Unannounced Primary Inspection

Name of establishment: **Ballymaconnell**

Establishment ID No: **1051**

Date of inspection: **26 June 2014**

Inspector's name: **Carmel McKeegan**

Inspection No: **18272**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of home:	Ballymaconnell
Address:	48 Ballymaconnell Road Bangor BT20 5PS
Telephone number:	028 91271819
E mail address:	Desmond.Wilson@wilsongroupni.co.uk
Registered organisation/ Registered provider / Responsible individual	Chester Homes Ltd Mr Desmond Wilson
Registered manager:	Mrs Elizabeth Doak
Person in charge of the home at the time of inspection:	Registered Nurse Jisha Ditro then Assistant Manager Lisa Donaldson
Categories of care:	NH-I, NH-PH , NH-PH(E) ,NH-TI
Number of registered places:	26
Number of patients / residents (delete as required) accommodated on day of inspection:	21
Scale of charges (per week):	£567.00 - £609.00
Date and type of previous inspection:	21 January 2014, Secondary unannounced inspection
Date and time of inspection:	26 June 2014 10:15am – 4:30pm
Name of inspector:	Carmel McKeegan

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year is required.

This is a report of an unannounced primary care inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were met.

3.0 Purpose of the inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008).

Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/Process

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the DHSSPS Nursing Homes Minimum Standards 2008.

The inspection process has three key parts; self-assessment (including completion of self- declaration), pre-inspection analysis and inspection visit by the inspector.

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

- analysis of pre-inspection information
- discussion with the assistant manager, Lisa Donaldson and the regional manager, Angela Dorrian
- observation of care delivery and care practices
- discussion with staff
- examination of records
- consultation with patients individually and with others in groups
- tour of the premises
- evaluation and feedback.

Any other information received by RQIA about this registered provider has also been considered by the inspector in preparing for this inspection.

5.0 Consultation Process

During the course of the inspection, the inspector spoke with:

Patients	**8**
Staff	**5**
Relatives	**3**
Visiting Professionals	**2**

Questionnaires were provided, during the inspection, to patients, their representatives and staff seeking their views regarding the service. Matters raised from the questionnaires were addressed by the inspector either during the course of this inspection or within the following week.

Issued To	**Number issued**	**Number returned**
Patients / Residents	**5**	**1**
Relatives / Representatives	**5**	**3**
Staff	**10**	**5**

6.0 Inspection Focus

The inspection sought to establish the level of compliance achieved regarding the selected DHSSPS Nursing Homes Minimum Standards.

Criteria from the following standards are included;

- management of nursing care – Standard 5
- management of wounds and pressure ulcers –Standard 11
- management of nutritional needs and weight Loss – Standard 8 and 12
- management of dehydration – Standard 12

An assessment on the progress of the issues raised during and since the previous inspection was also undertaken.
The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.

The registered persons and the inspector have rated the home's compliance level against each criterion of the standard and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Guidance - Compliance statements	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report.
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report.
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report.
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report.
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report.
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of service

Ballymaconnell Nursing home is situated on the Ballymaconnell Road in the suburbs of Bangor. The nursing home is one of a group of homes owned and operated by Chester Homes Limited.

The current registered manager is Mrs Elizabeth Doak.

Ballymaconnell Private Nursing Home was registered in January 1992. The original home was renovated and extended to provide accommodation for twenty six patients on three levels.

The home is pleasantly decorated and surroundings are generally homely. The presence of a lift ensures that all facilities are accessible to all patients.

The home provides an open plan lounge area which opens on to the dining area. An additional lounge area is also accessed from the central open lounge / dining room. Lounge areas are well presented with a selection of occasional seating to suit the needs of the patients. The lounges and dining room are bright and inviting.

The inspector reviewed the Certificate of Registration issued by The Regulation and Quality Improvement Authority (RQIA). It was appropriately displayed in the entrance hall of the home.

The home is registered to provide care for a maximum of 26 persons under the following categories of care:

<u>Nursing care</u>

- I old age not falling into any other category
- PH physical disability other than sensory impairment under 65
- PH(E) physical disability other than sensory impairment over 65 years
- TI terminally ill

8.0 Summary of Inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Ballymaconnell Nursing Home. The inspection was undertaken by Carmel McKeegan on 26 June 2014 from 10.15 to 16.30 hours.

The inspector was welcomed into the home by the registered nurse in charge, Jisha Ditro. The assistant manager Mrs Lisa Donaldson came on duty at 11.45am and was available throughout the remainder of the inspection. The regional manager, Ms Angela Dorrian arrived in the nursing home at lunchtime and provided support for the assistant manager throughout the inspection process. Verbal feedback of the issues identified during the inspection was given to Ms Dorrian and Mrs Donaldson at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector met with patients, staff and relatives. The inspector observed care practices, examined a selection of records, issued patient, staff and representative questionnaires and carried out a general inspection of the nursing home environment as part of the inspection process.

The inspector also spent a number of extended periods observing staff and patient interaction. Discussions and questionnaires are unlikely to capture the true experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience.

These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool was designed to help evaluate the type and quality of communication which takes place in the nursing home.

As a result of the previous inspection conducted on 21 January 2014, two requirements and two recommendations were issued.
These were reviewed during this inspection. The inspector evidenced that both requirements and both recommendations had been fully complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed. (Selected criteria).

Standard 8: Nutritional needs of patients are met. (selected criteria)

Standard 11: Prevention and treatment of pressure ulcers. (selected criteria)

Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (selected criteria).

Inspection findings

- **Management of nursing care – Standard 5**

The inspector can confirm that at the time of the inspection there were auditing processes in place to audit the standard of care and service provided for patients in Ballymaconnell Nursing Home.

Review of the admission policy/ procedures identified that further detail should be provided in relation to the admission process for both planned and emergency admissions to the home. A recommendation is made in this regard.

There was evidence of comprehensive and assessment of patient needs from date of admission with the exception of the Malnutrition Universal Screening Tool (MUST), this assessment had not been undertaken on the day of admission for two patients, a recommendation is made in this regard. A variety of risk assessments were used to supplement the general assessment tools. The assessment of patient need was evidenced to inform the care planning process.

It is recommended that any documents from the referring Healthcare Trust are dated and signed when received.

The inspector was unable to confirm that pain assessments were consistently used for patients who required an active pain relief prescription. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 15 (2) that pain assessment is utilised for any patient prescribed regular or occasional analgesia, it is also required in accordance with regulation 16 (2) (b) that care plans on pain management are put in place for these patients, care plans should be reviewed to show that pain management is evaluated in a timely manner.

Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis plus as required.

There was also evidence that the referring health and social care trust (HSCT) maintained appropriate reviews of the patient's satisfaction with the placement in the home, the quality of care delivered and the services provided.

