Announced Primary Inspection

Name of establishment:	**Beverly Lodge**
Establishment ID No:	**1062**
Date of inspection:	**3 and 9 July 2014**
Inspector's name:	**Heather Sleator**
Inspection No:	**017001**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of home:	Beverly Lodge Private Nursing Home
Address:	186a Bangor Road Newtownards BT23 7PH
Telephone number:	028 91 823573
E mail address:	ashdoncare@hotmail.co.uk
Registered organisation/ Registered provider / Responsible individual	Ashdon Care Ltd Mr James Cole
Registered manager:	Mrs Janet Davison
Person in charge of the home at the time of inspection:	Mrs Janet Davison
Categories of care:	NH-DE
Number of registered places:	43
Number of patients accommodated on day of inspection:	42
Scale of charges (per week):	£553.00
Date and type of previous inspection:	27 March 2014 Secondary Unannounced
Date and time of inspection:	3 July 2014 09:45 – 18:00 hours 9 July 2014 09:45 – 14:30 hours
Name of inspector:	Heather Sleator

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 registered 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.

5.0 Consultation Process

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

Patients	14
Staff	10
Relatives	0
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	0	0
Relatives / Representatives	0	0
Staff	6	6

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

Beverley lodge Nursing home is situated off the main road between Newtownards and Bangor Co. Down
The nursing home is owned and operated by Ashdon Care Ltd
The current registered manager is Janet Davidson who has worked in the home for a number of years.

The home is single storey and accommodation for patients is provided on a single room basis.

Communal lounge and dining areas are provided and are located in a central core area of the home.
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 home is registered to provide care for a maximum of 43 persons under the following categories of care:

Nursing care

DE dementia care

8.0 Summary of Inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Beverly Lodge. The inspection was undertaken by Heather Sleator on 3 July 2014from 09:45 to 18:00 hours and 9 July 2014 from 09:45 to 14:30 hours.

The inspector was welcomed into the home by Janet Davidson registered manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Janet Davidson and Mr Cole, responsible person, 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 on 1 May 2014 and the inspector has been able to evidence that the level of compliance achieved with the standards inspected was accurately measured by the registered 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, 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 27 March 2014 three requirements and two recommendations were issued.

These were reviewed during this inspection. The inspector evidenced that three requirements and two 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 was evidence to validate that patients received safe and effective care in Beverly Lodge.

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 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.

The inspector was impressed with the quality of patient care records maintained in Beverly Lodge. Registered nursing staff are commended for the quality of the person centred records maintained.

COMPLIANCE LEVEL: Compliant

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

The inspector evidenced that wound management in the home was 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 to a professional standard.

Following the review of four patients' care records the inspector recommended greater attention is given to the management of pain specifically in relation to the administration of analgesia prior to wound care management.

COMPLIANCE LEVEL: Compliant

- **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 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.

COMPLIANCE LEVEL: Compliant

- **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 residents were recorded and maintained for those patients assessed at risk of dehydration.

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

COMPLIANCE LEVEL: Compliant

Patient, representatives and staff questionnaires

Some comments received from staff:

"I feel management are very approachable"
"Communication between management and care assistants is of a very high standard"
"Staff are genuinely interested in the individual stories of each resident, this shows in the way care staff work"
"Excellent care is provided and management are excellent"
"Beverly Lodge is a good caring home"
"I feel there is a high standard of communication between management and care staff"
"I am very satisfied with the feedback I receive through appraisals/competencies".

A number of additional areas were also examined.

- records required to be held in the nursing home
- guardianship
- Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)
- 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.

Full details of the findings of inspection are contained in section 10 of the report.

Conclusion

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 aspects of care planning and ensuring the environment of the home is enabling for persons with dementia.

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

The inspector would like to thank the patients, registered manager, registered nurses and staff for their assistance and co-operation throughout the inspection process.

9.0 Follow-up on the requirements and recommendations issued as a result of the previous inspection on 27 March 2014

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1.	13 (7)	The registered person shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff. The flooring in the hallways/corridors needs to be replaced as deep cleaning was unsuccessful.	The inspector verified this requirement had been addressed. New carpeting had been laid in the corridors of the home. There were no malodours in the home at the time of inspection.	Compliant
2.	13(7)	In the interest of infection prevention and control, the following issues are required to be addressed; • staff should not wear cardigans when assisting/attending patients. • torn crash mattress in the bedroom identified	The inspector verified this requirement had been addressed. staff were not observed to be wearing cardigans at the time of inspection. eight new crash/fall out mats had been purchased. the housekeeping rota now includes the cleaning of sensor and crash mats. The cleanliness of the home and of equipment is completed on a monthly basis.	Compliant

		to the registered manager should be repaired in order to provide a surface that can be effectively cleaned. • the sensor mat and crash mattress in the bedroom identified to the registered manager need to be cleaned. • chipped paintwork should be made good in order to provide an intact surface.(to be completed immediately following re-flooring work).	The areas previously identified were being repainted at the time of inspection.	

