Inspection Report

14 & 23 February 2024

Rose Lodge

Type of service: Nursing
Address: 185 Belsize Road, Lisburn BT27 4LA
Telephone number: 028 9267 6301

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Rose Lodge Care Home (Lisburn) Ltd **Responsible Individual:** Mr Kevin McKinney	**Registered Manager:** Miss Lauren McElhone – registration pending
Person in charge at the time of inspection: Miss Lauren McElhone – Acting Manager	**Number of registered places:** 48 The home is approved to provide care on a day basis to 1 person in the Dowling Wing and 1 person in the Warnock Wing.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 35
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 48 patients. The home is divided in two units both situated on the ground floor of the home. Patients have access to communal living and dining spaces as well as to the garden areas.	

2.0 Inspection summary

An unannounced inspection took place on 14 February 2024 from 7.00 am to 6.00 pm by two care inspectors, and on 23 February 2024 from 10:00 am to 12:15 pm by an estates inspector. The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

As a result of this inspection serious concerns were identified regarding the lack of robust managerial oversight and governance systems or arrangements within the home.

The audits and overall governance systems were insufficiently robust in identifying deficits and addressing these to ensure the delivery of safe and effective care. Concerns were identified in relation to the management of risks to the health and welfare of patients, with fire doors found to be wedged open, one fire exit obstructed, and patients having access to potentially harmful substances/medications in an unlocked treatment room.

Some records in relation to staff induction were not available for inspection and RQIA were not assured that these processes were robust to ensure that staff were safe to work with patients. Maintenance records in relation to water safety checks were unavailable for inspection on the first day.

Observation of staff and their practices evidenced that basic infection prevention and control (IPC) practices were not adhered to and that the management team had not proactively managed these deficits with staff. During 2022/23 RQIA had received numerous assurances that refurbishment plans for the home would progress and it was disappointing to find the levels of disrepair and poor décor throughout the home and the lack of awareness that this impacted on patients' quality of life.

Despite advice and support from RQIA, the monthly monitoring reports of the visits undertaken by the Responsible Individual in accordance with Regulation 29, continued to evidence a lack of effective monitoring to ensure that the home was compliant with Regulations and Standards and that patients receive safe and effective care. The reports lacked detail in relation to the progress made against the areas for improvement identified during the previous inspections and they contained patient, staff or families' identifiable information when this detail should be anonymised to protect confidentiality.

RQIA had raised concerns in relation to management and governance systems following previous care inspections in March, July and October 2023. A Serious Concerns meeting was held on 2 August 2023 and a meeting with the intention of issuing Failure to Comply (FTC) notices was held on 8 November 2023. Despite assurances given by the Responsible Individual, there has been continued lack of compliance with the Regulations.

There has been a significant turnover of managers over the last two years and a manager has not been appointed who meets the minimum requirements as set out in the Care Standards for Nursing Homes (2022).

RQIA were not assured that the governance, management and leadership systems were effective to ensure the delivery of safe and effective care to patients, and that patients, staff and visitors may be at risk of harm.

Enforcement action resulted from the findings of this inspection. A meeting was arranged with the Responsible Individual on 26 February 2024 with the intention of issuing three Failure to Comply (FTC) notices in respect of The Nursing Homes Regulations (Northern Ireland) 2005; these were in relation to:

- Regulation 10 (1) relating to the management and governance arrangements
- Regulation 27 (2) (d) (1) relating the fitness of premises
- Regulation 13 (1) (a) (b) relating the health and welfare of patients

At the meeting the Responsible Individual provided RQIA with some assurances regarding the serious concerns identified. However, RQIA were not satisfied that robust management arrangements were in place.

As a result, one FTC notice (FTC Ref: FTC000217) was issued in respect of Regulation 10 (1) relating to the management and governance arrangements, with the date of compliance to be achieved by 25 April 2024.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

In preparation for this inspection, a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection patients, staff and relatives were asked for their opinion on the quality of the care and their experience of living, visiting or working in Rose Lodge. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The findings of the inspection were discussed with Miss Lauren McElhone, Acting Manager; and Mr Kevin McKinney, Responsible Individual at the conclusion of the inspection.

