Unannounced Care Inspection Report
3 May 2016

Ashbrooke Care Home

Address: 2a Ashbourne Manor, Old Tempo Road, Enniskillen, BT74 4BB
Tel No: 02866325500
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Ashbrooke Care Home took place on 3 May 2016 from 08.00 to 16.15 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 Ashbrooke Care Home which provides both nursing and residential care.

Is care safe?

There was evidence that there were safe recruitment and selection processes; staff received an induction and their skills and knowledge was supported through training, supervision and appraisal processes. Staff were knowledgeable, in regards to their roles and responsibilities in adult safeguarding; risk assessments were completed appropriately and were used to inform the care planning process. The environment was clean and all staff were observed to adhere to infection prevention and control procedures. No areas for improvement were identified during the inspection.

Is care effective?

There was evidence that patients' risk assessments and care plans were reviewed on a regular basis. The outcome of these assessments was used to inform the care planning process. There were also systems in place to involve patients and/or their representatives in the development of care plans; and there was evidence that staff enjoyed working together as a team.

Is care compassionate?

Patients and their representatives praised staff and a number of comments are included in the report. There was evidence of a wide range of activities and patients consulted with stated that they felt their concerns/queries were listened to. However, weaknesses were identified in the mealtime experience and one recommendation has been stated to ensure that patient choice and the lack of staff interaction with patients is addressed. One recommendation has also been stated in regards to staff training.

Is the service well led?

There was evidence that management and governance systems are established to meet the needs of patients. A robust system of audits was evidenced to be maintained and the outcomes of audits were taken for action as required. Further to the evidence of good management practices there were a number of positive comments from staff, patients and patients' representatives indicating that the home was well-led. All areas for improvement identified in the last inspection had been actioned.

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	2

Details of the QIP within this report were discussed with the 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 26 January 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action was not required following this inspection.

The complaints and safeguarding records provided evidence of incidents. A review of the records confirmed that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures.

2.0 Service details

Registered organisation/registered person: Countrywide Care Homes Limited Victoria Craddock	**Registered manager:** Heather Johnston
Person in charge of the home at the time of inspection: Heather Johnston	**Date manager registered:** 19 October 2010
Categories of care: NH-I, RC-DE, NH-DE A maximum number of 32 patients in category NH-DE and a maximum of 8 patients in category NH-I, accommodated in a separate unit.. A maximum of 24 residents in category RC-DE	**Number of registered places:** 64

3.0 Methods/processes

Specific methods/processes used in this inspection include the following:

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 returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with five patients, three care staff, two nursing staff and four patient's representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- staff training records
- accident and incident records
- notifiable incidents
- audits
- records relating to prevention and protection from harm
- complaints records
- recruitment and selection records
- NMC and NISCC registration records
- staff induction, supervision and appraisal records
- staff, patients' and relatives' meetings
- staff, patients' and patients' representative questionnaires
- monthly monitoring reports in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- policies and procedures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection

The most recent inspection of the home was an unannounced care inspection completed on 26 January 2016. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 26 January 2016.

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 36 **Stated:** Second time	All policies and procedures should be reviewed to ensure that they are subject to a three yearly review. A policy on palliative and end of life care should be developed in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines (2013)* and should include the out of hours procedure for accessing specialist equipment and medication and referral to palliative care specialists. The policies and guidance documents listed above should be made readily available to staff. **Ref: Section 5.2**	**Met**
	Action taken as confirmed during the inspection: A review of the palliative and end of life care policy evidenced that this had been updated, in line with this recommendation.	
Recommendation 2 **Ref**: Standard 35.3 **Stated:** First time	The accident/incident analysis should be further developed to include traceability of audit and follow up action on identified issues. **Ref: Section 5.3**	**Met**
	Action taken as confirmed during the inspection: The falls analysis had been further updated and provided meaningful analysis. There was evidence of action taken in response to patterns and trends identified.	

