Unannounced Primary Inspection

Name of establishment:	**Comber Care Home**
Establishment ID No:	**1075**
Date of inspection:	**12 August 2014**
Inspector's name:	**Carmel McKeegan**
Inspection No:	**16820**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of home:	Comber Care Home
Address:	17 Castle Street Comber BT23 5DY
Telephone number:	028 91878200
E mail address:	comber@fshc.co.uk
Registered organisation/ Registered provider / Responsible individual	Four Seasons Health Care Mr James McCall
Registered manager:	Mrs Anne Robertson
Person in charge of the home at the time of inspection:	Mrs Anne Robertson
Categories of care:	NH-I ,NH-PH ,NH-PH(E) ,NH-TI
Number of registered places:	72
Number of patients / residents accommodated on day of inspection:	58
Scale of charges (per week):	£581.00
Date and type of previous inspection:	13 September 2013, Primary unannounced inspection
Date and time of inspection:	12 August 2014 09.50 – 16.50
Name of inspector:	Carmel McKeegan

2.0 Introduction

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

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

3.0 Purpose of the inspection

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

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

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

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

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

4.0 Methods/Process

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

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

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

- analysis of pre-inspection information
- discussion with the registered manager, Mrs Anne Robertson

- 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
Staff	6
Relatives	5
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	7	5
Relatives / Representatives	6	2
Staff	10	1

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

Comber Care Home is situated in the centre of Comber close to all local amenities.

Comber Care Home is one of a number of homes owned and operated by Four Seasons Health Care.

The current home manager is Mrs Anne Robertson, who became the registered manager for the home on 28 May 2014. Mrs Robertson has held previous managerial positions within Four Seasons Health Care.

The home is designed to accommodate seventy-two patients in a purpose built two-storey building. Operationally this number has been reduced as several double rooms are used as large single rooms.

The majority of bedroom accommodation is provided in single bedrooms and in a designated number of double bedrooms. Single and double en-suite rooms are also available. Nurse call systems were available in all bedrooms.

Areas have been created to allow for small group living, and there are nine lounges, three dining rooms throughout the home.

A range of assisted bathrooms and toilets were positioned throughout the home and two passenger lifts were available.
Catering and laundry services are undertaken on the premises.

Car parking spaces are available to the front and side of the premises.

The home is registered to provide care for a maximum of 72 persons under the following categories of care:

<u>Nursing care</u>

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

8.0 Summary of Inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Comber Care Home. The inspection was undertaken by Carmel McKeegan on 12 August 2014 from 09.50 to 16.50 hours.

The inspector was welcomed into the home by Mrs Anne Robertson, registered manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Mrs Robertson 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 May 2014 .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, who commented positively on the care and services provided by the nursing home.

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 13 September 2013, five requirements and ten recommendations were issued. These were reviewed during this inspection. The inspector evidenced that four requirements and eight recommendations had been fully complied with. One requirement relating to the provision of individual formal supervision for all staff is now stated for the third and final time. Two recommendations are stated for a second time.

At the conclusion of this inspection the registered manager was made fully aware that enforcement action would be taken should compliance with the requirement relating to the provision of supervision for staff not be fully achieved within the required timeframe.

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 Comber Care Home

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.

- **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.

- **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.

Discussion with staff members confirmed that they were knowledgeable of the nutritional needs and preferences of the patients accommodated in the nursing home.

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.

The inspector spoke with several patients throughout the inspection. Patient's comments indicated that they were satisfied with meal choices provided in Comber Care Home.

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

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

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.

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

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

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

Patients, representatives and staff questionnaires

Some comments received from patients and their representatives:

“The girls are all very good; I am very well looked after.”
“The staff are all very good to me, they work hard and they are always patient and kind.”
“I am not feeling well today, the nurses have been looking after me very well.”
“The food is very good, they ask us every day what we would like for our meals and there is always a good choice.”

“As a family we are very happy with the nursing home, we feel we made a good choice, we can pop in any time and the staff are all so pleasant.”
“We have no complaints, and are very happy with the care in the home.
“No complaints, all the staff are very helpful, they keep the place spotless and look after all the patients very well”.