4.0 What people told us about the service

Patients spoke positively about the care that they received and about their interactions with staff. Patients confirmed that staff treated them with dignity and respect and that they would have no issues in raising any concerns with staff. One patient said, "I like the staff, they are nice and pleasant", while another patient said, "The girls work so hard, they are so busy. They are pleasant and caring and they get to know you as a person." A third patient said, "The staff are kind. I am as happy as I can be."

Comments received from one patient were discussed with the manager at the end of the inspection; the manager agreed to follow up with the patient directly to address the matter raised.

A regular visitor to the home told us that they always had “a good feel” about the home and that they observed the patient they visited to be content saying that they were “very happy and pampered”, and that the patient “never has a complaint.”

Staff spoken with said that Rose Lodge was a good place to work. Staff commented positively about the manager and described them as supportive and approachable. One staff member said, “we have a really good manager who takes care of us.” Discussion with the manager and staff confirmed that there were good working relationships between staff and management.

No responses were received to the online staff survey and no questionnaires were returned by patients or their relatives.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 25 October 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 13 (1) (a) (b) **Stated:** Third time	The registered person shall ensure that all falls are managed in line with best practice guidance and that neurological observations are consistently recorded.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for Improvement 2 **Ref:** Regulation 29 **Stated:** Third time	The registered person shall ensure that the Regulation 29 monitoring visits are robust and clear on the actions required to drive the necessary improvements to ensure compliance with regulations and standards.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement was not met and has been subsumed into the FTC notice issued under Regulation 10 (1). Refer to Section 5.2.5 for further details.	

Area for Improvement 3 **Ref:** Regulation 20 (1) (c) (i) **Stated:** Second time	The registered person shall ensure that all staff receive mandatory training to enable them to meet the needs of patients safely and effectively. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met.	**Met**
Area for Improvement 4 **Ref:** Regulation 27 (4) (e) (f) **Stated:** Second time	The registered person shall implement a robust system to ensure that staff receive training and participate in emergency evacuation fire drills **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met.	**Met**
Area for Improvement 5 **Ref:** Regulation 31 (1) (b) **Stated:** Second time	The registered person shall ensure that any changes in the management arrangements of the home are notified to RQIA without delay. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met.	**Met**
Area for Improvement 6 **Ref:** Regulation 10 (1) **Stated:** Second time	The registered person shall ensure that there is a robust system of governance in place to demonstrate managerial oversight of the home to ensure that the home is well led and is delivering safe, effective and compassionate care. **Action taken as confirmed during the inspection**: This area for improvement was not met and has been subsumed into the FTC notice issued under Regulation 10 (1). Refer to Section 5.2.5 for further details.	**Not met**

Area for Improvement 7 **Ref:** Regulation 24 **Stated:** First time	The registered person shall ensure that there is a robust complaints system in place to manage any expressions of dissatisfaction received.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for Improvement 8 **Ref:** Regulation 29 **Stated:** First time	The registered person shall ensure that a copy of the monthly monitoring report is submitted to RQIA on or before the 5th working day of each month until further notice. The reports shall include details of progress made in relation to the homes' quality improvement plan (QIP)	**Partially met**
	Action taken as confirmed during the inspection: This area for improvement was partially met and has been subsumed into the FTC notice issued under Regulation 10 (1). Refer to Section 5.2.5 for further details.	
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 4 **Stated:** Second time	The registered person shall ensure that patient care records are maintained up to date, with relevant and accurate information.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for Improvement 2 **Ref:** Standard 19.4 **Stated:** First time	The registered person shall ensure that there is a system in place to easily identify each member of staff by their name and role within the home.	**Partially met**
	Action taken as confirmed during the inspection: This area for improvement is partially met and is stated for a second time. This is discussed further in section 5.2.1.	

Area for improvement 3 **Ref:** Standard 41 **Stated:** First time	The registered person shall ensure that there is a system in place that effectively communicates to those visiting and living in the home, who the nurse in charge is	**Partially met**
	Action taken as confirmed during the inspection: This area for improvement is partially met and is stated for a second time. This is discussed further in section 5.2.1.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

A review of staff selection and recruitment records evidenced that staff members were recruited safely ensuring that pre-employment checks had been completed prior to each staff member commencing in post. Oversight of the required criminal record checks was not clearly recorded in the recruitment records held in the home. This was discussed with management who provided assurances that this evidence would be clearly recorded in future.

