Unannounced Care Inspection Report
19 May 2016

Faith House

Address: 25 Orpen Park, Belfast BT10 0BN
Tel No: 02890612318
Inspector: Sharon McKnight

1.0 Summary

An unannounced inspection of Faith House took place on 19 May 2016 from 09:15 hours to 17:35 hours.

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

For the purposes of this report, the term 'patients' will be used to described those living in Faith House which provides both nursing and residential care.

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 and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. A general inspection of the home confirmed that the premises and grounds were well maintained.

One area for improvement was identified with the update of care records following accidents. A recommendation was made.

Is care effective?

Evidenced gathered during this inspection confirmed that there were systems and processes in place to ensure that the outcome of care delivery was positive for patients. A review of care records confirmed that patients were subject to a comprehensive assessment of need which was then used to develop appropriate care plans. There was evidence to confirm that there was regular communication with patients and their relatives regarding their care. There were arrangements in place to monitor and review the effectiveness of care delivery. Patients, relatives and staff reported that they were happy with the care. We examined the systems in place to promote communication between staff, patients and relatives and were assured that these systems were effective.

There were no areas of improvement identified in the delivery of effective care.

Is care compassionate?

We observed numerous examples of how compassion was at the core of care delivery. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes and preferences.

There were no areas of improvement identified in the delivery of effective care.

Is the service well led?

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

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

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**0**	**3**

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

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 25 November 2015.

Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

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

2.0 Service details

Registered organisation/registered person: Board of Faith House – Trustees 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	**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 11 patients individually and with the majority of others in small groups, two registered nurses, one team leader, four care staff, a domestic supervisor and four relatives. Ten questionnaires were also issued to relatives and staff with a request that they were returned within one week of the date of this inspection.

The following information was examined during the inspection:

- three patient care records
- staff duty roster
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- complaints and compliments records
- incident and accident records
- records of audit
- records of staff meetings
- records pertaining to consultation with staff, patients and relatives.
- reports of monthly visits undertaken in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 25 November 2015.

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. The requirements and recommendations will be validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 25 November 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 12 (1) (b) **Stated:** First time	The registered persons shall ensure that patient individual needs and wishes regarding the end of life care are reflected in care records.	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that this requirement has been met.	
Requirement 2 **Ref**: Regulation 15 (2) (b) **Stated:** First time	The registered persons shall ensure that care records are reviewed and updated in relation to palliative care needs.	**Met**
	Action taken as confirmed during the inspection: A review of care records and discussion with the care manager evidenced that this requirement has been met.	
Requirement 3 **Ref**: Regulation 12 (1) (b) **Stated:** First time	The registered persons shall ensure all safeguarding issues are appropriately followed up and recorded.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that the previous safeguarding issue was reviewed by the relevant health and social care trust. There were no issues identified with the follow up or recording of safeguarding issues during this inspection. This requirement has been met.	