Recommendation 3 **Ref**: Standard 21.1 **Stated:** First time	The continence assessments and care plans of two identified patients should be reviewed, to include the input form HSC professionals. **Ref: Section 5.4**	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager confirmed that referral for continence assessment had been made for one identified patient. The second patient was no longer accommodated in the home. Increased attention had been provided to the patient and the cleanliness of the patient's bedroom. There were no malodours evident during the inspection.	
Recommendation 4 **Ref**: Standard 35.3 **Stated:** First time	The registered manager should ensure that the training matrix includes details of mandatory training attended by bank staff. Content of all training should be maintained in the home and available for inspection. **Ref: Section 5.4**	**Met**
	Action taken as confirmed during the inspection: A review of the training matrix evidenced that all staff, including bank staff, had received training in all mandatory areas. Content on training was also maintained in the home.	
Recommendation 5 **Ref**: Standard 6.1 **Stated:** First time	The registered manager should review the quality of the towels used by patients and replace those which are worn and beyond use. **Ref: Section 5.5**	**Met**
	Action taken as confirmed during the inspection: All towels were observed to be of a good quality.	

4.3 Is care safe?

Discussion with the registered manager confirmed that there were safe systems in place for the recruitment and selection of staff. Personnel files were reviewed by the registered manager and checked for possible issues. Where nurses and carers were employed, their pin numbers were checked with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), to ensure that they were suitable for employment. Staff

consulted stated that they had only commenced employment once all the relevant checks had been completed. The review of recruitment records evidence that enhanced criminal records checks were completed with AccessNI and a register was maintained which included the reference number and date received.

Discussion with the registered manager and a review of the nursing registration checks, confirmed that registered nurses' pin numbers had been checked with the Nursing and Midwifery Council (NMC) on a regular basis, to validate their continued registration status. Registration checks with the Northern Ireland Social Care Council (NISCC) were also conducted on a regular basis.

There was evidence that new staff completed an induction programme to ensure they developed their required knowledge to meet the patients' needs. Staff consulted confirmed that they received induction; and shadowed experienced staff until they felt confident to care for the patients unsupervised. This ensured that they had the basic knowledge needed to begin work.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A training matrix had been developed which provided clear information to enable the registered manager to review staff training and see when updates/refresher training were due. This confirmed that the majority of staff had received training in all mandatory areas. Overall compliance with training also informed the responsible persons' monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. Staff completed e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, dementia, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. One staff member described the e-learning training as being enjoyable and easy to understand.

Records were also available in regards to face to face training that had been provided. This included falls prevention and specific dementia training. Training had been provided for staff about managing the behaviours of patients which challenge. Staff told us that they did experience aggressive and other behaviours from some patients that challenged them and they felt they had the necessary skills to deal with these situations. Although observation of the delivery of care evidenced that training had generally been embedded into practice in most areas, the observation of the serving of patients' breakfast evidenced a need for further training in regards to the values and principles which underpin the Care Standards for Nursing Homes, 2015. Refer to section 4.5 for further detail.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance or to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, competency and capability assessments and annual appraisals. Training had also been provided to those staff members, who had been delegated the responsibility of carrying out appraisals with staff.

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. Discussion with patients evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way. Two staff members commented that the staffing levels as such, sometimes placed the staff under pressure and that this impacted upon the amount of time they could spend talking with patients. One staff member also commented that some of the patients, who were accommodated on the residential unit, often required assistance of two staff members. There

was no impact on patient care observed during the inspection; therefore this matter was raised with the registered manager to address.

Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings. A more detailed hand-over sheet was available, to orientate new/agency staff to the patients/building.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to prevention and protection of harm. The complaints and safeguarding records provided evidence of incidents. A review of the records confirmed that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately. There was also evidence that staff were aware of and had signed the whistleblowing policy.

The registered manager stated that the home had recently become involved in a 'keeping me safe' project, in association with the local healthcare Trust. A 'safeguarding' committee had been formed and although the project was in the early stages of development, there was evidence that patients' representatives had met with the committee, to inform them of the project and to ascertain their opinions/input. This is to be commended.

