Unannounced Primary Inspection

Name of establishment:	**Bangor (Stewart Suite)**
RQIA number:	**1055**
Date of inspection:	**18 August 2014**
Inspector's name:	**Linda Thompson**
Inspection number:	**18647**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of establishment:	Bangor (Stewart Suite)
Address:	27a Manor Avenue Bangor BT20 3NG
Telephone number:	028 91273342
Email address:	bangor@fshc.co.uk
Registered organisation/ Registered provider / Responsible individual	Four Seasons Health Care Mr James McCall
Registered manager:	Mrs Donna Mawhinney (registration pending)
Person in charge of the home at the time of inspection:	Mrs Donna Mawhinney home manager
Categories of care:	NH-I , NH-PH , NH- PH(E) ,NH-TI
Number of registered places:	30
Number of patients accommodated on day of inspection:	26
Scale of charges (per week):	£567.00
Date and type of previous inspection:	20 June 2013, Primary unannounced inspection
Date and time of inspection:	18 August 2014 09.00 - 13.30
Name of inspector:	Linda Thompson

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:

- Review of any notifiable events submitted to RQIA since the previous inspection
- analysis of pre-inspection information
- discussion with the home manager

- 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	10 individually and to others in small groups
Staff	5
Relatives	2
Visiting Professionals	0

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	9	9
Relatives / representatives	8	8
Staff	5	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

Bangor Care Home is situated in a quiet residential area on the outskirts of Bangor. The home is easily accessed off Bangor Ring Road.

Stewart Suite is one of four suites within Bangor Care home and is located on the first floor of the upper building. Access is provided from the car park via a ramp bridge direct to the Stewart Suite.

Accommodation for patients is provided over one single floor

Access to the relative's room on the lower floor is via a passenger lift and stairs.

Communal lounge and dining areas are provided throughout the Stewart Suite and patients are encouraged to make use of these facilities.

The home also provides for catering and laundry services on the ground floor.

A number of communal sanitary facilities are available throughout the home.

The nursing home is owned and operated by Four Seasons Healthcare.
Mrs Donna Mawhinney has been appointed as home manager and her registration with RQIA is pending. Ms Mawhinney has worked in the home for many years and recently was employed in the position of acting home manager.

The home is registered to provide care for a maximum of 30 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

The home's RQIA 'Certificate of Registration' was appropriately displayed in the entrance hall of the Suite.

8.0 Summary of inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Stewart Suite. The inspection was undertaken by Linda Thompson on 18 August 2014 from 08.30 to 13.30 hours.

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

The inspector was welcomed into the home by Ms Donna Mawhinney who had recently been appointed as home manager. Ms Mawhinney has been working in the home as deputy manager for many months and her registration with RQIA is pending. Ms Mawhinney was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Ms Mawhinney, Mrs Mary Moore regional manager and Ms Heather Turner care manager on behalf of South East HSC Trust Safeguarding team 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. This self-assessment was received by the Authority in July 2014 and the inspector has been able to evidence that the level of compliance achieved with the standards inspected was accurately measured by the home manager.

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, their representatives and staff to seek their opinions of the quality of care and service delivered. The inspector also examined the returned questionnaires from patients, their representatives and staff, observed care practices, examined a selection of records, and carried out a general inspection of the nursing home environment as part of the inspection process.

The inspector also spent two 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 20 June 2013 four requirements and three recommendations were issued. These were reviewed during this inspection and the inspector evidenced that all requirements and recommendations have 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).

8.1 Inspection findings

8.1.1 Management of nursing care – Standard 5

The inspector can confirm that at the time of the inspection there was evidence to validate that patients received safe and effective care in Stewart Suite.

There was evidence of comprehensive and detailed assessment of patient needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patient need was evidenced to inform the care planning process.

Comprehensive reviews of both the assessments of need, the risk assessments and the care plans were maintained on a regular basis plus as required. The inspector identified one area for improvement in the recording of patient bowel function.

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.

Compliance Level: Compliant

8.1.2 Management of wounds and pressure ulcers – Standard 11 (selected criteria)

The inspector evidenced that wound management in the home was generally well maintained.