Staff members employed to work in the home were provided with a comprehensive induction programme to prepare them for providing care to patients, this included agency staff. However, review of the duty rota and discussion with the manager confirmed that at least three staff from a separate care home had worked in Rose Lodge in recent weeks. There was no evidence that these staff had received a recorded induction specific to Rose Lodge. An area for improvement was identified.

Checks were made to ensure that staff maintained their registration with the Nursing and Midwifery Council (NMC) or with the Northern Ireland Social Care Council (NISCC). It was noted that evidence of managerial oversight of these records was not consistently recorded. This was discussed with the manager who gave assurances that these records would clearly record managerial oversight in the future.

The staff duty rota accurately reflected the staff working in the home on a daily basis. This rota identified the person in charge when the manager was not on duty. However, the rota did not include the full name of all staff. The rota was not signed by the nurse manager or a designated representative and it did not clearly record the actual hours worked by staff. An area for improvement was identified.

There was a system in place to identify the nurse in charge of the home to those living in and/or visiting the home. However, this system was not consistently updated by staff; the nurse in charge displayed on the day of inspection was incorrect. In addition, a number of staff were observed to not adhere to the home's uniform policy and did not wear name badges. Areas for improvement identified at the previous care inspection have been stated for a second time.

Review of records confirmed that most of the staff who take charge of the home in the absence of the manager had completed a competency and capability assessment to be able to do so; however, assessments for three staff had not been completed. This was discussed with the manager who advised these would be completed without undue delay and that the identified staff would not take charge until the appropriate assessment was completed. An area for improvement was identified.

There were systems in place to ensure that staff were trained and supported to do their job. Staff consulted with confirmed that they received regular training in a range of topics such as first aid, infection prevention and control (IPC) and fire safety.

Staff said they felt well supported in their role and were satisfied with the level of communication between staff and management. Staff reported good team work and had no concerns regarding the staffing levels. Records reviewed evidenced that staff meetings were not held on a regular basis. This was discussed with the manager and to ensure staff meetings are held on at least a quarterly basis, an area for improvement was identified.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Observation of the morning handover confirmed staff members were knowledgeable of patients' needs, their daily routine, wishes and preferences.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner and by offering personal care to patients discreetly. Staff members were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs.

Observation of the morning medicine round noted medicines had not been dispensed until approximately midday. This was discussed with the manager who agreed to meet with registered nursing staff and review the morning routine as some medicines need to be administered in a timely manner to ensure therapeutic benefits are effective.

Patients who were less able to mobilise required special attention to their skin care. These patients were assisted by staff to change their position regularly. Examination of the recording of repositioning evidenced these were generally well completed.

Management of wound care was examined. Review of an identified patient's care records confirmed that the wound was not redressed as prescribed; the care plan did not direct how the wound should be redressed and evaluations did not consistently comment on the progress or condition of the wound. An area for improvement was identified.

Improvements were noted regarding the management of falls. Examination of records confirmed that neurological observations were completed consistently in keeping with best practice guidance. However, care plans and risk assessments were not consistently updated following a fall. This was discussed with the manager and an area for improvement was identified.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Lunch was a pleasant and unhurried experience for the patients. The food served was attractively presented and smelled appetising and portions were generous. A variety of drinks were served with the meal. Patients spoke positively in relation to the quality of the meals provided. Patients may need support with meals ranging from simple encouragement to full assistance from staff. Staff attended to patients' dining needs in a caring and compassionate manner while maintaining written records of what patients had to eat and drink, as necessary.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake were in place to direct staff. Staff told us how they were made aware of patients' nutritional needs to ensure that patients received the right consistency of food and fluids.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment, care plans should be developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Review of a selection of care records evidenced that care plans had been developed in a timely manner and accurately reflected patients' assessed needs.

Examination of daily evaluations of care confirmed that while some entries were patient centred, there was evidence that some nursing staff had not evaluated the delivery of care during their shift. This was discussed with the manager who confirmed they were aware of this and had spoken with staff in relation to their record keeping. To ensure nursing staff evaluate care on a consistent basis, an area for improvement was identified.

It was observed that information relating to patients care and treatment was had been stored in an unlocked room and could be easily accessed by anyone entering the area. This was discussed with the manager who took necessary action to secure the information. An area for improvement was identified.