Validated risk assessments were completed as part of the admission process and were reviewed as required. The assessments included where patients may require the use of a hoist or assistance with their mobility and their risk of falling; the use of bedrails and restraint, if appropriate; regular repositioning due to a risk of developing pressure damage and wound assessment, if appropriate; assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties. Where required, further assessments had been completed on an individual basis addressing issues such as risk of entrapment associated with the use of tag monitors, when patients were in bed. These risk assessments informed the care planning process. Refer to section 4.4 for further detail.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous inspection, confirmed that these were appropriately reported in accordance with regulation 30, of the Nursing Homes Regulations (Northern Ireland) 2005. Falls risk assessments and care plans were completed following each incident; and care management and patients' representatives were notified appropriately.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. Discussion took place with the registered manager regarding the weekly cleaning schedules for two sluice rooms. Although there was evidence that regular checks had been completed, there was no evidence that these rooms had been deep cleaned. This was addressed on the day of the inspection.
Fire exits and corridors were maintained clear from clutter and obstruction. Personal evacuation plans had been completed for each patient taking into account, their mobility and assistance level. These plans were reviewed monthly to ensure that they were up to date. This was in place in case the building needed to be evacuated in an emergency.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0

4.4 Is care effective?

A review of five patient care records evidenced that that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. Risk assessments as discussed previously were well maintained and informed the care planning process.

Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day. Referrals were made to relevant health care professionals, such as GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of the patient's poor nutritional intake.

The review of care records evidenced that risk assessments were completed as part of the admission process and were reviewed as required. For example, where a patient had a wound, there was evidence of regular wound assessments and review of the care plan regarding the progress of the wound. A review of the daily progress notes, evidenced that the dressing had been changed according to the care plan. Another patient who had been prescribed antipsychotic medications had a care plan included to address there use; and a care plan had also been developed in regards to the approach and interventions staff should use to alleviate any distress to the patient.

Patients who were identified as requiring a modified diet, had the relevant choke risk assessments completed and the correct food and fluid consistencies were reflected in their care plans. Patients who required the use of bedrails, had the appropriate consent forms completed, risk assessments were in place and reviewed on a regular basis and this information was included in the patients care plans. Patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans. There were some gaps noted in one patient's pain assessment tool. However, there were plans in place for training to be provided to registered nurses, to ensure that the validated pain tools were being completed properly, to generate more meaningful assessment of the patients' pain.

The care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Registered nurses consulted with were aware of the local arrangements and referral process to access other multidisciplinary professionals.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate, and there was evidence of regular communication with patient representatives within the care records.

Supplementary care records were reviewed; these relate to personal care, repositioning, food/fluid intake and elimination patterns. The review evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored. Totals of food and fluid received were recorded at the end of each day and there was evidence of patient's intake being monitored regularly. However, entries of patients' food and fluid intake were not recorded contemporaneously. This was discussed with the registered manager, who agreed to address the matter.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and it provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. 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. Information on advocacy services was not available to patients. Advocates can represent the views for patients/patients' representatives who are unable or not confident in expressing their wishes. However, registered nursing staff confirmed that advocacy services could be accessed via the patients' care management process, if required. Patients' representatives were also asked to comment regarding the safety of their relative in the home. Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management.

Discussion with the registered manager and review of records evidenced that patients and/or relatives meetings were held on a regular basis and records were maintained. Surveys had also been sent to patients and their representatives to inform the annual Quality Assurance report, in accordance with regulation 17 of the Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement

No areas for improvement were identified during this inspection.

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

4.5 Is care compassionate?

Discussion with patients 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. Patients stated that they were involved in decision making about their own care.

Although, consultation with five patients individually and with others in smaller groups, confirmed that they were afforded choice and treated with dignity and respect, observation of the serving of breakfast on the first floor did not evidence that these principles had been

embedded into practice. Some staff interactions with patients were observed to be compassionate, caring and timely. However, we did not observe that the patients had been afforded choice.