3.	14 (2) (b)	A bed mattress should not be used as crash' or 'fall out' mattress' as they are not designed to be used in this way. Staff should be made aware of the risks they take if they use equipment outside of its purpose/use.	The inspector verified this requirement had been addressed. As previously stated new crash/fallout mats had been purchased. The inspector did not observe the use of mattresses as crash/fallout mattresses at the time of inspection.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1.	20.1	Guidance documents such as Nursing Midwifery Council (NMC) guidance and the Resuscitation Guidelines 2010 from the Resuscitation Council UK should be available for reference in the home.	The inspector verified this recommendation had been addressed. The required guidance documentation was available in the home for staff reference and viewed by the inspector.	Compliant
2.	5.6	Where a nursing assessment is made to monitor a patient's daily fluid intake, then 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 and validated by the registered nurse. Bowel function, reflective of the Bristol Stool Chart should be recorded on admission as a baseline measurement and thereafter in patients' daily	The inspector verified this recommendation had been addressed. Information pertaining to patients' fluid intake was recorded in individuals' care records. Information gained through the use of the Bristol Stool Chart was present in patients' care records.	Compliant

		progress records.		

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 27 March 2014 RQIA have received nil notifications of safeguarding of vulnerable adult (SOVA) incidents in respect of Beverly Lodge.

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 registered manager and two 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.

10.4 Quality of interaction schedule (QUIS)

The inspector undertook two periods of observation in the home which lasted for approximately 15 minutes each.

The inspector observed the lunch meal 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	24
Basic care interactions	2
Neutral interactions	0
Negative interactions	0

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

Staffing/Staff Comments

Discussion with the registered 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 residents currently in the home. 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 10 staff. The inspector was able to speak to a number of these staff individually and in private. On the day of inspection six staff completed questionnaires. The following are examples of staff comments during the inspection and in questionnaires;

"I feel management are very approachable"

"Communication between management and care assistants is of a very high standard"
"Staff are genuinely interested in the individual stories of each resident, this shows in the way care staff work"
"Excellent care is provided and management are excellent"
"Beverly Lodge is a good caring home"
"I feel there is a high standard of communication between management and care staff"
"I am very satisfied with the feedback I receive through appraisals/competencies"

Patients' comments

During the inspection the inspector spoke with 14 patients individually and with a number in groups. Questionnaires were not used on this occasion.

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

"People are friendly here"
"Staff are good to me".

Patient Representative/relatives' comments

There were no resident representatives available during the inspection visit.

Professionals' Comments

There were no professional visits made to the home during the inspection visit.

10.9 Review of care records

The inspector examined four patients' care records as part of the inspection process to validate the provider's self-assessment. Records were evidenced to be maintained to a commendable standard.

Records were evidenced to be person centred, detailed and comprehensive. The registered nursing staff are commended for the quality of the recording evidenced during the inspection visit.

Wound care records were examined for one resident. These records were well maintained to a professional standard.

However, the review of patients' care records highlighted a small number of areas which require attention. These were discussed with the registered manager and were as follows;

- Life story information should be available for each patient. This will further assist in providing person centred care.

- During the review of patients' care records information was present regarding the risk of choking and of seizure activity. The inspector did not view. corresponding care plans for this area of identified need. Care plans should be present for all assessed need or risk.
- The management of pain should be reviewed. Where pain is assessed records should evidence the effectiveness of the administration of analgesia.

10.10 The environment

The inspector undertook an inspection of the home in relation to dementia care. Whilst all areas of the home were found to be clean and attractively furnished the inspector made the following recommendations;

Dining room

Greater attention should be given to enhancing the appearance of the dining room. Dining tables should be appropriately set with tablecloths/placemats; crockery which is dementia friendly i.e. contrasting colours to enhance visibility and a full range of condiments should be available for patients.

The menu should be located so as all patients can clearly see and understand it. The use of daily menus on tables should be considered or pictorial menus.

Lounge areas

Again whilst the lounge areas were furnished with good quality furniture these areas would benefit from being made more homely in appearance. The use of soft furnishings and the rearrangement of chairs should be given consideration**.**

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Janet Davidson, registered 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:

Heather Sleator
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**
A pre admission assessment is completed for all potential admissions and an agreed plan of care is developed to meet the residents immediate care needs. This is to determine if the home is appropriate to meet the needs of the residents. Information for this assessment is obtained from the individual, their family or next of kin, their care provider (if applicable) and their care manager/social worker. The admission assessment tool is a holistic tool identifying physical, psychological, spiritual and social needs. All information received from care management teams is obtained by the home and signed by the registered manager prior to admission. All validated assessment tools, including the MUST, are completed within 11 days of admission. The waterlow prevention tool is completed on all residents prior to, or on admission to the home. A pre admission assessment	Substantially compliant

identifies a resident who may be 'at risk' of skin breakdown. Sound clinical judgement is used along with the prevention tool. Pre admission information and assessment and body mapping is also completed on admission.	