Patients spoke positively about the care that they received and confirmed that staff attended to them in a timely manner; patients also said that they would have no issue with raising any concerns to staff. It was observed that staff responded to patients' requests for assistance in a prompt, caring and compassionate manner.

5.2.3 Management of the Environment and Infection Prevention and Control

Multiple areas in the home required repair or decoration. Areas of concern observed included; stained flooring, stained/worn carpets throughout the home, stained bedroom and corridor walls and damaged/chipped skirting boards and door frames.

It was disappointing to observe the levels of disrepair and poor maintenance of décor throughout the home, despite the previous assurances received from the Responsible Individual. These serious concerns identified were discussed with the Responsible Individual during inspection feedback and at the meeting on 26 February 2024. While some assurances were provided at this meeting an area for improvement was identified with regard to maintenance of the home's environment.

Observation of patient areas evidenced that patient equipment such as chairs, moving and handling aids, a specialised inflatable mattress and some patients' personal toiletries were being stored inappropriately in bathrooms were there were toilets. Other patient equipment, such as a foam cushion and catheter tubing, was observed on top of a bin in a bathroom. This was brought to the attention of the manager early on the morning of the inspection and remained there until later in the afternoon. In order to drive the necessary improvements an area for improvement was identified.

RQIA evidenced serious concerns about the management of risks to the health safety and wellbeing of patients, staff and visitors to the home. For example, the home's treatment room was unlocked with access to medications and sharps; multiple oxygen cylinders were observed to have been unsafely stored and two fire doors were wedged or propped open while another fire exit was blocked with patient equipment. These matters were discussed with staff who took immediate action. Areas for improvement were identified.

Examination of the environment and discussion with staff evidenced deficits relating to legionella prevention controls. It was noted that a water outlet in one identified bathroom in the home had not been managed appropriately. RQIA requested records regarding flushing of infrequently used water outlets but were advised by staff that these were not on site. This was discussed with the manager and the aligned estates inspector following the inspection. An inspection was carried out by an estates inspector on 23 February 2024. These findings are discussed in section 5.2.6. Such records should be kept in the nursing home and be available for inspection. This formed part of the FTC Notice under Regulation 10 (1) of The Nursing Homes Regulations (Northern Ireland) 2005.

There were laminated posters displayed throughout the home to remind staff of good hand washing procedures. Hand sanitisers were readily available throughout the home. Personal protective equipment (PPE) such as aprons were stored on hand rails and some were found to be on the floor; this inappropriate storage may have led to this equipment being contaminated. This was discussed with the manager who provided assurances that this would be reviewed without delay.

Discussion with staff confirmed that training on IPC measures and the use of PPE had been provided, although shortfalls in staff practice were noted. Some staff members were observed to carry out hand hygiene at appropriate times and to use PPE correctly; other staff did not. Some staff members were not familiar with the correct procedure for the donning and doffing of PPE while others were not bare below the elbow. This was discussed with the manager and an area for improvement was identified.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. Some patients told us they liked the privacy of their bedroom, but would enjoy going to the dining room for meals.

Patients were observed enjoying listening to music, reading and watching TV, while others enjoyed a visit from relatives. Patient's said, "there are small wee activities in the home, games and things like that" and "I enjoy the colouring in and I went to the Christmas party. I am looking forward to the Valentine's party."

Discussion with staff and review of records evidenced that a meaningful programme of activities for patients was not being consistently delivered. Staff spoken with confirmed that there was no activity planner in place as the activity programme was not delivered. Activity records indicated that the last activity delivered was 'one to one' with four patients on 1 February 2024. The home does have an activity coordinator however, review of staff duty rotas evidenced that the activities coordinator was working most days as a care assistant. An area for improvement was identified.

5.2.5 Management and Governance Arrangements

There has been a change in the management of the home since the last inspection; RQIA were notified appropriately. Miss Lauren McElhone has been the manager since 25 October 2023.

Staff commented positively about the manager and described them as supportive, approachable and always available for guidance. Discussion with the manager and staff confirmed that there were good working relationships between staff and management.