- **Management of wounds and pressure ulcers – Standard 11 (selected criteria**

There was evidence of appropriate assessment of the risk of development of pressure ulcers which demonstrated timely referral to tissue viability specialist nurses (TVN) for guidance and referral to the HSCT regarding the supply of pressure relieving equipment if appropriate.

Care plans for the management of risks of developing pressure ulcers were maintained.

It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 16 (2) (b) that wound management care plans provide clear guidance for practitioners to ensure that best practice is provided in order to promote healing and comfort for the patient. Recommendations made by the tissue viability nurse should be followed.

As previously stated patients who required an active pain relief prescription should have a pain assessment undertaken and subsequently a pain management care plan implemented that is reviewed and evaluated as the patient's need predicts.

- **Management of nutritional needs and weight loss – Standard 8 and 12 (selected criteria)**

The inspector reviewed the management of nutrition and weight loss within the home. It is recommended that the policy and procedure in place to guide and inform staff in regard to nutrition and dietary intake are further developed to provide guidance for staff which reflects current best practice as defined by professional bodies and national standard setting organisations.

Robust systems were evidenced with risk assessments and appropriate referrals to General Practitioners (GP's), speech and language therapists (SALT) and or dieticians being made as required.

The inspector also observed the serving of the lunch time meal and can confirm that patients were offered a choice of meal and that the meal service was well managed and supervised by the registered nurse in charge. It is recommended that the current four week menu planner is dated to show when the menus had been reviewed and/or implemented.

A recommendation is also made to ensure that all relevant staff attend training in dysphagia awareness, which should include the use of thickening agents for patients with swallowing difficulties.

Patients were observed to be assisted with dignity and respect throughout the meal.

- **Management of dehydration – Standard 12 (selected criteria)**

The inspector examined the management of dehydration during the inspection which evidenced that fluid requirement and intake details for patients were recorded and maintained for those patients assessed at risk of dehydration.

Review of a sample of fluid intake charts for three patients revealed that there was evidence that patients were offered fluids on a regular basis throughout the day and also during the night time period.

The fluid intake charts for patients recorded the total fluid intake for patients over 24 hours, an effective reconciliation of the total fluid intake against the fluid target was established, with a record of reconciliation of fluid intake in the daily progress notes.

Patients were observed to be able to access fluids with ease throughout the inspection. Staff were observed offering patients additional fluids throughout the inspection. Fresh drinking water/various cordials were available to patients in lounges, dining rooms and bedrooms.

The inspector can confirm that based on the evidence reviewed, presented and observed; that the level of compliance with the standards inspected was substantially compliant.

Patient representatives and staff questionnaires

Some comments received from patients and their representatives:

"It's a good nursing home, the staff are very good to everybody."
"The food is lovely and they will get you whatever you want, can't fault any of the staff."
"I have no complaints; I am very well looked after".
"As a family we are very happy with how …… is cared for, the staff are very kind and attentive"
"The staff are very hard working, but always take time to see to the patients".

Some comments received from staff:

"I have worked in Ballymaconnell for X years. It is a very good home and clients are well cared for"
"The quality of care in the home is very good and staff treat the patients very well"
"Everybody works well as a team"

Staffing provision

Review of staff duty rotas, patient dependencies, and discussion with staff members revealed that the home is heavily reliant on bank staff and agency staff. The inspector can confirm that staff to patient ratios were found to be in line with 'Staffing guidance for Nursing Homes' RQIA (2009) for the number of patients currently accommodated in the home.

However, given that 73 registered nursing hours and 136 care assistant hours are provided by agency/bank nurses and care assistants each week is of concern. The continued use of bank/agency staff to this extent, may potentially have a detrimental impact on the named nurse process, and the provision of person centred care in relation to the continuity and quality of care for patients accommodated in the nursing home.

Review of three weeks duty rota revealed the following;

- over the weekend of 14 and 15 June 2014, 90% of nursing and care staff working were bank or agency staff.
- on 15 June 2104, a care assistant was delegated as 'cook' and 'HK'(housekeeping) to be undertaken between 8.00 am and 2pm.
- there was no laundry support on 14 and 15 June 2014.
- as a consequence on 15 June from 2pm onwards there was no cook or kitchen assistant, house keeper or laundry worker. (on this same day the nurse in charge was an agency nurse.)
- two registered nurses had been delegated as the nurse in charge of the nursing home without having completed a nurse in charge competency and capability assessment.
- the inspector was unable to evidence that all staff, including bank staff were appropriately supervised
- the inspector was unable to evidence that all staff, including bank staff had receive appraisal and mandatory training.

Following the inspection the regional manager and inspector have corresponded on several occasions, the regional manager has provided written detail of action taken by the registered person to secure permanent staff.

Five requirements for improvement have been made in relation to the deficits in staffing arrangements as evidenced, the registered/ assistant manager is required to submit a copy of the duty rota, as actually worked, to RQIA on a weekly basis until notified otherwise. A recommendation is also made that the duty rota is kept up to date.

Complaints

The inspector reviewed the complaints records. Several pages of the complaints recording book were not attached and therefore at risk of being lost, it is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 19 (1) (b) that records are kept securely in the nursing home.

The review evidenced that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought.

The inspector discussed the content of one complaint with the regional manager as the issue raised by the complainant should have been referred to the Designated Officer in the HSC Trust for screening and should also have been notified to RQIA. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 30 (1) that the registered person must report to the Trust Designated Officer and RQIA without delay any event in the home which may potentially be a safeguarding issue.

Accident records

The inspector reviewed the accident/incident record and reviewed records made since the previous inspection. A moving and handling incident which occurred on 1 March 2014 had been notified to RQIA on 10 March 2014. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 30 (1) that the registered provider notifies RQIA without delay of any event in the home which seriously affects the wellbeing or safety of any patient. Any notification made in accordance with this regulation shall be confirmed in writing within 3 days.

The incident form dated 10 March 2014 stated that both care assistants would attend moving and handling training on 7 March 2014. Records available on the day of this inspection showed that one of the care assistants had attended moving and handling training on 26 March 2014, the other care assistant had not yet attended moving and handling training. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 14 (3) that the registered person ensures that staff receive training and are assessed as competent in moving and handling patients.

Internal environment

The home's general environment was well maintained and patients were observed to be treated with dignity and respect.

A requirement is made in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 13 (7) that issues identified in interest of infection prevention and management are addressed.

In the interest of maintaining a safe environment for patients, staff and visitors, it is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 14 (2) (a) that where oxygen is in use in a patient's bedroom that appropriate signage is displayed.

The inspector observed a portable fan positioned on the floor of the bedroom corridor on the first floor, the position of the fan presented as an obstruction for anyone with poor mobility and/or a wheelchair user. The corridor is a vital means of escape in the event of a fire. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 27 (4) (c) that the portable floor fan is removed. The regional manager and assistant manager stated the fan would be removed that day.

