rectify. They must demonstrate a clear understanding of the process to vary the registration of the home, including timescales and action.

Following the inspection it was agreed that a meeting would be held with the registered manager to discuss our concerns, clarify the understanding of the registered manager in relation to the legislation and to seek assurances that an application to vary registration would be submitted to RQIA prior to the commencement of any future refurbishment work. This meeting has been scheduled to take place on Friday 16 June 2017.

Areas for improvement

The responsible person and registered manager must identify any gaps in their knowledge of the application of relevant legislation, take appropriate action to rectify and demonstrate a clear understanding of the process to vary the registration of the home, including timescales and action.

Number of requirements	1	Number of recommendations	0

5.0 Quality improvement plan

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

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

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

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 13(1)(a) **Stated:** First time time **To be completed by:** immediate from the day of inspection	The registered persons must ensure that there is proper provision for the health and welfare of patients. The nurse in charge of the home must ensure that all patients are assessed by a registered nurse following an accident and that any treatment required is delivered. In the event of a suspected head injury central nervous system (CNS) observations must be completed. **Ref section 4.3**
	Response by registered provider detailing the actions taken: All staff are aware of the need to ensure patients are assessed by a nurse following a fall. CNS observation charts are completed for all in the event of a sustpected head injury . Management complete audits of accident forms to ensure compliance.
Requirement 2 **Ref:** Regulation 10 (1) **Stated:** First time **To be completed by:** 15 June 2017	The responsible person and registered manager must identify any gaps in their knowledge of the application of relevant legislation, and take appropriate action to rectify. They must demonstrate a clear understanding of the process to vary the registration of the home, including timescales and action required. **Ref section 4.6**
	Response by registered provider detailing the actions taken: Both responsible person and registered manager have atended meeting with RQIA and have shown an understanding of what is required when requesting a variation of the home and especially of the importance of time scales
Recommendations	
Recommendation 1 **Ref**: Standard 43.2 **Stated:** First time **To be completed by:** 15 June 2017	The registered persons should ensure that the seating in the identified lounge is reviewed to ensure it is suitable to meet the needs of the patients. Any chair identified as compromising safe moving and handling practices should be replaced. **Ref section 4.3**
	Response by registered provider detailing the actions taken: Seating is being reviewed and adjustements are being made where needed.

Recommendation 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 15 June 2017	The registered persons should ensure that care plans are in place to direct wound care. **Ref section 4.4**
	Response by registered provider detailing the actions taken: All staff are aware of the importance of having care plans in place to direct wound care. Management complete regular audits to ensure this is completed.

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

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