Review of records confirmed that systems were in place for staff appraisal. Systems were in place for staff supervision although not all staff had completed supervision. This was discussed with the manager who advised they had plans to develop a new matrix to monitor supervision and appraisal of all staff. This will be reviewed at a future care inspection.

Improvements were noted in relation to complaints management, in that a system was now in place. The home's complaints policy was revised and staff were aware of how and where to record any expressions of dissatisfaction. Staff had been provided with complaints management training. However, discussion with patients confirmed that two complaints/expressions of dissatisfaction had been raised with staff on duty and had not been recorded in the complaints record. Details were discussed with the manager to ensure that staff training had been embedded.

A review of the records of accidents and incidents which had occurred in the home found that these were managed correctly and reported appropriately.

Serious concerns were identified regarding the lack of robust managerial oversight and governance systems within the home. The audit and overall governance systems were insufficiently robust in identifying deficits and addressing these to ensure the delivery of safe and effective care.

RQIA has raised concerns in relation to management and governance systems following previous care inspections in March, July and October 2023. A Serious Concerns meeting was held on 2 August 2023 and a meeting with the intention of issuing Failure to Comply notices was held on 8 November 2023. Despite assurances given by the Responsible Individual, there has been continued lack of compliance with the Regulations. There has been a significant turnover of managers over the last two years and a manager has not been appointed who meets the requirements as set out in the Care Standards for Nursing Homes (2022).

RQIA had raised concerns about the robustness and quality of the monthly monitoring visits, undertaken in accordance with Regulation, during previous care inspections and at enforcement meetings in August and November 2023. Despite advice and support from RQIA the reports continued to evidence a lack of monitoring to ensure that the home was compliant with

Regulations and Standards and that patients received safe and effective care. For example, the monthly monitoring reports from November 2023 to January 2024 made no reference to the enforcement action taken by RQIA in November 2023 and any actions plans devised were limited. The reports all lacked detail in relation to the progress made against the areas for improvement identified during the inspection on 25 October 2023, despite the Responsible Individual specifically agreeing to this following the meeting with RQIA on 8 November 2023. The reports also contained patient, staff or families' identifiable information when this detail should be anonymised to protect confidentiality.

RQIA were not assured that the governance, management and leadership systems are effective to ensure the delivery of safe and effective care to patients, and that patients, staff and visitors may be at risk of harm.

These concerns were discussed with the Responsible Individual during the inspection and at the meeting on 26 February 2024. While some assurances were provided at this meeting RQIA issued a FTC Notice under Regulation 10 (1) of The Nursing Homes Regulations (Northern Ireland) 2005. Actions stated within this notice require to be addressed by the compliance date of 25 April 2024.

5.2.6 Estate inspector's findings

The following documents were reviewed:

- Fire Risk Assessment
- service records for the premises fire alarm and detection system
- service records for the premises emergency lighting installation
- service records for the premises portable fire-fighting equipment
- LOLER 'Thorough Examination' reports of the premises lifting
- condition reports for the premises fixed wiring electrical installation
- condition report for the formal testing of the premises portable electrical appliances
- Legionella Risk Assessment, water safety plan and records of control measures
- Gas Safe certification the premises boilers, laundry & kitchen equipment
- service records for the premises nurse call system

A legionella risk assessment was undertaken on 16 January 2024 and the identified remedial actions were to be implemented within specific timescales. Suitable temperature monitoring of the premises' hot and cold water systems was in place with records being maintained as recommended. Servicing of all thermostatic mixing valves throughout the premises was carried out by the home's maintenance person and records reviewed confirmed that seldom used water outlets were flushed weekly. The flushing of the seldom used water outlets was discussed with the Responsible Individual, as guidance from the Health and Safety Executive (HSG274 Part 2: The control of legionella bacteria in hot and cold water systems) states that in healthcare premises the frequency of flushing should be increased to twice weekly. An area for improvement was identified.

A fire risk assessment had been undertaken by a suitably accredited fire risk assessor on 9 August 2023 and all required actions identified by this assessment had been signed as completed. Fire safety service records inspected, confirmed that the fire safety systems were maintained in accordance with current best practice guidance. Regular fire drills and training for staff had been undertaken, with the most recent fire drill recorded on 4 January 2024.

The premises' space and water heating services were maintained and serviced in accordance with best practice guidance. All gas appliances were serviced by a Gas Safe registered contractor on 14 November 2023.