Conclusion

The inspector can confirm that at the time of this inspection the delivery of care to patients was evidenced to be of a satisfactory standard. There were processes in place to ensure the effective management of the themes inspected.

During this inspection several areas were identified for improvement, in particular, staffing provision in the nursing home will be monitored on a weekly basis until sufficient progress has been made.

Therefore, fourteen requirements and eight recommendations are made. These requirements and recommendations are detailed throughout the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, the visiting professionals, regional manager, assistant manager and staff for their assistance and co-operation throughout the inspection process.

The inspector would also like to thank the patients, relatives and staff who completed questionnaires.

9.0 Follow-up on the requirements and recommendations issued as a result of the previous inspection on 21 January 2014

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	17(3)	In the interest of infection prevention and control, items for patients' use should not be stored on the floor of the linen store room.	Observation of two linen store rooms verified that linen was not stored on the floor. This requirement is assessed as compliant.	Compliant
2.	16 (2) (b)	It is required that one identified patient's care plan is further develop to evidence that discussions had taken place about cardiopulmonary resuscitation (CPR). The patient's healthcare record should contain clear documentation of the decision and how it was made, date of decision, reasons for it and the name and position of the person responsible for the decision.	Discussion with the assistant manager confirmed that this record had been updated immediately following the previous inspection. The inspector reviewed a separate patient's record which showed that discussions had taken place about cardiopulmonary resuscitation (CPR) and the patient's healthcare record should contain clear documentation of the decision and how it was made. This requirement is assessed as compliant.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1.	20.2	All emergency equipment should be included in the weekly checking procedures already in place.	Review of the emergency equipment checking procedures confirmed that this recommendation is compliant.	Compliant
2.	20.4	It is recommended that the nurse in charge competency and capability assessment is further developed to include emergency first aid and basic resuscitation.	Review of the nurse in charge competency and capability assessment showed that emergency first aid and basic resuscitation is included in this document. This recommendation is assessed as compliant.	Compliant

9.1 Follow up on any issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if there is considered to be a breach of regulation as stated in the Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

Since the previous care inspection on 21 January 2014, RQIA have received nil notifications of safeguarding of vulnerable adult (SOVA) incidents in respect of Ballymaconnell Nursing Home.

10.0 Inspection Findings

Section A

Standard 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment** **Standard 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission** **Standard 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent** **Standard 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.**
Inspection Findings:
Policies and procedures relating to patients' admissions were available in the home. It is recommended that the 'Admissions of Residents' policy is further developed to include the following; • the role, function and arrangement of the pre-admission procedure • the arrangements to ensure referral forms providing all necessary information, including risk assessments relating to the patient, are provided to the home before admission. • the arrangements to provide confirmation to the prospective patient that the home is suitable to meet their needs • the arrangements to respond to any unplanned admission • the arrangements to respond to self-referred patients. • admission policies and procedures should be reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance. The inspector reviewed two patients' care records which evidenced that patients' individual needs were established on the day of admission

to the nursing home through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks. It is recommended that any documents from the referring Healthcare Trust are dated and signed when received.

Specific validated assessment tools such as moving and handling, Braden scale, falls, Bristol stool chart and continence were also completed on admission. The Malnutrition Universal Screening Tool (MUST), had not been undertaken on the day of admission for either patient, a recommendation is made that this shortfall be addressed.

Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure ulcer/wound and if required, the specific care plans regarding the management of the pressure ulcer/wound.

Review of three patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 11 days of patient's admission to the home.

The assistant manager demonstrated a good awareness of patients who required wound management intervention for a wound and the number and progress of patients who were assessed as being at risk of weight loss and dehydration.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed **Sub**	**Substantially compliant**

Section B

Standard 5.3

- **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.**

Standard 11.2

- **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.**

Standard 11.3

- **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.**

Standard 11.8

- **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration**

Standard 8.3

- **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.**

The inspector observed that a named nurse and key worker system was operational in the home. The roles and responsibilities of named nurses and key workers were outlined in the patient's guide.

Review of two patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Records also evidenced discussion with patients and/or their representatives following changes to the plans of care.

Patients' care records revealed that the pressure relieving equipment in place on the patients' beds and when sitting out of bed was addressed in each patients' care plans on pressure area care and prevention.

The assistant manager informed the inspector that there was one patient in the home who required wound management for a wound, and one patient who required nursing intervention for bi-lateral leg ulcers. Review of these patient's care records revealed the following;

- A body mapping chart was completed for each patient on admission. Body mapping charts were reviewed and updated when any changes occurred to patient's skin condition.

- A care plan was in place for each patient which specified the pressure relieving equipment in place on the patient's bed and also when sitting out of bed.

- The type of mattress in use was based on the outcome of the pressure risk assessment. The specialist mattresses in use were being safely used and records were available to reflect they were appropriately maintained.

The inspector was unable to confirm that pain assessments were consistently used for patients who required an active pain relief prescription. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 16 (2) (b) that care plans on pain management are put in place for these patients, care plans should be reviewed to show that pain management is evaluated in a timely manner.

Discussion with the assistant manager and review of three patients' care records confirmed that where a patient was assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention plan and treatment programme.

The assistant manager confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local healthcare Trust. The nurse in charge during the morning period was a bank nurse, discussion with this nurse confirmed that as she previously had been employed in the nursing home she was knowledgeable regarding the referral process and of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

Review of the records of incidents revealed that the incidence of pressure ulcers, grade 2 and above, were reported to the RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005**.**

The inspector was able to confirm that;

- patient's weight was recorded on admission and on at least a monthly basis or more often if required.
- patient's nutritional status was also reviewed on at least a monthly basis or more often if required.
- daily records were maintained regarding the patient's daily food and fluid intake

Policies and procedures were in place for staff on making referrals to the dietician. These included indicators of the action to be taken and by whom. All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment, however as the home is participating in the Nutritional Research Project being undertaken by the Southern Eastern Healthcare Trust, the community dietician visits the nursing home on a monthly basis and can accept referrals directly which provides dietetic assessment in a timely manner.

Discussion with the regional manager and the assistant manager and review of the staff training matrix revealed that permanent nursing staff and care staff had attended training in wound management and pressure area care. The regional manager confirmed that training in nutrition for the older adult, use of thickeners and management of dysphagia is being arranged for later in 2014.

Patients' moving and handling needs were assessed and addressed in their care plans. There was evidence that manual handling aids were used to minimise risk of friction. Staff consulted confirmed there was sufficient nursing equipment available to move and handle patients' appropriately.