Requirement 4 **Ref**: Regulation 15 (1) **Stated:** First time	The registered persons shall ensure that a complete an audit of all care records and ensure they are reviewed to reflect the care delivered to patients.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of audit records evidenced that care records were included in the monthly audit programme. Care records reviewed were reflective of care delivered. This requirement has been met.	
Requirement 5 **Ref**: Regulation 15 (2) **Stated:** First time	The registered persons shall ensure that the term, "All care given", is not used to describe care delivery, the actual care delivered should be specifically recorded.	**Met**
	Action taken as confirmed during the inspection: The term "all care given" was not observed in the care records reviewed. This requirement has been met.	
Requirement 6 **Ref**: Regulation 12 (1) (b) **Stated:** First time	The registered persons shall ensure that all records are maintained contemporaneously.	**Met**
	Action taken as confirmed during the inspection: There were no issues identified with the contemporaneous recording of records during this inspection. This requirement has been met.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 19 **Stated:** First time	The registered persons should ensure that the policy regarding communication is updated and that management prepares and introduces a policy and procedure regarding the breaking of bad news. The policy and procedure regarding palliative care should be updated to reflect the GAIN Guidelines November 2013.	**Met**
	Action taken as confirmed during the inspection: A review of the policies regarding communication breaking of bad news and the palliative care policy evidenced that they had been reviewed and updated on 25 November 2015. The policies made reference to best practice guidance. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 19 **Stated:** First time	The registered persons should ensure that a record of all communication with patients and their representatives should be included in the care record.	**Met**
	Action taken as confirmed during the inspection: Discussion with patients evidenced that they were well informed regarding events in the home and their care. Care records reviewed evidenced regular communication with patients' families. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 32 **Stated:** First time	The registered persons should ensure that a palliative link nurse is appointed and suitably trained to guide and direct staff regarding palliative care, the palliative link nurse should attend the support meetings arranged by the local Healthcare Trust.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that a link nurse for palliative care had been identified and confirmed that they would be attending relevant training and meetings arranged by the local healthcare trust. Discussion with the link nurse confirmed that they were working with the registered manager to secure appropriate training. This recommendation has been met.	

4.3 Is care safe?

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

A review of the staffing roster for week commencing 16 May 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff, staffing rosters confirmed that administrative, catering, domestic and laundry staff were on duty daily. Two members of staff were employed to deliver activites. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients.

Patients spoken with during the inspection commented positively regarding the staff and care delivery. We also sought patient opinion on staffing via questionnaires; ten were returned following the inspection. The following comments were provided:

“busy times like mornings, sometimes have to wait.”
“would like more staff, somedays, don’t get needs met quickly enough.”

The comments received were discussed with the registered manager. They informed us that the recently appointed deputy manager commenced employment two weeks ago and will be undertaking a review of the morning routine next week This review will include staffing, skill mix and experience of staff. Given the comments received in the questionnaires it was agreed that registered manager would inform RQIA of the outcome of the review.

A form entitled “Senior cover sheet” was displayed at the front of the off duty file in the nursing and residential offices and on the notice board in the foyer of the home. This form clearly identified the nurse in charge of the home when the registered manager was off duty. A review of records evidenced that a competency and capability assessment had been completed with all nurses who were given the responsibility of being in charge of the home in the absence of the registered manager. The assessments included detail of what was discussed and the information shared under each heading. The level of detail recorded was commended. The assessments were signed by the registered nurse and the registered manager to confirm that the assessment process has been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home. A residential supervisor competency record was completed with any senior care assistant who took charge of the residential service on a daily basis. These records were signed by the senior care assistant and the registered manager.

A review of two personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. The two references in one file were printed and did not contain signatures. This was discussed with the registered manager who explained that the references had been received by electronic mail. The importance of ensuring authenticity of referees and references provided was discussed and it was agreed that the registered manager would consider measures to achieve this.

The registered manager explained that newly employed staff attended a three day, classroom based induction during which they commenced their mandatory training, for example moving and handling, and safeguarding. Following these three days new employees undertook a period of supervised practice and completed a structured orientation and induction programme. Two completed induction programmes were reviewed. On completion of the

induction programme one record had been signed by the employee and the inductor to confirm completion of the process. The registered manager also signed the record to confirm that the induction process had been satisfactorily completed. There were no dates recorded. The second induction record was signed by the inductor and the registered manager but had not been signed by the new staff member. The importance of ensuring that induction records were fully completed was discussed with the registered manager.

Mandatory training was provided by an external training organisation contracted by the home to deliver face to face training. Training opportunities were also provided by the local health and social care trust and external agencies such as The Royal College of Nursing (RCN). The registered manager had systems in place to monitor staff attendance and compliance with training. These systems included a training matrix which was colour coded to identify which staff had completed which training. Signing in sheets were also available to evidence staff attendance. A review of the training matrix evidenced good compliance with mandatory training; for example 90 out of 100 staff (90%) had completed adult safeguarding training in the past three months, 85 out of 100 (85%) had attended infection prevention and control training.