All patient lifting equipment was subject to regular 'thorough examination' in accordance with the current regulations, with the most recent 'thorough examinations' being undertaken on 8 January 2024.

As stated previously in section 5.2.3 it was disappointing to observe the levels of disrepair and poor maintenance of decor throughout the home, despite the previous assurances received from the Responsible Individual. These serious concerns identified were discussed with the Responsible Individual during inspection feedback and at the meeting on 26 February 2024. While some assurances were provided at this meeting an area for improvement was identified with regard to maintenance of the home's environment.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (December 2022).

	Regulations	Standards
Total number of Areas for Improvement	8	11*

*The total number of areas for improvement includes two that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Lauren McElhone, manager; and Kevin McKinney, Responsible Individual, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 20 (3) **Stated:** First time **To be completed by:** 14 February 2024	The registered person shall ensure competency and capability assessments are completed with any nurse who is given responsibility of being in charge of the home in the absence of the manager. Ref: 5.2.1
	Response by registered person detailing the actions taken: All nursing staff competency and capability assessments are completed as of this report dated 30/04/24.
Area for improvement 2 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** 14 February 2024	The registered person shall ensure that patient care plans and risk assessments are reviewed and updated as required following a fall. Ref: 5.2.2
	Response by registered person detailing the actions taken: Post fall folder is in use and completed post fall protocol have been uploaded into PCS, with a paper copy available for use in the office. Following a fall, residents' care plans and risk assessments are reviewed and updated as required.
Area for improvement 3 **Ref:** Regulation 19 (5) **Stated:** First time **To be completed by:** 14 February 2024	The registered person shall ensure that information about a patient's health and treatment is securely stored to ensure patient information is only accessible to those with permission. Ref: 5.2.2
	Response by registered person detailing the actions taken: The store lock has been replaced and is monitored regularly to ensure safe storage of archived records.
Area for improvement 4 **Ref**: Regulation 27 (2) (d) **Stated:** First time **To be completed by:** 23 February 2024	The registered person shall ensure the environmental deficits identified on inspection are addressed without delay. A suitable and achievable time bound program for this work should be submitted, along with the returned QIP, for information and comment. Ref: 5.2.3 and 5.2.6

	Response by registered person detailing the actions taken: All Warnock and Dowling corridors have already been painted. New LVT flooring has been fitted in Warnock corridor. All flooring to Warnock should be fitted by 10/05/24.
Area for improvement 5 **Ref**: Regulation 27 (2) (l) **Stated:** First time **To be completed by:** 14 February 2024	The registered person shall ensure appropriate storage of patient equipment. Ref: 5.2.3
	Response by registered person detailing the actions taken: All residents' equipment is now appropriately stored in equipment rooms.
Area for improvement 6 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time **To be completed by:** 14 February 2024	The registered person shall ensure that all areas of the home to which patients have access are free from hazards to their safety. Ref: 5.2.3
	Response by registered person detailing the actions taken: All store rooms are now locked, accessible by keypad.
Area for improvement 7 **Ref:** Regulation 27 (4) (b) **Stated:** First time **To be completed by:** 14 February 2024	The registered person shall ensure that fire doors are not wedged or propped open. Ref: 5.2.3
	Response by registered person detailing the actions taken: New fire guards have been fitted to doors where appropriate and are no longer wedged open.
Area for improvement 8 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:** 14 February 2024	The registered person shall ensure a system is implemented to monitor staff practice in relation to the appropriate use of personal protective equipment including donning and doffing and staff knowledge and practice regarding hand hygiene. Where deficits are identified during the monitoring system an action place should be put in place to drive the necessary improvement. Ref: 5.2.3
	Response by registered person detailing the actions taken: A memo has been issued to all staff advising them that they must adhere to the home's IPC practices at all times,