The assistant manager and the registered nurse informed the inspector that pressure ulcers were graded using an evidenced based classification system.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

Section C

Standard 5.4

- **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.**

Nursing Homes Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16

As previously referred to in Section B, the inspector reviewed the care records of two patient's receiving nursing interventions in respect of wound management and leg ulcer management. The following areas were identified for improvement;

Patient A (identity known to assistant manager)

- the patient had been assessed by the Tissue Viability Nurse on two occasions and had recommended on both occasions that the patient's legs are photographed, this had not been done.
- a pain assessment had not been completed for the patient, nor was there pain management plan of care in place.

Patient B (identity known to assistant manager)

- the wound management care plan did not state the frequency of dressing change for each wound. On admission the daily progress record stated that wounds should be redressed on alternate days, however records available indicated that dressings appeared to be renewed daily. There should be clear guidance provided in the patient's wound management care plan on the frequency of dressing change for each wound.
- patient's daily progress record should state either, that the patient's dressings have been checked and are intact, and also state when dressings have been renewed.
- a pain assessment had not been completed for the patient, nor was there pain management plan of care in place.

It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 15 (2) that pain assessment must be utilised for any patient prescribed regular or occasional analgesia, it is also required in accordance with regulation 16 (2) (b) that care plans on pain management are put in place for these patients, care plans should be reviewed to show that pain management is evaluated in a timely manner. Wound management care plans must provide clear guidance for practitioners to ensure that best practice is provided in order to promote healing and comfort for the patient.

Review of patients' care records evidenced that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs.
Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required.

The evaluation process included the effectiveness of any prescribed treatments, as previously identified this should also include the evaluation of prescribed analgesia and should be recorded in the patient's daily progress record.

Discussion with the assistant manager and review of governance documents evidenced that a number of care records were audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.
The inspector observed that whilst there was a named nurse system in place there was a notable deficit in the provision of permanent registered nurses working in the nursing home, this situation will have an impact on the successful application of an effective named nurse process. Staffing provision is further discussed in Section 11.8 in the main body of the report.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

Section D

Standard 5.5

- **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.**

Standard 11.4

- **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.**

Standard 8.4

- **There are up to date nutritional guidelines that are in use by staff on a daily basis.**

Nursing Homes Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)

As previously stated the inspector examined two patients' care records which evidenced that both patients' care records did not have the MUST assessment completed at the time of this inspection. The MUST is an essential risk assessment that should be completed on the day of admission to the nursing home, in order to establish the patient's specific and immediate nutritional needs. A recommendation is made in this regard.

The inspector confirmed the following research and guidance documents were available in the home;

- DHSSPS 'Promoting Good Nutrition' A Strategy for good nutritional care in adults in all care settings in Northern Ireland 2011-16
- The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.
- The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care
- The European Pressure Ulcer Advisory Panel (EPUAP)
- RCN/NMC guidance for practitioners.

Discussion with the assistant manager confirmed that she had a good awareness of these guidelines. Review of patients' care plans evidenced that registered nurses implemented and applied this knowledge.

The assistant manager confirmed that wound management was audited monthly. The registered nurse on duty appeared knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the

principles of providing good nutritional care.

The inspector spoke with two care staff who could identify patients who required support with eating and drinking, these care staff were observed to inform and advise the bank care assistant and agency care assistant of the nutritional requirements and preferences of patients. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held at the dining area for access by staff.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

Section E

Standard 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Standard 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Standard 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.**
A policy and procedure relating to nursing records management was available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance. Registered nurses spoken with were aware of their accountability and responsibility regarding record keeping. Review of two patients' care records revealed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient. As previously identified these statements should also reflect wound and pain management intervention for patients as required. Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patients' status or to indicate communication with other professionals/representatives concerning the patients. Entries were noted to be timed and signed with the signature accompanied by the designation of the signatory. The inspector reviewed a record of the meals provided for patients. Records were maintained in sufficient detail to enable the inspector to judge that the diet for each patient was satisfactory.

The inspector reviewed the care records of three patients identified of being at risk of inadequate or excessive food and fluid intake. This review confirmed that;

- daily records of food and fluid intake were being maintained
- the nurse in charge had discussed with the patient/representative their dietary needs
- where necessary a referral had been made to the relevant specialist healthcare professional
- a record was made of any discussion and action taken by the registered nurse
- care plans had been devised to manage the patient's nutritional needs and were reviewed on a monthly or more often basis.

Review of a sample of fluid intake charts for three patients revealed that there was evidence that the patients were offered fluids on a regular basis throughout the day and also during the night time period.

The fluid intake charts for patients recorded the total fluid intake for patients over 24 hours, an effective reconciliation of the total fluid intake against the fluid target was established, with a record of reconciliation of fluid intake in the daily progress notes.

The inspector observed that permanent care staff were knowledgeable regarding patients' nutritional needs and were providing guidance to the bank and agency care staff on duty.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially Compliant**

Section F

Standard 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.**
Please refer to criterion examined in Section E. In addition the review of three patients' care records evidenced that consultation with the patient and/or their representative had taken place in relation to the planning of the patient's care. This is in keeping with the DHSSPS Minimum Standards and the Human Rights Act 1998.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section G

Standard 5.8
- **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate**

Standard 5.9
- **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.**

Prior to the inspection a patients' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that the majority of patients in the home had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014.

The assistant manager informed the inspector that patients' care reviews were held post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff preferably the patient's named nurse and/or the registered manager attends each care review. A copy of the minutes of the most recent care review was held in the patient's care record file. The assistant manager confirmed that a process is in place to monitor the provision of care reviews by the Commissioning HSCT.

The inspector viewed the minutes of three care management care reviews which evidenced that, where appropriate patients and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended an updated assessment of the patient's needs and a record of issues discussed. Care plans were evidenced to be updated post care review to reflect recommendations made where applicable.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section H

Standard 12.1
- **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.**
  Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.

Standard 12.3
- **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.**
  A choice is also offered to those on therapeutic or specific diets.

A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. Following review of the home's 'Nutritional Policy ' and the 'Procedure regarding Weight Loss\nutritional intake', it is recommended that the policy/procedure is updated as follows;
- the policy should refer to the MUST as this is the nutritional screening tool used in the nursing home, not the CNRST as stated in the current nutritional policy.
- clearly state the indicators for onward referrals to the relevant professionals. e.g. speech and language therapist (SALT), dietician and/or the general practitioner (GP).
- provide details of the current referral procedures to access other relevant healthcare professionals
- state the registered nurse's responsibility to review, evaluate and update patients care plans and risk assessments to ensure the recommendations made by SALT, GP and/or Dietician are recorded and addressed.
- state the internal governance arrangements to support staff, the auditing process undertaken by management.

There was a four weekly menu planner in place. The cook informed the inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home. It is recommended that the current menu planned is dated to show when the menus had been reviewed and/or implemented.