The registered manager explained that the provision of mandatory training had recently been reviewed and extended to include dementia, deprivation of liberty and human rights.

Staff spoken with confirmed that a range of mandatory training was available but commented that the scheduling of recent training resulted in them having to attend a number of sessions in close proximity; this also resulted in numerous changes to the staffing roster. These comments were shared with the registered manager who was aware of the challenges the recent training had presented for staff. We discussed the benefits of a rolling programme planned throughout the year to ease pressure on staff.

Discussion with the registered manager and a review of records evidenced that the arrangements for monitoring the registration status of nursing with the Nursing and Midwifery Council (NMC) and care staff with the Northern Ireland Social Care Council (NISCC) were appropriately managed. The registered manager was knowledgeable regarding the management of NISCC registration process for newly employed care staff.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. The registered nurses, care staff and domestic staff were aware of whom to report concerns to within the home.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk and inform the patient's individual care plans.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. The registered manager completed a monthly analysis of accidents to identify any trends or patterns. The importance of ensuring that care records were updated following an accident to reflect any identified risks was discussed and a recommendation made.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The majority of patients' bedrooms were

personalised with photographs, pictures and personal items. The home was fresh smelling, clean and appropriately heated.

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

There were no issues identified with infection prevention and control practice.

Areas for improvement

Care records should be updated following an accident to reflect any identified risks.

Number of requirements	**0**	**Number of recommendations**:	**1**

4.4 Is care effective?

We reviewed three patient care records; two of patients receiving nursing care and one receiving residential care. This review evidenced that initial plans of care were based on the pre admission assessment and referral information. A comprehensive, holistic assessment of patients' nursing needs was commenced at the time of admission to the home. As previously discussed a range of validated risk assessments were completed as part of the admission process. We identified that the range of risk assessments completed for those patients in receipt of nursing care and residential care were the same. Following discussion with the registered manager it was agreed that they would review which risk assessments were appropriate for patients in receipt of residential care. 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. Care records were regularly reviewed and updated, as required, in response to patient need. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

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

Discussion with the registered manager and staff advised 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. Staff spoken with confirmed that the shift handover provided the necessary information regarding any changes in patients' condition. A written report was completed for the registered manager at the end of each 24 hour period.

The registered manager confirmed that staff meetings were held approximately every three months and that records of these meeting were maintained. The record of each meeting was sent to the relevant head of department and a copy displayed in the home to inform staff.

Staff advised that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to

communicate effectively with their colleagues and other healthcare professionals. Staff also confirmed that if they had any concerns, they would raise these with the registered manager.

Patients spoken with commented positively in regard to the care they received. The following comments were provided:

"Anything you want done they will do it."
"I haven't had a problem since I came in."

One relative commented positively regarding staffing, communication and the general care and atmosphere in the home.

Areas for improvement

The registered manager should review which risk assessments were appropriate for patients in receipt of residential care.

Number of requirements	**0**	**Number of recommendations**:	**1**

4.5 Is care compassionate?

Throughout the inspection there was a calm atmosphere in the home and staff were quietly attending to the patients' needs. Patients were sitting in the lounges, or in their bedroom, as was their personal preference. The dining room was currently being decorated; this resulted in a section of the main lounge being used as a temporary dining space. Patients spoken with were well informed of the progress of the redecoration. When we sympathised with them regarding the disruption to normal routine it was the patients who assured us that the work was almost complete and that they would be back in the dining room by the next week. Similarly a lady in the residential unit discussed with us the planned building work and commented that whilst it would change the view from her bedroom the work was to be welcomed as it would improve the bedroom accommodation. We concluded from these interactions that patients were well informed of the day to day issues affecting them.