	especially in relation to bare below the elbows, no watches, jewellery, or nail varnish or gel, as well as the appliance and removal of PPE and handwashing. Also, supervision, as well as the home's disciplinary procedures will be used to ensure compliance. Spot checks on staff knowledge in relation to the 7 steps of hand hygiene and the 5 moments for hand hygiene have been implemented, including audits to track staff competency and compliance. Posters detailing handwashing procedure are placed at all sink areas around the home.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 19.4 **Stated:** Second time	The registered person shall ensure that there is a system in place to easily identify each member of staff by their name and role within the home. Ref: 5.1 and 5.2.1
To be completed by: 14 February 2024	**Response by registered person detailing the actions taken:** All staff are now wearing name badges which include their designations at all times.
Area for improvement 2 **Ref:** Standard 41 **Stated:** Second time	The registered person shall ensure that there is a system in place that effectively communicates to those visiting and living in the home, who the nurse in charge is. Ref: 5.1 and 5.2.1
To be completed by: 14 February 2024	**Response by registered person detailing the actions taken:** A board displaying the Nurse in Charge is now on display at the reception area at the entrance to the home.
Area for improvement 3 **Ref**: Standard 39.1 **Stated:** First time	The registered person shall ensure orientation and induction records are completed for all staff. Records should be available for inspection. Ref: 5.2.1
To be completed by: 14 February 2024	**Response by registered person detailing the actions taken:** All staff employee files are kept within the home and full inductions have been completed.
Area for improvement 4 **Ref**: Standard 41 **Stated:** First time	The registered person shall ensure the staffing rota accurately reflects and includes the full name, designation and the actual hours worked by all staff. Ref: 5.2.1

To be completed by: 14 February 2024	**Response by registered person detailing the actions taken:** Staffing rota accurately reflects and includes the full name, designation, and the actual hours worked by all staff.
Area for improvement 5 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 14 February 2024	The registered person shall ensure that staff meetings take place on a regular basis, at a minimum quarterly. Ref: 5.2.1
	Response by registered person detailing the actions taken: A staff meeting was held on 14/03/24, with the next meeting scheduled to be held on 12/06/24. A staff meeting planner has also been implemented.
Area for improvement 6 **Ref**: Standard 21.1 **Stated:** First time **To be completed by** 14 February 2024	The registered person shall review the provision of wound care to ensure that wounds are managed in keeping with best practice guidance. Ref: 5.2.2
	Response by registered person detailing the actions taken: Wound protocol for staff to follow has been implemented, to ensure that wounds are managed in line with best practice guidance.
Area for improvement 7 **Ref:** Standard 4.9 **Stated:** First time **To be completed by** 14 February 2024	The registered person shall ensure nursing staff record a meaningful evaluation of care on a regularly basis within the patient record. Ref: 5.2.2
	Response by registered person detailing the actions taken: All nursing staff to complete daily progress notes during their shift.
Area for improvement 8 **Ref**: Standard 30.1 **Stated:** First time **To be completed by:** 14 February 2024	The registered person shall ensure that oxygen cylinders are stored in a safe and secure manner at all times. Ref: 5.2.3
	Response by registered person detailing the actions taken: Oxygen cylinders are now chained in the treatment room.

Area for improvement 9 **Ref**: Standard 46.2 **Stated:** First time **To be completed by:** 14 February 2024	The registered person shall ensure that patient equipment such as chairs, mattresses, toiletries are not stored where there is a toilet or on the top of a bin. Ref: 5.2.3
	Response by registered person detailing the actions taken: All residents' toiletries are now stored properly in sink cabinetry or other appropriate place. Resident equipment such as chairs and mattresses are being stored appropriately in storage room.
Area for improvement 10 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 14 February 2024	The registered person shall ensure that a meaningful programme of activities is available to patients. Ref: 5.2.4
	Response by registered person detailing the actions taken: Permanent activity co-ordinator is currently off for approximately six weeks due to fractured ankle. A Care Assistant is temporarily taking on the role of Activity therapist 2 – 3 times per week, alongside external entertainment.
Area for improvement 11 **Ref**: Standard 44.8 **Stated:** First time **To be completed by:** 23 February 2024	The registered person shall ensure that the flushing of all identified seldom used water outlets is increased to twice weekly, with suitable records maintained and available for inspection within the home. Ref: 5.2.6
	Response by registered person detailing the actions taken: Legionella risk assessment report received on the 16/01/2024 and the high-risk recommendation in relation to the flushing of seldom used water outlets on a twice weekly basis has been actioned. Furthermore, a monitoring form for recording the flushing programme has been introduced to monitor progress and ensure adherence to the programme as per recommendation.

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

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Assurance, Challenge and Improvement in Health and Social Care