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 and wound care were maintained however the inspector identified a need for improvements in the recording of wound records.

A requirement is raised.

Compliance Level: Substantively Compliant

8.1.3 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.

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 breakfast and 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 registered nurses.

Patients were observed to be assisted with dignity and respect throughout the meal, however concerns were raised regarding the use of plastic crockery for patients. In the inspector's professional opinion the use of plastic mugs and plates is considered undignified. It is required that the home source suitable light weight china crockery within the next two months.

A requirement is raised.

Compliance Level: Substantively Compliant

8.1.4 Management of dehydration – Standard 12 (selected criteria)

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

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.

Compliance Level: Compliant

8.3 Patient, representatives and staff questionnaires

Some comments received from patients and their representatives:

"This is a great home"
"I am very happy here"
"The food is good and I also have enough to eat"
"Bangor Care Home are fab! The staff are so friendly and helpful and can't do enough for you. They are great with residents and show a caring and loving attitude towards all residents."

"The care and food is excellent, staff always pleasant, there is nothing missing, I don't know how they have the patience.

Some comments received from staff:

"I work on most units within Bangor Care Home within my current role. I find on all units that staff work well together and everybody helps each other out."
"I have been working here since 2010 and I feel very happy here. There is good management and team work. It is a very pleasant place to work"
"I have had a good induction experience and felt well prepared for my role."

8.4 A number of additional areas were also examined.

- records required to be held in the nursing home
- Human Rights Act 1998 and European Convention on Human Rights (ECHR)
- Patient and staff quality of interactions (QUIS)
- Complaints
- patient finance pre-inspection questionnaire
- NMC declaration
- staffing and staff comments
- comments from representatives/relatives *and visiting professionals*
- environment

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

The home's general environment was well maintained and patients were observed to be treated with dignity and respect. However, areas for improvement were identified in relation to the use of plastic crockery and some record keeping issues.

Therefore, nil requirements and recommendations are restated and two requirements and one recommendation is raised as a consequence of this inspection.
These requirements and recommendations are detailed throughout the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients and their representatives, the home manager, the regional manager, registered nurses 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 20 June 2013.

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1.	14 (4) (a)	The registered person must review the serving of breakfast for patients accommodated to ensure that breakfast is served at a more traditional breakfast time, unless a later time is specifically requested by individual patients.	The inspector can confirm that the timing of all meals has been reviewed and updated as required.	Compliant
2.	16 (2) (b) &(d)	The registered person must implement a rigorous monitoring system to ensure that 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. Care records should evidence that; • All documents are signed by the author. • Relatives' communication sheets are kept up to date.	The inspector can confirm that all nursing care records were evidenced to be; • signed by the author • communications sheets are evidenced to be kept up to date • admission records evidenced that the patient's baseline weight is recorded within 24 hours of admission to the home • the records and reasons for use of restraint such as a lap belt is appropriately maintained • fluid intake records are reconciled into daily progress notes daily	Compliant

		• Patient's initial baseline weight is recorded within a 24 hour time frame. • Care plan relating to the use of a lap belt demonstrates the appropriate consultation took place prior to implementation of this intervention. • Where a patient is assessed as at risk of malnutrition and/or dehydration, the patients daily (24hour) fluid intake should be recorded in their daily progress record in order to show that this area of care is being properly monitored. • Care records should evidence that consultation has taken place with all relevant persons prior to the use of a lap belt for any patient. Thereafter regular review and evaluation must be recorded.		

3.	20 (1) (b)	It is required that the registered person shall ensure that the employment of temporary staff will not prevent patients from receiving such continuity of nursing as is reasonable to meet their needs.	The inspector can confirm that the use of temporary staff is kept to a minimum and if agency staff are required then continuity in the use of such staff is considered essential.	Compliant
4.	27 (4) (b)	The registered person must ensure that doors are not wedged/propped open.	The inspector can confirm that there was no evidence of doors being wedged open during the period of inspection.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1.	5.9	Patients and/or their representatives should be made aware of any change in the patient's assessed needs, prescribed treatment and or required nursing interventions, with a record maintained accordingly.	The inspector can confirm that the patient communication records evidenced that communication between the staff and the patient representatives was appropriately maintained.	Compliant
2.	5.7	Repositioning charts should be completed to evidence that the patient's skin condition is assessed at agreed time intervals.	The inspector examined a number of patient repositioning charts and can confirm that these are maintained as required.	Compliant
3.	6.3	It is recommended that the final draft of the staff rota is completed in black ink.	The inspector observed the final draft of the staff duty rota and can confirm that is maintained in black ink.	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.