Work was ongoing to create mural scenes within the home. The art work was being undertaken by a member of staff and was to a high standard. One mural currently being created was an outline of a tree. The artist explained that they were creating a dignity tree; she explained that when the mural was complete all of the patients would be asked to provide a word, or phrase, that was important to them in the preservation of their dignity. These words would then be displayed on the tree. It was originally planned that the words would be painted on to the mural but to enable staff to update the tree as patients change it was decided the words would be attached rather than painted. The member of staff explained that as new patients arrive in the home their words will be included and hopefully reinforce to them that their dignity matters. This project and the future proofing of it were commended.

The nursing sister informed us of an initiative being introduced to help remind staff, patients and visitors of the need for a quiet, peaceful environment. It was explained that, with the consent of the patient and/or their relatives, a laminated photo of a waterlily would be displayed in the surrounding corridor areas of a patient who was nearing end of life. They explained that prior to implementing the initiative staff, patients and relatives would be informed of the significance of the waterlily and that the pictures would act as a reminder to keep noise and activity in the identified area to a minimum.

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. The registered manager has regular, daily contact with the patients and visitors and was available, throughout the day, to meet with both on a one to one basis if needed. Patients spoken with confirmed that they knew who the registered manager was and that she was regularly available in the home to speak with. The registered manager explained that quality assurance questionnaires were sent out annually to relatives. These were last completed in 2015, the results had been analysed and displayed in the home. We discussed what action would be taken if areas for improvement were identified in the returned responses.

The registered manager provided the example of one area that was rated as "quite poor" in a number of responses; the availablilty of refreshments for visitors. Following the responses from 2015 the Trustees of the home met and agreed that a lounge area would be refurbished in the style of a Victorian tea room. The Blue Hyacinth Tearoom opened in 2016. The attention to detail in the décor and atmosphere was commended. A patient commented that the noise of the china cups and saucers added to the atmosphere A selection of homemade buns was available, each were individually wrapped with a small label attached stating the day they were baked. There were facilities provided for patients and visitors, if they wished to make voluntary contributions towards their refreshments. A member of staff informed us of the self worth evident with one patient as they informed their relative this was their treat as they "paid" for their afternoon tea.

We were informed that prayer meetings were held every morning in the residential lounge. As patients gathered to attend the meeting they informed us of how much they valued this daily activity and looked forward to it. Hymn singing took place each evening and an evening prayer service was held on a Tuesday, Friday and Sunday. Patients also received visits from their individual ministers throughout the week.

Numerous compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

"My father was always treated with respect and dignity and all members of staff looked after him very well."

"The staff just don't deliver the care and tick the boxes - they do it with compassion and love …"

Ten patient questionnaires were issued and returned following the inspecton. All of the respondents indicated that they were satisfied or very satisfied with the care delivery in the home. Comments included:

"Quite happy here, well looked after."
"No complaints, fit in with whatever's going."

Comments provided within the domain of safe and well led have been discussed in section 4.3 and 4.6 respectively.

Ten relative questionnaires were issued; eight were returned within the timescale for inclusion in this report. The respondents comments positively regarding the care their loved ones were receiving. The following are examples of comments included.

"I have total confidence that mum is safe, cared for well and protected from harm."

"Face to face contact with manager and staff has been very good……attended relatives meetings and had opportunites to express her opinion and listen to others doing the same."

"I feel the staff do an incredible job but I feel that there just aren't enough of them…."

"The nursng staff do listen and are generally knowledgeable about the nursing needs of my relative. I feel however that more training is required in caring for residents in dementia."

Ten questionnaires were issued to staff; four were returned within the timescale for inclusion in this report. Comments provided within the domain of well led are discussed in section 4.6. All of the comments received in the questionnaires were discussed with the registered manager prior to the issue of the report.

Areas for improvement

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

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

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within its registered categories of care. The Statement of Purpose and Patient Guide were available in the home.

Staff spoken with were knowledgeable regarding line management and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Discussions with staff also confirmed that there were good working relationships between staff.