Tables were not set in advance of the breakfasts being served. Some patients were seated in the dining room 45 minutes before breakfast was served and one patient commented that they 'could get on with their breakfast, if (the staff) gave it to them'. The menu displayed in the dining room listed porridge, cereals, scrambled eggs and toast as the available choices for breakfast. We did not observe any patients being offered scrambled eggs, preserves were also not offered and there was no evidence that any patient had been offered juice. All patients drank tea with their breakfast. When we raised this with staff, we were told that 'none of them drink coffee'. Staff consulted stated that if there was a patient who liked coffee that staff would make it for them. Menus in pictoral format were not available to help patients to make a choice or make them aware of the meal to be served.

Although the atmosphere was quiet and tranquil and staff spoke in a friendly manner when encouraging patients to eat their food, there was little interaction with the patients seated in the dining room. One staff member stood up whilst providing assistance. This meant there were missed opportunities for meaningful engagement with patients. Another patient was encouraged to finish their breakfast and asked for sugar. A review of this patients care record identified the patient's preference for Weetabix in the morning had been ascertained on the preadmission assessment; however the staff did not demonstrate a detailed knowledge of patients' wishes and preferences as identified within the care record. Another patient was observed asking questions and the staff did not answer the patient for some time.

Where patients chose/were required to eat in their bedrooms, trays were delivered to their bedrooms. The trays were observed to hold up to three bowls of uncovered porridge and some staff carried single bowls of porridge to patients' rooms in their hands. Staff were also observed handling toast from the bain-marie, without wearing gloves or aprons and the door to the bain-marie was left open, so the toast was getting cold before the patients could eat it. Staff members were observed placing bowls of porridge in front of patients, without first having asked them what they wanted. These practices demonstrated that patients' dignity had not been considered. A recommendation has been made to ensure that the mealtime experience is reviewed, to ensure that patients are afforded choice and treated with respect and dignity. Refer to section 4.6 for further detail. A recommendation has also been stated regarding staff training.

As the home is registered to provide care for patients who have a diagnosis of dementia, the environment was considered in terms of how it could best support the patients living in the home. A dementia audit had previously been completed, in response to the RQIA inspection conducted on 30 July 2015. Although there was evidence that this had been completed and many improvements had been made to the environment, there were areas which remained that could be improved upon. For example, there was no signage or pictures at the bedroom doors to show the patients that the room was theirs. Bedroom doors held only nameplates and numbers. This made it more difficult for them to identify their bedroom. This was discussed with the registered manager, who acknowledged that work was still in progress in this regard and agreed to repeat the dementia audit, in order to identify further changes that could be made to make the environment more dementia-friendly.

Patients consulted with stated that they knew how to use their call bells and stated that staff usually responded to their needs in a timely manner. Patients also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain

friendships and socialise within the home. We observed a list of activities on the ground floor that included pampering, board-games, walking word games, musical activities, quizzes, reminiscence and chair-exercises. The activities co-ordinator was not present on the day of the inspection but there was evidence that a rolling programme of activities was in place. We observed that the hairdresser also visited weekly and plans were in place for hairdressing to be provided on a second day each week. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

The registered manager also described how two patients had been involved in painting a garden wall, as they had formerly worked as painters/decorators. A review of one patient's care record evidenced that social needs had been identified in an activities care plan, which was person-centred; however, not all patients had life histories completed. This was discussed with the registered manager who advised that the completion of the life histories was ongoing with the activities coordinator.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Views and comments recorded were analysed and areas for improvement were acted upon.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. There were several cards available from patients' representatives. One comment reflected the gratitude expressed by a relative and stated that the staff treated their relative with 'respect, care, kindness and compassion'. The cards also reflected that end of life care was managed sensitively and with care. Patients' care plans, as appropriate detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for the patient. This ensured that up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. All comments on the returned questionnaires were positive. Some comments received are detailed below:

Staff

'The support from staff here is very good'.
'It's a very caring home and the patients are well looked after'.
'I would be quite happy to have a relative of mine, be a patient here'.
'It's good'.
'Well-run'.