There have been one notification to RQIA regarding potential safeguarding of vulnerable adults (SOVA) incident since the previous inspection. The incident was being managed in accordance with the regional adult protection policy by the safeguarding team within the South East HSC Trust.

The inspector was kept informed of the investigation by the South East HSC Trust safeguarding team and the care manager representing the safeguarding team received feedback at the end of the inspection visit.
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10.0 Additional areas examined

10.1 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.

10.2 Patients/residents under guardianship

There were no patients currently under guardianship resident at the time of inspection in the home.

10.3 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 home manager and one of the registered nurses. The inspector can confirm that copies of these documents were available in the home.

The home manager and registered nurse demonstrated an awareness of the details outlined in these documents.

The home 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.

10.4 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 during the serving of breakfast and lunch 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	45
Basic care interactions	0
Neutral interactions	0
Negative interactions	0

The inspector evidenced that the quality of interactions between staff and patients/residents was positive.

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

10.5 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. 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 registered manager informed the inspector that lessons learnt from investigations were acted upon.

10.6 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.

10.7 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.

10.8 Questionnaire findings

10.8.1 Staffing/staff comments

Discussion with the home manager and a number of staff and review of a sample of staff duty rosters evidenced that the registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients currently in the home. The care and ancillary staffing levels were found to be satisfactory.

Staff were provided with a variety of relevant training including mandatory training since the previous inspection.

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 five staff completed questionnaires. The following are examples of staff comments during the inspection and in questionnaires;

"I work on most units within Bangor Care Home within my current role. I find on all units that staff work well together and everybody helps each other out."
"I have been working here since 2010 and I feel very happy here. There is good management and team work. It is a very pleasant place to work"
"I have had a good induction experience and felt well prepared for my role."

10.8.2 Patients' comments

During the inspection the inspector spoke with10 patients individually and with a number in groups. In addition, on the day of inspection, nine patients completed questionnaires.

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

"This is a great home"
"I am very happy here"
"The food is good and I also have enough to eat"

10.8.3 Patient representative/relatives' comments

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

"Bangor Care Home are fab! The staff are so friendly and helpful and can't do enough for you. They are great with residents and show a caring and loving attitude towards all residents."
"The care and food is excellent, staff always pleasant, there is nothing missing, I don't know how they have the patience.

10.8.4 Professionals' comments

One professional visited the home during the inspection. This professional expressed high levels of satisfaction with the quality of care, facilities and services provided in the home.

11.0 Review of care records

The inspector examined a number of patient care records as part of the inspection process to validate the provider's self-assessment. Records were evidenced to be maintained to an acceptable standard.

Improvements are required to the recording of patient's bowel function. This is currently recorded separately to the patient's nursing care records and was not evidenced to be transferred across as required.

A recommendation is raised.

Wound care records were examined for two patients. The inspector identified some areas for improvement in the management of wound care and associated records.

In the records of patient 'A' identity known to the home manger the inspector identified the following;

1. The term pressure ulcer was used incorrectly to describe venous ulceration
2. Wound records were maintained for one wound dressing when in fact there were two different wounds on the patient's leg
3. There were delays noted in the prescribed date for wound re dressing and the actual date of wound re dressing.

A requirement is raised to address wound management.

In the records for patient 'B' identity known to the home manager the inspector found the wound care records to be maintained appropriately.