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**
The named nurse is allocated on admission and introduced to the resident on admission (if possible). The name of the named nurse is displayed in the residents room. Care plans are developed using information obtained during the admission process. Separate communication documents for the multidisciplinary team and families are clearly evident in the care records. The resident and their representative are involved in the care planning process, a care planning discussion document is signed to evidence this. Care plans reflect advice provided by health care professional.	Substantially compliant

If a resident is assessed as 'at risk, a detailed care plan is completed by the named nurse and agreed with the resident and/or their representative. The information and plan is communicated to all staff. If advice is sought by other professionals, this information is documented and communicated throughout the team. A written policy is available for staff to refer to in relation to tissue viability, including referrals to the tissue viability podiatrist for advice for residents who have lower limb or foot ulceration. Staff competencies are completed to ensure awareness of when it is appropriate to seek advice and refer to the revelant health professionals. Nurses are knowledgable on the referal process of how to and when to access dietetics. If a nutritional plan is implemented the dieticians recommendations are filed in the residents records and a care plan is implemented according to the specialist recommendations.	

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**
Agreed time intervals are recorded in the residents care plan and communicated throughout the team. Triggers are placed in the nursing diary. Reassessment is an ongoing progress.	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 are governed by professional bodies and national standard setting organisations. Research evidence is available for nursing and care staff to study. The waterlow grading tool is used to screen all residents, at least on a monthly basis and more often if required. A care plan is implemented for residents who may be vulnerable to skin damage and an appropriate plan implemented. Trust guidelines are adhered to, to ensure a timely referral. Current nutritional guidelines, including the DHSSPS 'Promoting Good Nutrition' are available at Beverly Lodge for staff to refer to.	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 are recorded for all mnursing interventions, activities and procedures that are carried out for each resident. Individual, detailed records are kept for all meals provided and the amount consumed. An independent dietician assesses the meals in Beverly Lodge to ensure they are adequately nutritious. The Nurse in Charge examines each residents dietary and fluid intake during and on completion of the shift. The Nurse is required to sign the intake document to confirm that she/he has evidenced each residents intake and taken action, if required.	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**
Care delivery is monitored, evalutated and recorded on a daily basis. All care plans and risk assessments are reviewed at least monthly, more regular if required. Relatives are involved in the 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**
Formal multidisciplinary review meetings are arranged annually by the appropriate HSC Trust, or more regularly if required. Residents are encouraged to participate. A review action plan is completed during the review and changes, if suggested or required, are documented and actioned as appropriate. Residents and/or their representative are kept informed of the process to achieve 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**
Residents are provided with a nutritious diet which is assessed by an independent dietician to ensure the menu is appropriate for our residents and is nutritious. Menus are rotated over a three week cycle and revised at least six monthly. Recommendations by dieticians or other professionals are relayed to the chef, documented in the residents care records and implemented in a care plan. All residents are catered for individually. All residents are offered a choice of menu each morning. If a resident requests an alternate meal, this is provided.	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**
All staff are currently undergoing refresher training in the management of residents who have swallowing difficulties. Staff have all been supervised in thickening agents and the consistency required according to the SLT recommendations. Hot and cole drinks and snacks are available when required. Spring bottled water is available at all times. Care plans are detailed according to the residents individual needs.The care plan details risk management, the level of assistance required and any aids that may be required.	Substantially compliant

All nurses attend wound care training to ensure they have up to date knowledge regarding wound assessment and management.	

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	COMPLIANCE LEVEL
	Provider to complete

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.

Quality Improvement Plan

Unannounced Primary Inspection

Beverly Lodge

3 and 9 July 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 Janet Davidson, registered manager, at the conclusion of the inspection.

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.

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	5.5	It is recommended that lifestory information is completed for all patients. Lifestory information should be readily available for staff to reference. **Ref: additional areas examined, 10.9 care records.**	One	Residents life stories being further developed and documented by the Activities co-ordinator and the residents named nurse.	Three months
2	5.3	It is recommended that where assessed need or risk has been identified by registered nurses a corresponding care plan is written and evidences regular review, for example; seizure activity or risk of choking. **Ref: additional areas examined, 10.9 care records.**	One	Care plans for all identified risks implemented.	From the time of inspection
3	5.4	It is recommended the management of pain is reviewed and revised. Evidence should be present in care records of the effectiveness of analgesia. **Ref: additional areas examined, 10.9 care records.**	One	Management of pain reviewed. Effectiveness of pain relief reviewed in the residents daily records.	From the time of inspection

4	32.3	It is recommended a dementia audit of the home is completed. The audit should focus on the lounge and dining areas of the home. The focus of the audit is to ensure the environment of the home is enabling for persons with dementia. **Ref: additional areas examined, 10.10 the environment.**	One	Environmental audit completed. Further developments to enhance the environment planned for the incoming year.	Three months

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	Janet Davison
Name of Responsible Person / Identified Responsible Person Approving Qip	Jim Cole

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	X	Heather Sleator	15/01/2015
Further information requested from provider			