Patients

'It's very good. You get whatever you want'.
'The staff are polite. Very good really'.
'I'm alright here. Couldn't say a bad word about them'.

Patients' representatives

'I couldn't fault them'.
'Sometimes you keep having to remind them to do things'.
'The staff really go above and beyond treating (my relative) with care and compassion'.

One visiting general practitioner was also consulted and had no concerns to raise.

Areas for improvement

The mealtime experience should be reviewed, to ensure that patients are afforded choice and treated with respect and dignity. This review should address training needs of staff, as appropriate, in the principles of choice, dignity and respect which underpin the DHS Care Standards for Nursing Homes, 2015.

The registered persons should ensure that training is provided to staff, as appropriate, in the principles of choice, dignity and respect which underpin the care standards for nursing homes, 2015.

Number of requirements	**0**	**Number of recommendations**:	**2**

4.6 Is the service well led?

We received written feedback from staff, patients and relatives, who all viewed the home as being well-led. This inspection evidenced that all areas for improvement which were identified on the previous care inspection had been addressed. The registered manager also had prepared a comprehensive folder that contained much of the information that was required for inspection purposes. This is to be commended.

Consultation with staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

The registered manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis and the staff confirmed that they had access to the home's policies and procedures. There were also 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. These included medication and equipment alerts.

The home was observed to be operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was also current and displayed. The Statement of Purpose had also recently been updated.

Discussion with the registered manager and review of records evidenced that Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, monitoring visits were completed in accordance with the regulations and/or care standards and copies of the reports were available for patients, their representatives, staff and trust representatives. The monthly

monitoring report provided a comprehensive overview of areas that were meeting standards and areas where improvements were required. An action plan was generated to address any areas for improvement. Discussion with the registered manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed. Advice was given in regards to the need to specify the date the visit was conducted on.

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. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Advice was given in regards to where complaints (expressions of dissatisfaction) should be recorded and the registered manager acted upon this advice immediately. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the registered manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, the registered manager outlined how the following audits were completed in accordance with best practice guidance:

- falls
- medicines management
- care records
- infection prevention and control
- home presentation audit
- complaints
- health and safety
- kitchen audit
- in pursuit of excellence
- prevention and protection from harm audit
- training audit
- patients weight loss
- dining experience audits

Discussion with the registered manager confirmed that a range of audits were conducted on a regular basis. An audit of patients' falls was used to reduce the risk of further falls. As discussed in section 4.2, the audits for incidents and accidents had been further developed since the last inspection. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. Action had been taken to address any deficits identified. A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

However, we were not assured about the effectiveness of all the audits. For example, one recommendation has been stated in regards to the mealtime experiences, despite audits having also been conducted in these areas. The registered manager was very disappointed

that the meal-time experience had not been positive and agreed to address the matter immediately with staff. Assurances were also provided that the dining audit would be completed more frequently until the values of choice, dignity and respect are embedded into practice.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0

5.0 Quality improvement plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the 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 weaknesses that exist in the service. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 5.1 **Stated:** First time **To be completed by:** 30 June 2016	The registered persons should ensure that the mealtime experience is reviewed, to ensure that patients are afforded choice and treated with respect and dignity. **Ref: Section 4.5**
	Response by registered person detailing the actions taken: This has been reviewed and discussed with all staff. Supervisions with staff have also been addressed.
Recommendation 2 **Ref**: Standard 39.4 **Stated:** First time **To be completed by:** 30 June 2016	The registered persons should ensure that training is provided to staff, as appropriate, in the principles of choice, dignity and respect which underpin the care standards for nursing homes, 2015. **Ref: Section 4.5**
	Response by registered person detailing the actions taken: The standards has been discussed and training provided to staff.

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
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