12.0 Quality improvement plan

The details of the quality improvement plan appended to this report were discussed with Donna Mawhinney, home manager, Mary Moore regional manager and Heather Turner care 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:

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The Regulation and Quality Improvement Authority
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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**
Prior to admission to the home, the Home Manager or a designated representative from the home carries out a pre admission assessment. Information gleaned from the resident/representative (where possible), the care records and information from the Care Management Team informs this assessment. Risk assessments such as the Braden Tool are carried out, if possible, at this stage. Following a review of all information a decision is made in regard to the home's ability to meet the needs of the resident. If the admission is an emergency admission and a pre admission is not possible in the resident's current location then - a pre admission assessment is completed over the telephone with	Substantially compliant

written comprehensive, multidisciplinary information regarding the resident being faxed or left into the home. Only when the Manager is satisfied that the home can meet the residents needs will the admission take place. On admission to the home an identified nurse completes initial assessments using a patient centred approach. The nurse communicates with the resident and/or representative, refers to the pre admission assessment and to information received from the care management team to assist her/him in this process. There are two documents completed within twelve hours of admission - an Admission Assessment which includes photography consent, record of personal effects and a record of 'My Preferences' and a Needs Assessment which includes 16 areas of need - the additional comments section within each of the 16 sections includes additional necessary information that is required to formulate a person centred plan of care for the Resident. In addition to these two documents, the nurse completes risk assessments immediately on admission. These include a skin assessment using the Braden Tool, a body map, an initial wound assessment (if required), a moving and handling assessment, a falls risk assessment, bed rail assessment, a pain assessment and nutritional assessments including the MUST tool, FSHC nutritional and oral assessment. Other risk assessments that are completed within seven days of admission are a continence assessment and a bowel assessment, Following discussion with the resident/representative, and using the nurse's clinical judgement, a plan of care is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations. This can be evidenced in the care plan and consent forms. The Home Manager and Regional Manager will complete audits on a regular basis to quality assure this process	

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 completes a comprehensive and holistic assessment of the resident's care needs using the assessment tools as cited in section A, within 7 days of admission. The named nurse devises care plans to meet identified needs and in consultation with the resident/representative. The care plans demonstrate the promotion of	Substantially compliant

maximum independence and focuses on what the resident can do for themselves as well as what assistance is required. Any recommendations made by other members of the mutidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable. Registered nurses in the home are fully aware of the process of referral to a TVN via email when necessary. Referrals are also made via this process in relation to residents who have lower limb or foot ulceration to either the TVN or a podiatrist. If necessary, a further referral is made to a vascular surgeon by the G.P, TVN or podiatrist. Where a resident is assessed as being 'at risk' of developing pressure ulcers, a Pressure Ulcer Management and Treatment plan is commenced. A care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. The care plan will give due consideration to advice received from other multidisciplinary members. The treatment plan is agreed with the resident/representative, Care Management and relevant members of the MDT. The Regional Manager is informed via a monthly report and during the Reg 29 visit. The Registered Nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Dietician referral forms are held within the home. These forms can be completed by staff in the home and faxed directly to the dietician for referral. The dietician is also available over the telephone for advice until she is able to visit the resident. All advice, treatment or recommendations are recorded on the MDT form with a subsequent care plan being compiled or current care plan being updated to reflect the advice and recommendations. The care plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in the home and other members of the MDT are kept informed of any changes.The home is currently involved in a pilot scheme with the community dieticians to enhance dietary knowledge.	

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**
The Needs Assessment, risk assessments and care plans are reviewed and evaluated at a minimum of once a month or more often if there is a change in the resident's condition. The plan of care dictates the frequency of review and re assessment, with the agreed time interval recorded on the plan of care. The resident is assessed on an ongoing daily basis with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the Home Manager's attention. The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.	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**
The home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to. The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading sysytem. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime or if the condition of the pressure ulcer changes. There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', ' PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in	Substantially compliant

relation to nutritional care, diabetic care, care of subcuteanous fluids and care of percutaneous endoscopic gastrostomy (PEG)..	