The inspector discussed with the assistant manager, the cook and two care staff the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients.

Staff spoken with were knowledgeable regarding the individual dietary needs of patients to include their likes and dislikes. Discussion with staff and review of the record of the patient's meals confirmed that patients were offered choice prior to their meals.

The assistant manager and registered nurse were knowledgeable regarding the indicators for onward referrals to the relevant professionals. e.g. speech and language therapist or dieticians.

As previously stated under Section D relevant guidance documents were in place.

Review of the menu planner and records of patients' choices and discussion with a number of patients, registered nurses and care staff it was revealed that choices were available at each meal time. The assistant manager confirmed choices were also available to patients who were on therapeutic diets.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section I

Standard 8.6
• **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.**
Standard 12.5
• **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.**
Standard 12.10
• **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:**
  • **risks when patients are eating and drinking are managed**
  • **required assistance is provided**
  • **necessary aids and equipment are available for use.**
Standard 11.7
• **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.**

The inspector discussed the needs of the patients with the registered manager. It was determined that a number of patients had swallowing difficulties. Discussion with the regional manager and assistant manager confirmed that training in dysphagia awareness is planned for later in 2014. It is recommended that all relevant staff attend training in dysphagia awareness, which should the use of thickening agents for patients with swallowing difficulties. Discussion with assistant manager confirmed that meals were served at appropriate intervals throughout the day and in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes. The registered manager confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning afternoon and at supper times. The inspector observed that a choice of fluids to include fresh drinking water were available and refreshed regularly. Staff were observed offering patients fluids at regular intervals throughout the day.

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Care staff consulted could identify patients who required support with eating and drinking, agency and bank staff were provided with guidance from the permanent care staff. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held in the dining room for easy access by staff. This is good practice as a reference for all staff, and especially temporary staff.

On the day of the inspection, the inspector observed the lunch meal. Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely manner.

Staff were observed preparing and seating the patients for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients with their meal and patients were offered a choice of fluids. The tables were well presented with condiments appropriate for the meal served.

Discussion with the assistant manager and the registered nurse clearly evidenced their knowledge in the assessment, management and treatment of wounds.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

11.0 Additional Areas Examined

11.1 Records required to be held in the nursing home

Prior to the inspection a check list of records required to be held in the home under Regulation 19(2) Schedule 4 of The Nursing Homes Regulations (Northern Ireland) 2005 was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required records were maintained in the home and were available for inspection. The inspector reviewed the following records:

- the patient's guide
- sample of staff duty rosters
- record of complaints
- record of food and fluid provided for patients
- staff training matrix
- sample of incident/accident records

The inspector reviewed the accident/incident record and reviewed records made since the previous inspection. A moving and handling incident which occurred on 1 March 2014 had been notified to RQIA on 10 March 2014. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 30 (1) that the registered provider notifies RQIA without delay of any event in the home which seriously affects the wellbeing or safety of any patient. Any notification made in accordance with this regulation shall be confirmed in writing within 3 days.

The incident form dated 10 March 2014 stated that both care assistants would attend moving and handling training on 7 March 2014. Records available on the day of this inspection showed that one of the care assistants had attended moving and handling training on 26 March 2014, the other care assistant has yet to attend moving and handling training. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 14 (3) that the registered person ensures that staff receive training and are assessed as competent in moving and handling patients.

11.2 Patients/residents under Guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) Order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection.

There were no patients/residents currently resident at the time of inspection in the home.

11.3 Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspector discussed the Human Rights Act and Human Rights Legislation with the regional manager and the assistant manager. The inspector can confirm that copies of these documents were available in the home.

The regional manager and assistant manager demonstrated an awareness of the details outlined in these documents. The nursing home has developed a 'Deprivation of Liberty and Human Rights Policy'.

The registered manager informed the inspector that these documents will be discussed with staff during staff meetings and that staff will be made aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patients care and accompanying records.

The inspector also discussed the Deprivation of Liberty Safeguards (DOLs) with the assistant manager including the recording of best interest decisions on behalf of patients.

11.4 Quality of interaction schedule (QUIS)

The inspector undertook two periods of observation in the home which lasted for approximately 20 minutes each.

The inspector observed the interactions between patient and staff as the lunch time meal was being served in the dining room. The inspector also observed care practices in the main sitting room following the lunch meal.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area being observed.

Positive interactions	All positive
Basic care interactions	0
Neutral interactions	0
Negative interactions	0

The inspector observed staff preparing for and serving the mid-day meal. Observation confirmed that meals were served promptly and assistance required by patients was provided in a timely manner.

Staff were observed preparing and seating patients for their meal in a caring, sensitive and unhurried manner. Staff were seen to speak directly to each patient, making eye contact and actively communicating with each person. Care staff were also noted assisting patients with their meals, staff sat down beside the patient and were fully engaged in the activity of providing the patient's meal and offering encouragement and prompting as appropriate.

The inspector evidenced that the quality of interactions between staff and patients was positive. Staff were polite and courteous when speaking with patients, conversation was relaxed and respectful.

A description of the coding categories of the Quality of Interaction Tool is appended to the report.

11.5 Complaints

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being pro-actively managed.

The inspector reviewed the complaints records. Pages of the complaints recording book were not attached and therefore at risk of being lost, it is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 19 (1) (b) that records are kept securely in the nursing home.

This review evidenced that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought.

The inspector discussed the content of one complaint with the regional manager as the issue raised by the complainant should have been referred to the Designated Officer in the HSC Trust for screening and should also have been notified to RQIA. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 30 (1) that the registered person must report to the Trust Designated Officer and RQIA without delay any event in the home which may potentially be a safeguarding issue.

11.6 Patient finance questionnaire

Prior to the inspection a patient financial questionnaire was forwarded by RQIA to the home for completion. The evidence provided in the returned questionnaire indicated that patients' monies were being managed in accordance with legislation and best practice guidance.

11.7 NMC declaration

Prior to the inspection the registered manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC. This was also evidenced by the inspector on the day of inspection.

11.8 Staffing Provision

On the day of the inspection the nurse in charge of the nursing home was a bank nurse, the nurse informed the inspector she had previously been employed in the nursing home and would work some on some occasions when requested. As previously stated in the report, there were two agency care assistants working on this day also.

Discussion with the assistant manager and observations made confirmed that whilst the staff to patient ratios were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients currently accommodated in the home, the home was heavily reliant on bank staff and agency staff.

The inspector reviewed three weeks duty rota from 9 June 2014 to 29 June 2014 and the following issues were identified.

Duty Rota Week Commencing 9 June 2014

10 June 2014, night duty - the nurse in charge (NIC) was an agency nurse and the care assistant was bank staff, no permanent staff were on duty during this shift.