Some comments received from staff:

“I am very happy with the standard of care; we all work together as a team for the benefit of the patients”
“I think the home provides a good standard of care, if it didn’t I wouldn’t be here.”
“We all do our best for the patients; it would be nice to have more time”
“Our home is a friendly and welcoming place. All visitors are made to feel very welcome and most of them are complimentary about the standard of care their relatives receive”.

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
- environment

Full details of the findings of inspection are contained in section 11 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.

One requirement and two recommendations are restated, there were no requirements and recommendations generated as a result of this inspection. The requirements and recommendations are detailed 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.

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 13 September 2013

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1.	20(1)(c)(i)	The registered persons must ensure that recorded individual formal supervision of staff is fully established and that the supervision planner is up to date.	Discussion with the registered manager confirmed that group supervision had been undertaken, which focused on issues prioritised for improvement. The inspector was able to verify that records were maintained of the group supervision sessions. The registered manager stated that there has not been time to provide individual formal supervision for all staff since her appointment as registered manager for the home. The registered manager also stated that she is keen to establish individual formal supervision over the following months before the end of 2014. The inspector was unable to verify that recorded individual formal supervision has been undertaken. **This requirement is now raised for the third and final time. Further non-compliance with result in enforcement action.**	Not compliant

2.	12(4)(a)-(d)	The registered persons must ensure t the following issues have been addressed in full: • Patients receive a nutritious and varied diet which meets their individual and recorded dietary needs and preferences • Patients receiving a pureed meal receive a daily choice with improved systems implemented to ensure that patients/or representatives are aware of the meal being served. • Meals are served in suitable portion sizes and sufficient quantities of food are available at all times • The timing of meals provided meet the needs of individual patients • There are improved systems for monitoring and supervision of meals and mealtimes by staff to ensure that meal services are effectively delivered on a day to day basis • There is daily monitoring and	The inspector can confirm that on the day of this inspection, the home demonstrated that significant progress has been achieved in the following areas: • Discussions with patients and their families indicated that patients were satisfied with the choices and variety of meals provided. • A new four week menu had been implemented in July 2014. The menu planner also detailed the choices provided for modified diets at each meal time. • Discussion with nursing and care staff indicated that meal choices and presentation was of a good standard. Staff commented that they considered the meals and choices available to be of a good standard. • Records were kept of patient's meal choices which included the patient's preferred portion choice. • Records were kept of patient/relative meetings which show that consultation has taken place regarding menu planning and ongoing meal provision. • Discussion with the cook indicated that catering staff monitor meal provision each day and discuss any developments with the registered	Compliant

		management oversight of the food quality with any issues arising of poor quality, insufficient food reported to the registered persons in a timely manner and appropriately addressed. • Patients/representatives are involved and consulted in any decisions affecting their quality of life in the home, including the introduction or review of the home's routines and or practices, for example, changing meal time arrangements.	manager. This requirement is assessed as compliant	
3.	16 (1)	The registered person shall ensure that a written nursing plan is prepared by a nurse in consultation with the patient or patient's representative as to how the patient's needs in respect of his health and welfare are to be met by: • ensuring the specific type of pressure relieving equipment (including mattress, cushion) and moving and handling equipment in use is recorded in the care plan section of an identified patient's record	The inspector reviewed the care records of two patients identified at risk of developing pressure damage. The inspector was able to verify that the specific type of pressure relieving equipment (including mattress, cushion) and moving and handling equipment in use is recorded in the care plan section of an identified patient's record. This requirement is assessed as compliant	Compliant

4.	13 (1) (a)	The registered person shall ensure that the nursing home is conducted so as to make proper provision for the nursing, health and welfare of patients by: • ensuring that the repositioning schedule is adhered to and records of same are up to date • ensuring that further communication takes place with the General Practitioner and relatives of one identified patient in relation to "Do Not Resuscitate" (DNR) status and that appropriate records are maintained.	The inspector reviewed a random sample of patient repositioning charts which showed that patients' repositioning schedules were up to date with a contemporaneous record maintained. Review of two patient's care records confirmed that the required detail regarding cardiopulmonary resuscitation (CPR) for each patient was documented in the patient's record as required. This requirement is assessed as compliant	Compliant
5.	27 (4) (d) (1)	The registered person shall make adequate arrangements for detecting, containing and extinguishing fires by ensuring that: • fire doors are not wedged open	Observations made on the day of this inspection confirmed that there were no doors wedged open in any area of the home. The registered manager confirmed that 15 automated door closing devices had been fitted since the previous inspection. The registered manager also confirmed mandatory fire training is provided and staff attendance is closely monitored. This requirement is assessed as compliant.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1.	17.11	Confirm with RQIA that the outcome of the care manager's input into the monitoring arrangements in relation to the resolution of a specific complaint has been received	The registered manager confirmed that the complaint referred to had been resolved. This recommendation is assessed as compliant.	Compliant
2.	3.4	The registered persons should ensure that pre-admission templates are completed fully to record if correspondence had been issued confirming the patient's care needs can be met by the home. In addition admission information received from referring health and social care trust should consistently dated and signed on receipt.	Review of two patient's care records who had recently been admitted recorded that correspondence had been issued confirming the patient's care needs can be met by the home. Admission information received from referring health and social care trust was seen to have been consistently dated and signed on receipt. This recommendation is assessed as compliant.	Compliant

3.	5.3	The registered persons should augment current practices of involving patients and representatives in assessment and care planning by ensuring the actual discussions held with patients/representatives, the information which is shared for example in relation to the patient's wishes and preferences and any agreements that are reached are recorded in sufficient detail.	Review of two patient's care records who had recently been admitted, evidenced that care planning had been undertaken following discussion and consultation with the patient and/or their relative. Care records provided details of patient's wishes and preferences, a person centred approach had been followed. This recommendation is assessed as compliant.	Compliant
4.	5.8	The registered manager should submit the requested information to RQIA in respect of care reviews.	The inspector was able to verify that this recommendation was compliant.	Compliant
5.	17.1	The registered person should ensure that upon completion of a compliant investigation, systems which confirm if the complainant is satisfied with the investigation and outcome are implemented.	The returned Quality Improvement Plan confirmed that the issue referred to in this recommendation, had been successfully addressed. This recommendation is assessed as compliant.	Compliant

6.	25.12 & 25.13	It is recommended that: • dates of the Regulation 29 visits are unambiguous • there is no risk of staff or patients potentially being identified from the information in the report • patients and their representatives are reminded regarding the availability of the home's annual quality review report and Regulation 29 visit reports	Review of three Regulation 29 reports confirmed the following; • the date of the actual unannounced monitoring visit was clearly recorded. • unique patient identification numbers were used as reference to show that discussion had taken place with patients and relatives. • notification of the availability of Regulation 29 reports was displayed throughout the home. This recommendation is assessed as compliant.	Compliant

7.	16.3	It is recommended that: • that the registered manager confirms that the competency and capability assessment template for registered nurses taking charge of the home in the absence of the registered manager includes a section in relation to safeguarding vulnerable adults	Review of the competency and capability assessment template for registered nurses taking charge of the home in the absence of the registered manager revealed that a section in relation to safeguarding vulnerable adults was not included. This recommendation is assessed as not compliant and is stated for second time.	Not compliant
8.	5.3	It is recommended that: • the responsibilities of named nurses are outlined in the Service User Guide.	The inspector reviewed the Service User Guide and was unable to verify that the responsibilities of named nurses were outlined as recommended. This recommendation is assessed as not compliant and is stated for a second time.	Not compliant

9.	28.1 & 28.4	It is recommended that: • the registered manager confirms the percentage of care staff who have successfully completed training in relation to pressure area care and the prevention of pressure ulcers • the induction template for care assistants includes pressure area care / pressure ulcer prevention	The returned Quality Improvement Plan confirmed that the issues referred to in this recommendation, had been successfully addressed. Discussion with the registered manager and review of records enabled the inspector to verify this recommendation as compliant.	Compliant
10.	30.1	It is recommended that: • the registered manager undertakes a Rhys Hearn patient dependency analysis and confirms with RQIA if the current staffing arrangement meets the patient dependencies in terms of registered nurse hours and overall care hours.	Discussion with the registered manager confirmed that a Rhys Hearn patient dependency assessment is undertaken monthly for each patient. The inspector evidenced that staffing provision was also reviewed monthly as part of the unannounced Regulation 29 visit. Review of the staff duty rota for the week of the inspection confirmed that 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. This recommendation is assessed as compliant.	Compliant

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

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

Since the previous care inspection on 13 September 2013, RQIA have received nil notifications of safeguarding of vulnerable adult (SOVA) incidents in respect of Comber Care Home.

10.0 Inspection Findings

Section A

Standard 5.1

- **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment**

Standard 5.2

- **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission**

Standard 8.1

- **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent**

Standard 11.1

- **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.**

Inspection Findings:

Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

The inspector reviewed three patients' care records which evidenced that patients' individual needs were established on the day of admission to the nursing home through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks.

Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart and continence were also completed on admission. Pain, infection control assessments and wound care assessments were undertaken for patients where appropriate.

Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure

ulcer/wound and if required, the specific care plans regarding the management of the pressure ulcer/wound.

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

In discussion with the registered manager she demonstrated a good awareness of the patient who required wound management intervention for a wound and the number and progress of patients who were assessed as being at risk of weight loss and dehydration.

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

Section B

Standard 5.3

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

Standard 11.2

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

Standard 11.3

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

Standard 11.8

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

Standard 8.3

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

The inspector observed that a named nurse system was operational in the home. The roles and responsibilities of the named nurse were not outlined in the Service User's Guide. A recommendation had been made at the previous inspection that the responsibilities of named nurses are outlined in the Service User Guide. As stated in Section 9.0, the inspector was unable to evidence compliance with this recommendation which is therefore stated for a second time.

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

Patients' care records revealed that the pressure relieving equipment in place on the patients' beds and when sitting out of bed was addressed in patients' care plans on pressure area care and prevention.
The inspector was able to confirm that pain assessments were appropriately used for these patients with an active pain relief prescription and/or patient's with a medical history and/or medical condition associated with pain or discomfort. It is acknowledged that care plans on pain management were in place for these patients.

The inspector reviewed one patient's care records who required wound management for a wound. Review of this patient's care records revealed the following;

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

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

- Wound care records evidenced that the dressing regime was recorded appropriately.

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

- A daily repositioning and skin inspection chart was in place for the patient with the wound and also for patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these charts revealed that patients' skin condition was inspected for evidence of change at each positional change. It was also revealed that patients were repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention.

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

The registered manager and registered nurses confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local healthcare Trust. Staff spoken with were knowledgeable regarding the referral process. Discussion with two registered nurses evidenced that they were knowledgeable of the action to take to meet the patients' needs in the interim period while

waiting for the relevant healthcare professional to assess the patient. A tissue viability link nurse was identified in the home, this is good practice.

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

The patient's weight was recorded on admission and on at least a monthly basis or more often if required.

The patient's nutritional status was also reviewed on at least a monthly basis or more often if required.

Daily records were maintained regarding the patient's daily food and fluid intake.

Policies and procedures were in place for staff on making referrals to the dietician. These included indicators of the action to be taken and by whom. All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment.

Review of care records evidenced that patients were referred for a dietetic assessment in a timely manner and where the need was identified, referrals were also made to the speech and language therapist. Care plans reviewed confirmed that the dietician's and the speech and language therapist's recommendations were addressed.

Discussion with the registered manager, registered nurses, care staff and review of the staff training records revealed that nursing staff attended wound management and pressure area care and prevention on 16 May 2014. On the day of the inspection the registered manager could not access the staff training matrix recorded on the computer. It was agreed that verification of staff training provision would be forwarded to the inspector post inspection.

The inspector received an email on 18 August 2014 from the registered manager which stated;

- that 100% of staff have attended safe moving and handling training.
- 19 care staff have attended face to face training on the management and prevention of pressure ulcers provided by the Trust Tissue Viability Nurse with another training date arranged for September 2014.
- all staff have completed clinical supervision in completion of repositioning charts, nutrition, supplements and the use of thickeners.

On the day of the inspection, the was able to verify that patients' moving and handling needs were assessed and addressed in their care plans. There was evidence that manual handling aids were used to minimise risk of friction. Staff consulted confirmed there was sufficient

nursing equipment available to move and handle patients' appropriately.

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

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

Section C

Standard 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Homes Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**
Review of three patients' care records evidenced that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care including wound care for each patient. Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. Review of one patient's care records in relation to wound care indicated that these care records were reviewed each time the dressing was changed and also when the dressing regime was changed or the condition of the wound had deteriorated. Review of care records also evidenced that nutritional care plans for patients were reviewed monthly or more often as deemed appropriate. The evaluation process included the effectiveness of any prescribed treatments, for example prescribed analgesia. Discussion with the registered manager and review of governance documents evidenced that a number of care records were audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

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

Section D

Standard 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Standard 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Standard 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Homes Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**
The inspector examined three patients' care records which evidenced the completion of validated assessment tools such as; • the Roper, Logan and Tierney assessment of activities of daily living • Braden pressure risk assessment tool • Nutritional risk assessment such as Malnutrition Universal Screening Tool (MUST) The inspector confirmed the following research and guidance documents were available in the home; • DHSSPS 'Promoting Good Nutrition' A Strategy for good nutritional care in adults in all care settings in Northern Ireland 2011-16 • The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes. • The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care • The European Pressure Ulcer Advisory Panel (EPUAP) • RCN/NMC guidance for practitioners. Discussion with the registered manager and registered nurses confirmed that they had a good awareness of these guidelines. Review of patients' care records evidenced that registered nurses implemented and applied this knowledge. Discussion with the registered manager, registered nurses and review of governance documents evidenced that the quality of pressure

ulcer/wound management was audited each time dressings were changed and discussed at each hand over report. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process. Registered nursing staff were found to be knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care.

Six staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was easily accessible by staff. This is good practice.

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

Section E

Standard 5.6

- **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.**

Standard 12.11

- **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.**

Standard 12.12

- **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.**
  Where a patient is eating excessively, a similar record is kept
  All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.

A policy and procedure relating to nursing records management was available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

Registered nurses spoken with were aware of their accountability and responsibility regarding record keeping.

Discussion with two registered nurses confirmed that staff had received training on the importance of record keeping commensurate with their roles and responsibilities in the home.

Review of three patients' care records revealed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient. These statements reflected wound and nutritional management intervention for patients as required.

Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patients' status or to indicate communication with other professionals/representatives concerning the patients.

Entries were noted to be timed and signed with the signature accompanied by the designation of the signatory.

The inspector reviewed a record of the meals provided for patients. Records were maintained in sufficient detail to enable the inspector to judge that the diet for each patient was satisfactory.

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

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

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

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

Staff spoken with were evidenced to be knowledgeable regarding patients' nutritional needs.

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

Section F

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

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

Section G

Standard 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate** **Standard 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.**
Prior to the inspection a patients' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that all the patients in the home had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014. The registered manager informed the inspector that patients' care reviews were held post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff preferably the patient's named nurse attends each care review. A copy of the minutes of the most recent care review was held in the patient's care record file. The inspector viewed the minutes of three care management care reviews which evidenced that, where appropriate patients and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended, an updated assessment of the patient's needs and a record of issues discussed. Care plans were evidenced to be updated post care review to reflect recommendations made where applicable.

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

Section H

Standard 12.1

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

Standard 12.3

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

A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance.

There was a four weekly menu planner in place. The registered manager informed the Inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home. The current menu planner was implemented on the July 2014. The current menu planner was dated to show when this menu was implemented.

The inspector discussed with the number of staff the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients.

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

Staff spoken with were knowledgeable regarding the indicators for onward referrals to the relevant professionals. E.g. speech and language therapist or dieticians.

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

Review of the menu planner and records of patients' choices and discussion with a number of patients, registered nurses and care staff it was confirmed that several choices were available at each meal time. The head cook confirmed choices were also available to patients who were on therapeutic diets. The menu plan also included choices for snacks for patients on therapeutic diets.

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

Section I

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

The inspector discussed the needs of the patients with the registered manager. It was determined that a number of patients had swallowing difficulties. Discussion with the registered manager, registered nurses and care staff, confirmed that staff receive annual training in dysphagia awareness and the use of thickening agents for patients. Review of patient's care records evidenced that care plans included reflect the instructions of the most recent speech and language swallow assessment. Discussion with registered manager confirmed that meals were served at appropriate intervals throughout the day and in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes. The registered manager confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning afternoon and at supper times.

The inspector observed that a choice of fluids to include fresh drinking water were available and refreshed regularly. Staff were observed offering patients fluids at regular intervals throughout the day.

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Eight staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was readily available for staff.