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**
Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are comtemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines - Record keeping:Guidance for nurses and midwives. Records of the meals provided for each resident at each mealtime are recorded on a daily menu choice form. The Catering Manager also keeps records of the food served and include any specialist dietary needs. Residents who are assessed as being 'at risk' of malnutrition, dehydration or eating excessively have all their food and fluids recorded in detail on a daily basis using a FSHC food record booklet or fluid record booklet. These charts are	Substantially compliant

recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. The nurse utilises the information contained in these charts in their daily evaluation. Any deficits are identified with appropriate action being taken and with referrals made to the relevant MDT member as necessary. Any changes to the resident's plan of care is discussed with them and/or their representative. Care records are audited on a regular basis by the Manager with an action plan compiled to address any deficits or areas for improvement - this is discussed during supervision sessions with each nurse as necessary.Staff are receiving in house training on dehydration.	

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 daily basis on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan of care or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their representatives are involved in the evaluation process.	Substantially 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**
Care Management Reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the resident's file. Any recommendations made are actioned by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals.	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**
The home follows FSHC policy and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs on admission and review on an ongoing basis. The care plan reflects type of diet, any special dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if necessary. The home has a 3 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives - residents advocacy meetings, one to one meetings and food questionnaires. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied. Copies of instructions and recommendations from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs.	Substantially compliant

Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything from the daily menu an alternative meal of their choice is provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet.Finger foods are available for those who wish to have them. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room.	

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**
Registered nurses have completed the e-learning module on nutrition..The cook is attending training in July 2014.. The Speech and Language therapist and dietician also give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document - 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language therapist are incorporated	Substantially compliant

into the care plan to include type of diet, consistency of fluids, position for feeding, equipment to use and assistance required. Meals are served at the following times:- Breakfast - 9am-10.30am Morning tea - 11am Lunch - 12.50pm Afternoon tea - 3pm Evening tea - 4.50pm Supper - 8-9pm There are variations to the above if a resident requests to have their meals outside of these times. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. There are foods available outside of these times for those resident's who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedrooms, these are replenished on a regular basis. Any matters concerning a resident's eating and drinking are detailed on each individual care plan - including for eg. likes and dislikes, type of diet, consistency of fluid, any special equipment required and if assistance is required. A diet notification form is completed for each resident with a copy given to the kitchen and one held in the care file. Meals are not served unless a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Each nurse has completed an education e-learning module on pressure area care. The home has a link nurse who has received enhanced training, to provide support and education to other nurses within the home on an ad hoc basis. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the home have a competency assessment completed. Competency assessments have a quality assurance element built into the process The home liaises directly with the Trust clinical facilitator who will hold training sessions and offer advice on a 1-1 basis..	

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

Bangor (Stewart Suite)

18 August 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 Donna Mawhinney home manager, Mary Moore regional manager and Heather Turner care manager representing the safeguarding team of the South East HSC Trust 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.	13 (1)	The registered person must ensure that the management of wound care and associated records are maintained appropriately. The registered person must ensure the following; • The wound must be correctly identified • The prescribed interval between dressings must be adhered to unless clear reason for the change in frequency is recorded • Each individual wound should have its own wound record **Ref section 11.0**	One	The nursing team have received a supervision session regarding the management of wounds and record keeping.	From date of inspection and on going
2.	12(1)	The registered person must ensure that suitable light weight china crockery is made available to meet the needs of the patients. All due consideration to patients' rights of dignity and respect must be afforded and the use of plastic crockery should be withdrawn. Plastic crockery should only be used in exceptional circumstances and only following appropriate risk assessment. **Ref section 8.1.3**	One	The plastic crockery will be removed. If this crockery is required by any residen a risk assessment will be completed and a best interest care plan will be formulated in consultation with all stake holders.	By end October 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.	5.7	It is recommended that the records of patient's bowel functions are recorded in the patient's nursing care records against the Bristol Stool Chart. This will allow for a continuous professional assessment and evaluation of the effectiveness of laxative therapies. **Ref section 11.0**	One	The nursing team have received a supervision session regarding record keeping in relation to residentss bowel functions.	Within one month

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	Donna Mawhinney
Name of Responsible Person / Identified Responsible Person Approving Qip	Jim McCall CARL COUSINS DIRECTOR OF OPERATIONS

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Linda Thomps	6/10/14
Further information requested from provider			