14 June 2014 day duty – the nurse in charge was a bank nurse, one care assistant was a permanent staff member, there was also a bank care assistant and two agency care assistants. Five persons working, only one of which was a permanent member of staff.

15 June 2104 day duty - the rota does not state the designation of the nurse in charge, however it is clear they are not permanent staff. One care assistant was a permanent staff member and there were two bank care assistants working. Four persons working, only one of which was a permanent member of staff.

It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 20 (1) (b) that the registered provider ensures that the employment of any persons on a temporary basis at the nursing home will not prevent patients from receiving such continuity of nursing as is reasonable to expect.

The duty rota does not show that house-keeping or laundry support was provided on 14 and 15 June.

15 June 2014, a care assistant was delegated as cook and 'HK' (housekeeper); this is not in compliance with Food Safety Regulations.

It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 20 (1) (a) that the registered person ensures that there are suitably qualified, competent and experienced persons working in the nursing home in such numbers as are appropriate for the health and welfare of patients.

Duty Rota Week Commencing 16 June 2014

The duty rota shows that the registered manager and two registered nurses attended Pharmacy training on 18 June 2014. The duty rota does not show who provided nursing cover for patients accommodated in the nursing home during this period of

time. It is recommended that the staff duty rota is kept up to date and clearly states the nurse in charge of the home at any given time.

Duty Rota Week Commencing 23 June 2014

The duty rota shows that the registered manager worked on Monday 23, Tuesday 24 and Wednesday 25 June, there was nothing recorded for the rest of the week. The inspector was informed that the registered manager was on annual leave for three weeks, this was not recorded on the duty rota. As previously stated, the staff duty rota should be kept up to date and clearly states the capacity in which staff have actually worked.

Discussion with the assistant manager confirmed the either of the nurse in charge of the nursing home on the 28 and 29 June 2014, did not have a nurse-in-charge competency and capability assessment completed. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 20 (3) that the registered manager carries out a competency and capability assessment with any nurse who is given the responsibility of being in charge of the home for any period of time in her absence.

The inspector discussed the staffing arrangements with the regional manager and requested that patient dependencies and current staff provision was forwarded to RQIA. The inspector can confirm that this information was received by the date requested.

Further analysis of the patient dependencies as provided by the regional manager shows that the home should have a total of 518 care hours

The minimum skill mix of 35% trained staff and 65% care staff should be provided.

518 hours required per week.	Should have	Actually have	Deficit
35% trained staff	181	108	73 hours per week
65% care staff	336	200	136 hours per week

Review of duty rotas and discussion with the regional manager verified that the deficit of registered nursing hours and care assistant hours was provided by bank and agency staff. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 20 (2) that the registered person shall ensure that persons, including bank staff, are appropriately supervised.

In addition it is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 20 (1) (c) (iii) that the registered manager must ensure that all staff employed in the nursing, including all bank staff, receive appraisal, mandatory training and other training appropriate .

Following the inspection, the regional manager, Ms Dorrian provided written detail of the measures taken by herself and the registered provider to recruit permanent staff.

The registered provider is also required to submit the weekly duty rota to RQIA until further notice.

11.9 Questionnaire findings

During the inspection the inspector spoke to five staff. The inspector was able to speak to a number of these staff individually and in private. On the day of inspection nine staff completed questionnaires. The following are examples of staff comments during the inspection and in questionnaires;

"I have worked in Ballymaconnell for X years. It is a very good home and clients are well cared for"
"The quality of care in the home is very good and staff treat the patients very well"
"Everybody works well as a team"

Patients' comments

During the inspection the inspector spoke with eight patients individually and with a number in groups. In addition, on the day of inspection, three patients completed questionnaires.

The following are examples of patients' comments made to the inspector and recorded in the returned questionnaires.

"It's a good nursing home, the staff are very good to everybody."
"The food is lovely and they will get you whatever you want, can't fault any of the staff."
"I have no complaints; I am very well looked after".

Patient Representative/relatives' comments

During the inspection the inspector spoke with two representatives/relatives/visitors. In addition, on the day of inspection, three representatives/relatives competed and returned questionnaires.
The following are examples of relatives' comments during inspection and in questionnaires;

"As a family we are very happy with how …… is cared for, the staff are very kind and attentive"
"The staff are very hard working, but always take time to see to the patients".

Professionals' Comments

Two professionals visited the home during the inspection. Both professionals expressed satisfaction with the quality of care, facilities and services provided in the home.

11.10 Internal environment

The inspector toured the home as part of the inspection process and observed the communal living area, dining area, a random sample of patient's bedrooms, sanitary areas, the main kitchen and the laundry room.

In the interest of infection prevention and management it required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 13 (7) that the following issues are addressed;

- a commode lid covering was torn at the corner, this should be made good to provide an intact surface that can be effectively cleaned
- the disabled toilet just off the main communal living space should be repainted. Items such as a drinking glass, toothbrush, man's razor, and basin were stored on top of the wall mounted storage cupboard, these items should not be kept in a toilet area. Items should not be stored on top of the cupboard.
- small toilet just off the main communal living space should be repainted. The raised toilet seat was notably stained with faecal matter. The small waste receptacle bin lid was rusted. A wire square container with a black plastic bin liner should be replaced with a pedal operated waste receptacle.
- the main lounge area carpet was notably stained/marked and should be deep cleaned or replaced.

In the interest of maintaining a safe environment for patients, staff and visitors, it is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 14 (2) (a) that where oxygen is in use in a patient's bedroom that appropriate signage is displayed.

The inspector observed a portable fan positioned on the floor of the bedroom corridor on the first floor, the position of the fan presented as an obstruction for anyone with poor mobility and/or a wheelchair user. The corridor is a vital means of escape in the event of a fire. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 27 (4) (c) that the portable floor fan is removed. The regional manager and assistant manager stated the fan would be removed that day.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Angela Dorrian, regional manager and Mrs Lisa Donaldson, assistant manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider / manager is required to record comments on the Quality Improvement Plan.

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.

Enquiries relating to this report should be addressed to:

Carmel McKeegan
The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
At the time of each client's admission to the Home, a nurse carries out and records an initial risk assessment, using a validated assessment tool and draws up an agreed plan of care to meet the client's immediate care needs. Information received from the care management team and pre-admission assessment of the client is used to formulate the plan of care. Clients and Family input is also included during assessments. A comprehensive,holistic assessment of the client's care needs using validated assessment tools is completed within 11days of admission to the Home. 'Malnutrition Universal Sceening Tool' is used on admission to carry out a Nutritional screening of the client and any	Compliant

short comings are referred via GP to SALT or directly to the Community Dietician for further assessment. Clinical judgement, information and knowledge of the client from persons directly involved in the care of the client at the time of pre-admission assessment and information from the client's nursing notes, are utilised to carry out a risk assessment of the risk of the client developing a pressure ulcer. A full risk assessment is carried out on admission to the Home as an actual body check is carried out to visually determine the status of the client's skin.	