Patients and relatives spoken with confirmed that they knew who the registered manager was and that she was regularly available in the home to speak with. Those spoken with were confident that staff and /or management would address any concern raised by them appropriately. Patients confirmed that they were aware of who the registered manager was.

As previously discussed questionnaires were issued to patients, relatives and staff as part of the inspection process. Eight patients indicated that they were satisfied or very satisfied with the care delivery in the home. One patient, whilst satisfied with the care, commented that they were not sure who the manager was and another stated that since they moved lounge they didn't see as much of the registered manager.

Two other patients indicated in their returned questionnaires that they were either not well informed or would like more information (no detail of what type of information they would like).

Two staff commented that "the manager does not come to see staff or residents on a daily basis." While another suggested they could spend time getting to know everyone better.

These opinions were contrary to what was reported by patients and staff during the inspection.

The comments received in the questionnaires were discussed with the registered manager prior to the issue of the report. The registered manager responded that with the addition of a deputy manager and with the nursing sister moving to day duty this would provide a more accessible management team and an increased management presence throughout the home.

Relatives' meetings were held quarterly. The registered manager explained that they display posters on the home to advertise the date and they are currently setting up a "text master" system to remind relatives by text message.

A record of complaints was maintained. There were details of correspondence with the relevant healthcare trust and details of the action taken. The nature of the complaint was recorded in the patient's care record. There was no record of the complainant's level of satisfaction. Following discussion with the registered manager it was agreed that the recording of complaints would be further developed to include whether or not the complainant was satisfied with the outcome and how this level of satisfaction was determined. A recommendation was made.

There were numerous thank you cards and letters received from former patients and relatives; examples of these have been included in the previous domain.

As previously discussed there were systems in place to ensure that notifiable events were investigated as appropriate and reported to the relevant bodies. The registered manager completed a monthly analysis of falls to identify any trends or patterns.

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

The unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. A copy of the report was maintained and available in the home; the report included an action plan to address any identified areas for improvement. There was evidence in the reports that the action plan was reviewed during the next visit.

The registered manager explained that they meet with the Professional Nurse Advisory Committee quarterly. This is a committee set up to discuss nursing issues and advise the Board of Trustees, Faith House on matters related to nursing. There was evidence in the report of the unannounced monthly visit in March 2016 of how the advisory committee could work in collaboration with the nursing staff regarding environmental improvements. It was good to note that Board of Trustees, Faith House, as the registered provider, has support and guidance from a professional nursing committee.

Areas for improvement

The recording of complaints should be further developed to include whether or not the complainant was satisfied with the outcome and how this level of satisfaction was determined.

Number of requirements	**0**	**Number of recommendations**:	**1**

5.0 Quality improvement plan

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

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the 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 person/s meets legislative requirements based on 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to *Nursing.Team@rqia.org.uk* and assessed 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 person/manager 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 person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref:** Standard 4.8 **Stated:** First time **To be completed by:** 16 June 2016	Care records should be updated following an accident to reflect any identified risks. **Ref section 4.3**
	Response by registered person detailing the actions taken: · Staff completing accident forms aware of need to review any identified risks and update accordingly within care plans. Management completing audits to ensure compliance.
Recommendation 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 16 June 2016	It is recommended that the registered manager review which risk assessments are required for patients in receipt of residential care. **Ref section 4.4**
	Response by registered person detailing the actions taken: · Management team addressing risk assessments used in residential care and using guidance from minimum standards are removing those not necessary.
Recommendation 3 **Ref:** Standard 16.11 **Stated:** First time **To be completed by:** 16 June 2016	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. **Ref section 4.6**
	Response by registered person detailing the actions taken: Management have made provision within complaints book for entry of discussion had with complainant re outcome.

Registered manager completing QIP	[signature]	**Date completed**	5/7/16.
Registered person approving QIP	[signature]	**Date approved**	5/7/16
RQIA inspector assessing response	[signature]	**Date approved**	13-7-16.

The **Regulation** and **Quality Improvement** Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews