Unannounced Care Inspection Report
25 and 26 May 2016

Holywood Nursing Home

Address: 221 Old Holywood Road, Holywood, BT18 9QS
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Inspector: Dermot Walsh

1.0 Summary

An unannounced inspection of Holywood took place on 25 May 2016 from 09.40 to 17.00 and 26 May 2016 from 10.05 to 15.00.

The inspection sought to assess progress with 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.

Is care safe?

Safe systems were in place for recruitment and for monitoring the registration status of nursing and care staff. Weaknesses were identified in the delivery of safe care, specifically in relation to compliance with best practice in infection prevention and control and with the management of a malodour within the home. One requirement and one recommendation have been stated to secure compliance and drive improvement.

Is care effective?

There was evidence that assessments informed the care planning process. Staff were aware of the local arrangements for referral to other health professionals. Communications between health professionals were recorded within the patients' care records. A weakness had been identified in the delivery of effective care specifically in relation to the accurate completion of fluid balance charts. However, it is acknowledged that staff were following a directive from Four Seasons Health Care (FSHC) regarding the completion of the fluid balance charts. This directive has since been withdrawn by FSHC. Staff meetings should take place on a quarterly basis for all members of staff and appropriate records of the meetings should be maintained. Two recommendations have been made in this domain. A requirement on the completion of contemporaneous care records has been stated for the second time.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. Patients and their representatives were very praiseworthy of staff and a number of their comments are included in the report. The mealtime experience was observed to be well organised and pleasurable for the patients.

Is the service well led?

Audits reviewed, evidenced actions taken to address any shortfalls. This had been verified by the registered manager. Systems were in place to manage urgent communications, safety alerts and notices. Monthly monitoring visits included an overview of governance arrangements within the home and formulated an action plan to address any shortfalls identified. A procedure was in place to manage complaints. There were no requirements or recommendations stated in the well led domain. In total one requirement and three recommendations have been made in the other three domains as detailed above. One requirement and two recommendations have been stated for a second time from the previous QIP.

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*	5*

*The total number of requirements and recommendations made includes one requirement and two recommendations that have been stated for the second time.

Details of the QIP within this report were discussed with Mauro Magbitang, 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 care inspection

The most recent inspection of the home was an unannounced care inspection dated 5 November 2015. Other than those actions detailed in the previous QIP there were no further actions required.

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

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Dr Claire Royston	**Registered manager:** Mr Mauro J Magbitang Jr
Person in charge of the home at the time of inspection: Mr Mauro J Magbitang Jr	**Date manager registered:** 5 May 2015
Categories of care: NH-DE, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 73

3.0 Methods/processes

Prior to inspection we analysed the following information:

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

During the inspection we met with 10 patients individually and others in small groups, six patient representatives, four care staff, three registered nursing staff and one ancillary staff member.

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 inspector.

Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff not on duty. Nine patient, nine staff and seven patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- three patient care records
- staff training records
- staff induction template
- complaints records
- incidents / accidents records since the last care inspection
- minutes of staff meetings
- a selection of audit documentation
- a recruitment file
- competency and capability assessments for nurse in charge
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- fire log book
- duty rota from 16 - 29 May 2016

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 5 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 and will be validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 5 November 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 15 (2) (b) **Stated:** First time	It is required that the assessment of patients' needs are revised as required but not less than annually.	**Met**
	Action taken as confirmed during the inspection: A review of three patient care records evidenced that the assessment of patients' needs had been revised appropriately.	
Requirement 2 **Ref:** Regulation 19 (1) (a), schedule 3, (3) (k) **Stated:** First time	It is required that the registered person must ensure contemporaneous records of all nursing provided to the patient are recorded accurately to evidence actual care given and accounts for any concerns or deficits identified. Particular attention should focus on the areas identified on inspection.	**Not Met**
	Action taken as confirmed during the inspection: Three patient care records were reviewed and evidenced that contemporaneous records of nursing care provided to the patients were not appropriately or consistently recorded. Please see section 4.4 for further clarification. This requirement will be stated for the second time.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 4 Criteria (5) (6) (11) **Stated:** First time	It is recommended that care records should evidence patients and/or their representatives' involvement in the assessment; planning and evaluation of the patients care to meet their needs. If this is not possible the reason should be clearly documented within the care record.	**Met**
	Action taken as confirmed during the inspection: Two out of three care records had been signed as reviewed by the patient/representative. An assurance was given by the registered manager that the third patient care record would be reviewed and signed by the patients' next of kin at the earliest opportunity.	
Recommendation 2 **Ref:** Standard 4 Criteria (1) (7) **Stated:** First time	It is recommended that patients' continence assessments and care plans are fully completed and include the specific continence products required by the patient	**Partially Met**
	Action taken as confirmed during the inspection: Two out of three continence assessments reviewed had been appropriately completed and contained the specific continence product required to meet the continence need of the patient. The third record did not specify the product required. This recommendation will be stated for the second time.	
Recommendation 3 **Ref:** Standard 46 Criteria (1) (2) **Stated:** First time	It is recommended that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection.	**Not Met**
	Action taken as confirmed during the inspection: During a review of the environment, it was observed that compliance with best practice in infection prevention and control had not been complied with. Please see section 4.3 for further clarification. This recommendation will be stated for the second time	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 16 - 29 May 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives and staff evidenced that all but one patient representative had no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training. The registered manager would review training records monthly and identified training needs would be communicated to staff through an online 'care blox' system. Once a staff member signed in online to commence duty, the care blox message would appear to remind the staff to complete the named training. Compliance with mandatory training for 2015 to 2016 was at 96 percent.

Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Observation of the delivery of care evidenced that training had been embedded into practice.

Competency and capability assessments of the nurse in charge of the home in the absence of the manager had been completed appropriately and signed by the nurse and the person conducting the assessment. The completed assessments were reviewed and verified by the registered manager. A competency and capability of the nurse in charge assessment was observed to have been completed on a nurse who was completing their preceptorship period. This was discussed with the registered manager who confirmed that this was used as an assessment for a nurse in charge of a unit within the home. As this assessment was the same one used for assessing the nurse in charge of the home, it was agreed that a distinction should be made between the two assessments.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC). NMC and NISCC checks were monitored monthly and evidenced within a file.

A review of the recruitment process evidenced a safe system in practice. Relevant checks and interviews had been conducted prior to the staff member commencing in post. The registered manager maintained a file of registered nurses who had been suspended or removed from the NMC register.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Discussion with the registered manger confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures.

Review of three patient 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.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since 5 November 2015 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The rooms and communal areas reviewed were clean and spacious with the exception of one room as detailed below. Fire exits and corridors were observed to be clear of clutter and obstruction. However, a range of issues were identified within the home which were not managed in accordance with best practice infection prevention and control guidelines:

- inappropriate storage in identified rooms
- rusting commodes and shower chairs in use
- commodes and shower chairs not effectively cleaned after use
- pull cords in use without appropriate covering
- identified ripped furniture and ripped crash mats in use
- un-replenished personal protective equipment holders
- the use of nail clippers between patients without appropriate decontamination as stated by a staff member
- high dusting required on wardrobes

The above issues were discussed with the registered manager on the day of inspection and a requirement was made. An assurance was provided by the registered manager that these areas would be addressed with staff and measures taken to prevent recurrence. A recommendation was made in the previous QIP that management systems are put in place to ensure compliance with best practice in infection prevention and control. This recommendation has been, stated for a second time.

During a review of the premises a malodour was detected in an identified room. The room was revisited later the same day and on the second day of inspection. The malodour remained prevalent. A recommendation was made.

Areas for improvement

It is required that the registered person ensures the infection control issues identified on inspection are managed to minimise the risk and spread of infection.

It is recommended that the identified malodour within the home is managed appropriately.

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

4.4 Is care effective?

Review of three 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. Care plans had been reviewed monthly.

Staff demonstrated an awareness of patient confidentiality in relation to the storage of records. Records are stored securely in lockable cabinets at the nursing stations. A review of bowel management records and repositioning charts evidenced these had not been completed in accordance with best practice guidelines. One patient's care record indicated a gap of 11 days between recorded bowel movements. The patient's daily evaluation notes, within the care record, referred to "incontinence care given" and not indicating if a bowel movement had occurred or making reference to the Bristol Stool Chart. Repositioning charts were recorded inconsistently with regards to evidencing skin checks at the time of repositioning. One patient had a potential of four fluid targets within the care records. A requirement regarding the accurate completion of contemporaneous records to evidence care delivery was stated as a result of the previous care inspection (see section 4.2). This requirement has been stated for a second time.

Printed on the fluid balance charts in use in the home, issued by FSHC, was a direction that 'prescribed nutritional drinks should only be recorded as fluid intake where a person is on fluids only with no solid food intake.' This was discussed with a senior community dietician following the inspection, who confirmed that as nutritional drinks are largely fluid they should be included as part of the patients daily fluid intake and recorded on their fluid balance chart. This would be particularly significant if a patient was on a prescribed fluid restriction relating to a medical condition. A requirement would have been made to ensure the accurate recording of patients' fluid intake. However, the resident experience manager gave assurances during feedback of the actions taken by FSHC to ensure the accurate recording of fluid intake. Following the inspection confirmation was received that an email was sent to all FSHC home managers with the instruction that with immediate effect, all fluid supplements must be included in the fluid balance chart for any resident that has been assessed as requiring their fluids to be monitored. This will be reviewed on the next inspection.

Registered nurses were aware of the local arrangements and referral process to access other relevant professionals, for example General Practitioner's (GP), SALT, dietician and TVN. Care records reviewed adhered to recommendations prescribed by other healthcare professionals.

Discussion with the registered manager confirmed that a general staff meeting had been scheduled for October 2016. There was evidence of a meeting having occurred on 24 May 2016 between the registered manager and the team leaders in the home. The registered manager confirmed that it would be the responsibility of the team leaders to disseminate the information received during this meeting to all appropriate staff within their identified units. A review of documentary evidence of these meetings having occurred was found to be poorly recorded. One unit had informal meetings which were not documented. The other unit had minutes of three meetings in the past year; the only recorded attendee was the chairperson.

There was evidence of a registered nurse meeting for all registered nurses within the home conducted on 18 June 2015. Separate staff meetings were also held for domestic and kitchen staff twice yearly. The registered manager confirmed that minutes of meetings would be displayed on the staff noticeboard and staff would be advised of the availability of the minutes via the 'care blox' system. The registered manager confirmed that an action plan would be developed if actions had been identified within the meetings. It was recommended that staff meetings take place on a regular basis and at a minimum quarterly. A record of the meeting should be maintained including details of date, attendees, discussions had and actions agreed.

The registered manager confirmed that, following a request from relatives, relatives meetings were now conducted on a six monthly basis. A meeting was scheduled for 27 June 2016.

Relatives had been advised of the meeting via post and a poster was displayed with the details of the meeting. Patients may also attend the relatives meeting if they wish. Minutes of the relatives' meetings are posted to all named relatives in the home. The registered manager confirmed that guest speakers are also invited to attend meetings, for example, The Alzheimer's Society. The registered manager also confirmed that they operate an open door policy to allow relatives and patients to meet with them at any time.

The registered manager informed us that any important communications to relatives, outside the six monthly meetings, would be sent via post. A copy of all communications sent would be maintained in a personal patient named file in the administrator's office. This file would also contain all business correspondence such as contracts or finance dealings.

Additional patients' meetings were conducted by the Personal Activity Leader (PAL) in the home. These meetings would be informal. The registered manager and the PAL would meet on a monthly basis and discuss topics for inclusion in the patients' meetings. The meetings could be on a one to one basis or on a group basis as required. Records of the meetings were maintained by the PAL.

The registered manager confirmed that they would undertake a daily, recorded walk around the home and would avail of the opportunity to engage with patients and relatives at this time.

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

Patients and representatives were confident in raising any concerns they may have with the staff and/or management.

Information leaflets were available to staff, patients and/or representatives at the entrance to the home. These included information on the quality of life programme (QOL), advice on funding for care, laundry, incontinence, dementia care and infection prevention and control issues.

A notice was at the entrance to the dementia unit informing all visitors to speak with the nurse in charge before giving any food or drinks to patients. This was due to dietary requirements and to minimise the risk of choking.

During the inspection, two patient representatives in the dementia unit commented on what they perceived to be a lack of activities in the unit. An electronic activities programme was available at the reception area to the home. A plan of weekly visits from people outside of the home was on display in the dementia unit. A recommendation was made to review the programme of activities to ensure meaningful activities were carried out with patients in the dementia unit.

Areas for improvement

It is recommended that staff meetings take place regularly and at a minimum quarterly. Records should be maintained to include detail of date, attendees, minutes of discussions and any actions agreed.

It is recommended that the programme of activities is reviewed to ensure meaningful activities are carried out with patients in the dementia unit.

Number of requirements	0	Number of recommendations:	2

4.5 Is care compassionate?

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, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent. Nine staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. Six of the questionnaires were returned within the timescale for inclusion in the report. The respondents indicated that the care in the home was of a high standard. On inspection three registered nurses, four carers and one ancillary staff member were consulted to ascertain their views of life in Holywood.

Some staff comments are as follows:
'I really enjoy it here.'
'I like the job I'm doing.'
'I really like it here.'
'It's a nice environment to work in.'

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives, and staff on the running of the home. A 'Quality of Life' feedback system was available at the reception area. This is an iPad which allows patients, relatives/representatives, visiting professionals and/or staff to provide feedback on their experience of Holywood. A portable iPad is also available to record feedback from patients. This feedback is ongoing and is shared with the regional manager. Anyone completing the feedback has the option to remain anonymous or leave their name. Management have the option to contact people who leave their contact details to gain further clarification on the feedback received.

All feedback reports are acknowledged by the registered manager. Any actions taken as a result of the feedback is submitted to FSHC head office. Views and comments recorded were subsequently analysed and an action plan was developed and shared with staff, patients and representatives through staff and relative meetings. Any urgent feedback would be communicated with staff through the 'care blox' system. The registered manager confirmed the results and any actions taken would also be included within the annual quality report.

Patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Consultation with 10 patients individually, and with others in smaller groups, confirmed that the care was safe, effective, compassionate and well led. Nine patient questionnaires were left in the home for completion. Six patient questionnaires were returned within the timeframe.

Some patient comments are as follows:
'I'm well looked after.'
'I have no complaints.'
'I find it satisfactory here.'
'It's very good here.'
'It's perfect.'

Six patient representatives were consulted on the day of inspection. Seven relative questionnaires were left in the home for completion. One relative questionnaire was returned within the timeframe.

Some representative comments are as follows:
'I find the care absolutely brilliant.'
'I find the care fine.'
'Staff don't communicate very well. Wouldn't tell us how …is unless we asked.'
'I'm concerned about the number of staff on duty. It's hard to find staff at times.'
'I find the care staff very attentive.'

As previously stated in section 4.4, two representatives were concerned with the activities provision in the dementia unit. A recommendation was made in the previous section. All comments were reported to the home's management at feedback.

The patients' mealtime experience was reviewed during the inspection in the dementia unit. The mealtime was well supervised. Food was served from a bain-marie when patients were ready to eat or be assisted with their meals. Staff wore the appropriate aprons when serving or assisting with meals and patients wore dignified clothing protectors. One patient was observed wearing a blue plastic apron. This was discussed with the nurse in charge of the unit and it was evidenced within the patient's nutrition care plan that this was the patient's choice.

A selection of condiments were on the tables and a range of drinks were offered to the patients. The food appeared nutritious and appetising. A patient's family member was present during the dining experience and this was welcomed by staff. A menu was on display on the wall of the dining area in a written format. It was discussed during feedback that a pictorial menu may be more appropriate to assist patients choose their meal. The mealtime experience was observed to be well organised and pleasurable for the patients.

Areas for improvement

No areas for improvement were identified during the inspection under the compassionate domain.

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

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the registered manager evidenced that the home was operating within its registered categories of care.

Discussion with the registered manager and review of the home's complaints record evidenced 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 procedure was displayed at reception. The complaints policy had been reviewed on 25 March 2015.

Policies and procedures were maintained electronically. Policies specific to each unit had been printed and maintained within files which were located at the nursing stations. Staff had 24 hour access to online facilities within the home. The registered manager confirmed that new policies and any reviews of policies or procedures were communicated to staff via the previously mentioned 'care blox' system.

A record of compliments was maintained. Some examples of compliments received are as follows:

'A big thank you for all your care during mum's stay. We were so happy to know mum was well cared for in her last days.'
'Thank you for all the care provided to … during her recent admission and rehabilitation. This contributed greatly to her being able to get back to her baseline.'

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

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, monthly audits were completed in accordance with best practice guidance in relation to wound analysis, care records, infection prevention and control, falls, medicines management, complaints, restraint, bed rails, hand hygiene, personal protective equipment, hoists/slings, health and safety and incidents/accidents.

As previously indicated in section 4.3, the system to monitor best practice compliance with infection prevention and control requires further development. Online 'TRaCA' audits are conducted on housekeeping, daily/weekly medications management, health and safety, resident care, weight loss and the homes governance arrangements. All TRaCA audits demand an 'actions taken' section to be completed for every audit even if the audit had achieved 100 percent compliance. The action taken could be confirmation that the information was shared with staff. All actions taken are documented online by the registered manager. The system would notify the registered manager of any audit that had not been actioned.

A care record audit was reviewed. The audit had been completed by the deputy manager of the home. The deputy manager developed an action plan to address shortfalls identified within the audit. The action plan was given the named nurse responsible for the care record who would address the actions and sign the action plan as completed. The registered manager would verify the actions as completed with a signature. The registered manager confirmed that audit results would be discussed at staff meetings. More urgent findings would be communicated through the 'care blox' system.

Urgent communications, safety alerts and notices were reviewed by the registered manager on receipt and, where appropriate, were shared with staff. A system was in place to ensure that all relevant staff had read the communication or had been notified about it. A safety alert folder was maintained at the nurses' station.

Discussion with the registered manager and review of records evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. An action plan was generated within the report to address any areas for improvement and a review of the previous action plan was included within the report. Copies of the reports were available for patients, their representatives, staff and trust representatives.

Discussions with staff confirmed that there were good working relationships within the home and that management were responsive to any suggestions or concerns raised.

Areas for improvement

No areas for improvement were identified during the inspection under the well led domain.

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

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mauro Magbitang, Registered Manager, 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

Statutory requirements

Requirement 1 **Ref:** Regulation 19 (1) (a), schedule 3, (3) (k) **Stated:** Second time **To be completed by:** 21 June 2016	It is required that the registered person must ensure contemporaneous records of all nursing provided to the patient are recorded accurately to evidence actual care given and accounts for any concerns or deficits identified. Particular attention should focus on the areas identified on inspection. **Ref: Section 4.2**
	Response by registered person detailing the actions taken: Care plans reviewed and revised to appropriately reflect the identified residents current assesssed needs. Registered Nurses and Care Assistants attended planned supervision which focused on completion of care documentation. The Registered Manager will monitor documentation through the FSHC audit process and actions identified will be included in an action plan which will be addressed within a specified timeframe. This will be reviewed and signed off by the Registered Manager when completed.
Requirement 2 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** 14 June 2016	The registered person must ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. **Ref: Section 4.3**
	Response by registered person detailing the actions taken: All infection control issues identified at the time iof inspection have been addressed as follows 1. All items appropriately stored in correct locations 2. Shower chairs and commodes that had areas of rust have now been replaced 3. Staff supervision has commenced to demonstrate the decomtamination procedure for equipment, these will continue until all staff have been completed. 4. A review of all pull cords has been completed and all now have appropriate covering in place 5. Furniture and crash mats with torn areas have been disposed of and replaced 6. A review of PPE stations has been completed and will be fully stocked going forward 7. The decontamination of nail clippers is included in the supervision as detailed in point 3 above. 8. High dusting of wardrobes has been completed

Recommendations	
Recommendation 1 **Ref:** Standard 4 Criteria (1) (7) **Stated:** Second time **To be completed by:** 30 June 2016	It is recommended that patients' continence assessments and care plans are fully completed and include the specific continence products required by the patient **Ref: Section 4.2**
	Response by registered person detailing the actions taken: Patients continence assessments and care plans are being reviewed and updated to include details of the specfic continence product to be used.
Recommendation 2 **Ref:** Standard 46 Criteria (1) (2) **Stated:** Second time **To be completed by:** 30 June 2016	It is recommended that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. **Ref: Section 4.2**
	Response by registered person detailing the actions taken: Infection control audits will be completed as per FSHC Infection Control Audit planner. The outcome of these will be reviewed and monitored by the Registered Manager and Infection Control Link Nurse and the action plan signed off when completed.
Recommendation 3 **Ref**: Standard 44 Criteria (1) **Stated:** First time **To be completed by:** 31 July 2016	The registered person should ensure that the identified malodour within the home is managed appropriately. **Ref: Section 4.3**
	Response by registered person detailing the actions taken: The identified bedroom with malodour is monitored daily and deep cleaned. This is an effect of the residents medical condition and is included in their care plan.
Recommendation 4 **Ref:** Standard 41 **Stated:** First time **To be completed by:** 31 August 2016	The registered person should ensure that staff meetings take place on a regular basis and at a minimum quarterly. A record of the meeting should be maintained including details of date, attendees, discussions had and actions agreed. All staff should have the opportunity to attend a quarterly meeting. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: Quarterly staff meetings will be held and minutes maintained.

Recommendation 5 **Ref**: Standard 11 Criteria (1) **Stated:** First time **To be completed by:** 14 July 2016	The registered person should review the programme of activities in the dementia unit to ensure meaningful activities are offered to patients. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: Activities were discussed at the recent Relatives meeting on 27.6.16; suggestions have been put forward by relatives and will be included in the activities programme planned during July, August and September. These suggestions have been based on the current residents and will be reviewed at the end of the 3 months.

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

The Regulation and Quality Improvement Authority

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