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet the identified assessed needs with individual clients and their representatives, where possible. The nursing care plan demonstrates the promotion of independence and rehabilitation, where possible and appropriate. It also takes into account any advice and recommendations from relevant health professionals.	Compliant

There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability. When a client is assessed as 'at risk' of developing a pressure ulcer, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant professionals as required. When clients are assessed as requiring the assistance of specialists in the care of lower limb or foot ulceration referrals are made to the relevant Health care professionals. At present Ballymaconnell Nursing Home is participating within a Pilot scheme with the Community Dieticians and we are able to contact them directly for client assessment if required and once a nutritional treatment is drawn up, in conjunction with other relevant health care providers,these plans are adhered to.	

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Re-assessment is an on-going process that is carried out daily, using clinical skills and knowledge and at identified agreed time intervals as recorded in nursing care plans.	Substantially compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All nursing interventions,activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national setting organisations. A validated pressure ulcer grading tool is used to screen clients who have skin damage (European Pressure Ulcer Advisory Panel(EPUAP)2001) and an appropriate treatment plan is implamented. 'Nutritional Guidelines for residential and nursing homes for older people 2014' are in use daily by staff and additional information booklet provided by Community Dietician is also used to provide knowledge on food fortification.	Substantially compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each client. These records contain outcomes for clients. A record is kept of the daily menu and may enable any person inspecting them to ascertain if the diet is satisfactory for a client. Individual records are kept on a daily basis of all meals eaten and fluids taken by all clients.Clients were possible are involved in their choices of dietry intake and if none is suitable, alternatives offered as far as possible. If further assessment is required by other relevant professionals, a record is maintained regarding action to be taken	Substantially compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care delivered is monitored and recorded on a day-to-day basis and is subject to documented review at agreed time intervals and evaluation carried out, using benchmarks where appropriate, with the involvement of clients and their representatives, where possible.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Clients are given the opportunity to actively participate within their formal and informal care review meetings and to voice their wishes in all aspects of their care,as appropriate. The results and minutes of review meetings are kept within all clients' individual care files once received from respective Care Managers.	Substantially compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Clients are provided with a nutritious and varied diet on a daily basis which meets their individual dietry needs and preferences. Choices are offered and recorded but if a client wishes to change their mind at mealtime, they are provided with an alternative whenever possible. Guidance is taken from relevant documents and from dieticians/Speech and Language Therapists in meeting clients nutritional needs.	Substantially compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nurses are aware and knowledgable in the management of feeding techniques for clients who have swallowing difficulties and ensure that all Speech and Language therapist's instructions are disseminated to all staff and that they are adhered to. Meals are served at the conventional times throughout the day, hot and cold drinks are offered at mealtimes and at	Substantially compliant

customary intervals during the day, along with snacks Fresh drinking water is freely available at all times. Staff are fully aware of any matters regarding clients dietry/fluid intake and any issues that may occur are reported to the Nurse in Charge immediately.Adequate staff numbers are available when serving meals so as to reduce any risks to the clients,provide assistance as needed to clients and that the necessary aids/equipment are available to use. Where a client requires wound care, nurses will have gained knowledge and skills in wound management via research evidence and treatment programmes drawn up with relevant professionals to enable them to assess a wound and apply appropriate wound care products and dressings. A wound care link nurse has been appointed within the Home.	

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	**COMPLIANCE LEVEL**
	Substantially compliant

Appendix 2

Explanation of coding categories as referenced in the Quality of Interaction Schedule (QUIS)

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic Care: (BC) –** basic physical care e.g. bathing or use if toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc. (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away • Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others	**Examples include:** Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (NS) –** communication which is disregarding of the residents' dignity and respect.
Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions • Not showing interest in what the patient or visitor is saying	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness') • Seeking choice but then ignoring or over ruling it • Being angry with or scolding older patients • Being rude and unfriendly • Bedside hand over not including the patient

References

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Primary Inspection

Ballymaconnell

26 June 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Ms Angela Dorrian, regional manager and Mrs Lisa Donaldson, assistant manager, either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers/managers should note that failure to comply with regulations may lead to further enforcement and/or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider/manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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.

Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on the HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and the Nursing Homes Regulations (NI) 2005

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	15 (2)	The registered person shall ensure that the assessment of the patient's needs is (a)kept under review ; and (b) revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually. • pain assessments must be utilised for any patient prescribed regular or occasional analgesia **Ref; Section B and C**	One	Care reviews are carried out annually and any changes affecting clients in any circumstance is reviewed and discussed with Care Management Team. Pain assessment is carried out using Abbey Pain Scale with clients unable to verbally express their pain.	From the date of the inspection
2.	16 (2) (b)	The registered person shall ensure that – (b) the patient's plan is kept under review. • wound management care plan should clearly state the frequency of dressing change • photography as recommended by the tissue viability nurse should be utilised (with the patient's consent) to inform the review in relation to leg ulcer healing. • the effectiveness of analgesia should be regularly evaluated and recorded.	One	Wound management care plan is updated as required and clearly states the frequency of dressing change A new camera has been bought and with client's consent, photography of leg ulcer has been initiated. Pain assessment is reviewed regularly.	From the date of the inspection

		Ref; Section B and C			
3.	30 (1)	The registered person should notify RQIA without delay of any event in the home which seriously affects the wellbeing or safety of any patient. Any notification made in accordance with this regulation shall be confirmed in writing within 3 days. **Ref; Section 11.1**	One	All departments within the Care Home are currently covered by staff, recent reruitment drive was successful and now awaiting all relevant documentation prior to employment. Any notification will be made to RQIA in writing within 3 days.	From the date of the inspection
4.	14 (3)	The registered person must ensure that staff receive training in moving and handling of patients. This requirement refers specifically to the action to be taken as stated by the registered manager following an untoward event involving a moving and handling procedure. **Ref; Section 11.1**	One	Staff have been trained and deemed competent in moving and handling procedures.	30 June 2014
5.	30 (1)	The registered person must report to the Trust Designated Officer and RQIA without delay any event in the home which may potentially be a safeguarding issue. **Ref; Section 11.2**	One	All safeguarding issues are reported to the Designated Officer of the RQIA without delay. The issue noted on the day of inspection had been reported to the Care Manager and deemed 'not a safeguarding issue'.	From the date of the inspection

6.	19 (1) (b)	The registered person should ensure that records are kept securely in the nursing home. **Ref; Section 11.5**	One	All records are securely retained within the nursing home.	From the date of the inspection
7.	20 (1) (b)	The registered person must ensure that the employment of any persons on a temporary basis at the nursing home will not prevent patients from receiving such continuity of nursing as is reasonable to expect. The identified deficit of 76 registered nursing hours and 136 care assistant hours should be provided by permanent staff employed by the nursing home in order to provide continuity of care with a person centred approach. The weekly duty rota is to be submitted to RQIA each Monday until further notice. **Ref; Section 11.8**	One	All relief staff undergo training and supervision. Appraisals to be completed by end of August 2014. Recent successful recruitment drive of Nurses/Care Assistants/Housekeeper. Awaiting Access NI and relevant documentation prior to employment. Weekly duty rota continues to be forwarded to RQIA each Monday.	From the date of the inspection
8.	20 (1) (a)	The registered person must ensure that there are suitably qualified, competent and experienced persons working in the nursing home in such numbers as are appropriate for the health and welfare of patients. This requirement refers to the inadequate provision of ancillary staff, which includes catering, housekeeping and laundry staff.	One	Staffing levels reflect the occupancy of the Nursing home, as above (awaiting Access NI and relevant documentation).	From the date of the inspection

		Ref; Section 11.8			
9.	20 (3)	The registered manager should complete a competency and capability assessment with any nurse who is given the responsibility of being in charge of the home for any period of time in her absence. **Ref; Section 11.8**	One	All Nurses have undergone Nurse-in-Charge (NIC) competency and capability assessments and are deemed competent and capable in their duties as NIC.	From the date of the inspection
10.	20 (2)	The registered person shall ensure that persons, including bank staff, are appropriately supervised. **Ref; Section 11.8**	One	Supervisions ongoing.	From the date of the inspection
12.	20 (1) (c) (iii)	The registered manager must ensure that all staff employed in the nursing, including all bank staff, receive appraisal, mandatory training and other training appropriate. **Ref; Section 11.8**	One	All staff,contracted or bank will receive appraisal, mandatory and all other relevant training as appropriate.	31 July 2014
12.	13 (7)	In the interest of infection prevention and management it required that the following issues are addressed; • a torn commode lid , identified to the assistant manager, should be made good to provide an intact surface that can be effectively cleaned • the disabled toilet just off the main communal living space should be repainted. Items such as a drinking	One	Cammode lid replaced. All items have been removed from the disabled toilet and appropriately stored. Disabled toilet is to be upgraded during September 2014.	31 July 2014

		glass, toothbrush, man's razor, and basin were stored on top of the wall mounted storage cupboard, these items should not be kept in a toilet area, and items should not be kept on top of the cupboard. • Small toilet just off the main communal living space should be repainted. The raised toilet seat was notably stained with faecal matter. The small waste receptacle bin lid was rusted. A wire square container with a black plastic bin liner should be replaced with a pedal operated waste receptacle. • the main lounge area carpet was notably stained/marked and should be deep cleaned or replaced. **Ref; Section 11.10**		Toilet was cleaned immediately and staff alerted to this matter. Wire basket removed. Infection control audit carried out and 8x new pedal operated bins ordered and now insitu around the Home. Small toilet also included in the refurbishment plan in September 2014 Lounge carpet has been deep cleaned.	
13.	14 (2) (a)	In the interest of maintaining a safe environment for patients, staff and visitors, it is required that where oxygen is in use in a patient's bedroom that appropriate signage is displayed. **Ref; Section 11.10**	One	Staff aware to place "oxygen in use" signage on clients' bedroom door when required.	From the date of the inspection
14.	27 (4) (c)	It is required that all means of escape in the event of a fire are free from obstruction, the portable fan should be removed from the main bedroom corridor on the first floor as a matter of urgency. **Ref; Section 11.10**	One	Portable fan removed immediately when informed of the same, by staff.	26 June 2014

Recommendations

These recommendations are based on the Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	26.2	It is recommended that the 'Admissions of Residents' policy is further developed to include the following; • the role, function and arrangement of the pre-admission procedure • the arrangements to ensure referral forms providing all necessary information, including risk assessments relating to the patient, are provided to the home before admission. • the arrangements to provide confirmation to the prospective patient that the home is suitable to meet their needs • the arrangements to respond to any unplanned admission • the arrangements to respond to self-referred patients. • admission policies and procedures should be reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance. **Ref; Section A**	One	'Admission of Clients Policy has been further updated to include all points raised.'	31 August 2014

2.	3.4	It is recommended that any documents from the referring Healthcare Trust are dated and signed when received.	One	Nursing staff are now fully aware that they must date and sign all paperwork received into the home from refering Healthcare Trust.	From the date of the inspection
3.	8.1	The Malnutrition Universal Screening Tool (MUST) should be undertaken for patients on the day of admission to the nursing home. **Ref: Section A and D**	One	On day of admission to the nursing home the MUST along with all other risk assessments are carried out.	From the date of the inspection
4.		It is recommended that care plans on pain management are put in place for these patients, care plans should be reviewed to show that pain management is evaluated in a timely manner. **Ref: Section B**	One	Care plan in place regarding pain management and evaluated in a timely manner to ensure effectiveness.	From the date of the inspection
5.	26.2	The policy and procedure in place to guide and inform staff in regard to nutrition and dietary intake should be reviewed and further developed as follows; • the policy should refer to the MUST as this is the nutritional screening tool used in the nursing home, not the CNRST as stated in the current nutritional policy. • clearly state the indicators for onward referrals to the relevant professionals. e.g. speech and language therapist (SALT), dietician and/or the general practitioner (GP). • provide details of the current referral	One	Nutritional Policy and procedure has been reviewed and further developed to encompass all points raised.	31 August 2014

		procedures to access other relevant healthcare professionals • state the registered nurse's responsibility to review, evaluate and update patients care plans and risk assessments to ensure the recommendations made by SALT, GP and/or Dietician are recorded and addressed. • state the internal governance arrangements to support staff, the auditing process undertaken by management. **Ref: Section H**			
6.	12.13	The current menu planner should be dated to show when the menus had been reviewed and/or implemented. **Ref: Section H**	One	Clients had been involved in reviewing menu prior to inspection and now implemented.	From the date of the inspection
7.	8.6	It is recommended that all relevant staff attend training in dysphagia awareness, which should the use of thickening agents for patients with swallowing difficulties. **Ref: Section I**	One	Community Speech and Language therapy department contacted, awaiting date to be scheduled for dysphagia awareness training.	31 August 2014
8.	30.7	It is recommended that the staff duty rota is kept up to date and shows the capacity in which staff have actually worked. **Ref; Section 11.8**	One	Off-duty is reflective of all staff working times and within the capacity in which they have worked.	From the date of the inspection

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person and return to nursing.team@rqia.org.uk

Name of Registered Manager Completing Qip	Elizabeth Doak
Name of Responsible Person / identified Responsible Person Approving Qip	Desmond Wilson

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	✓	Linda Thomas	22/9/14
Further information requested from provider			