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

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

Discussion with the registered nurses clearly evidenced their knowledge in the assessment, management and treatment of wounds, registered nurses stated that each nurse has to complete a competency and capability wound care assessment. Records were available to support this statement.

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

11.0 Additional Areas Examined

11.1 Records required to be held in the nursing home

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

11.2 Patients/residents under Guardianship

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

There were no patients/residents subject to a Guardianship Order currently resident at the time of inspection in the home.

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

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

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

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

The inspector also discussed the Deprivation of Liberty Safeguards (DOLs) with the registered manager and registered nurses including the recording of best interest decisions on behalf of patients. A copy of DOLS was also available in the home**.**

11.4 Quality of interaction schedule (QUIS)

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

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

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

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

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

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

Following lunch patients were respectfully offered assistance to move to whatever area of the home they preferred. Some patients chose the communal lounge areas whilst others chose to go to their own bedrooms or other areas of the home.

Planned activities were ongoing during the inspection. Patients were informed by staff of the planned activity and patients were free to choose whether to participate or not. Patients were observed to respond positively to the activities available.

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

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

11.5 Complaints

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

The inspector reviewed the complaints records. 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.

11.6 Patient finance questionnaire

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

11.7 NMC declaration

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

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

11.8 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 patients currently in the home. An activity therapist is employed to provide additional hours for the provision of activities to patients, this is good practice.

The ancillary staffing levels were found to be satisfactory; the home was organised, clean and tidy throughout.

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

During the inspection the inspector spoke to six staff. The inspector was able to speak to these staff individually. On the day of inspection one member of staff completed questionnaires, a review of which indicated that staff were 'very satisfied ' or 'satisfied' in relation to their induction, training provision and with the general standard of care provided in the home. The following are examples of staff comments during the inspection and in questionnaires;

"I am very happy with the standard of care; we all work together as a team for the benefit of the patients"
"I think the home provides a good standard of care, if it didn't I wouldn't be here."
"We all do our best for the patients; it would be nice to have more time"
"Our home is a friendly and welcoming place. All visitors are made to feel very welcome and most of them are complimentary about the standard of care their relatives receive".

Patients' comments

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

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

"The girls are all very good; I am very well looked after."
"The staff are all very good to me, they work hard and they are always patient and kind.
"I am not feeling well today, the nurses have been looking after me very well."
"The food is very good, they ask us every day what would like for our meals and there is always a good choice."

Patient Representative/relatives' comments

During the inspection the inspector spoke with five representatives/relatives. In addition, on the day of inspection, two representatives/relatives competed and returned questionnaires.

The following are examples of relatives' comments during inspection and in questionnaires;

"As a family we are very happy with the nursing home, we feel we made a good choice, we can pop in any time and the staff are all so pleasant."
"We have no complaints, and are very happy with the care in the home.
"No complaints, all the staff are very helpful, they keep the place spotless and look after all the patients very well".

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Anne Robertson, 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:

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

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Prior to admission to the home the home manager or a desingated representative 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 thebraden 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 aadmission and the pre-admission is not possible in the residents current location then a pre-admission assessment is completed over the phone with written comprehensive, multidiscilpinary information regarding the resident being faxed or left into the home. Only when the manager is	Compliant

satisfied that the home can meet the residents needs will the admission take place. On admission the the home an identified nurse completes initial assessments using a patient centred approach. The nurse communicated with the resident and/or representative referring to the pre-admission assessment and to the information received from the care management team to assist him/her in this process. There are two documents completed within 12 hours of admission, an admission assessment which included photographic 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 formualte 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, nutritional assessments including the MUST tool, FSHC nutritional and oral assessment, other risk assessments that are completed within 7 days of admission ae an incontinence assessment and a bowel assessment. Following discussion with the resident/representative, and using the nurses clinical judgement a care plan is then developed to meet the residents needs in relation to any identified risks, wishes and expectations. This can be evidenced in the care plans and consent forms. The Home Manager and Regional Manager will complete audits on a regular basis to 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 residents care needs using the assessments 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 maximum independence and focuses on what the resident can do for themselves as well as what assistance is	Compliant

required. Any reccommendations made by other members of the multidisciplinary team are included in the careplan. 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 when necessary. These referral forms are held in a designated file in the nurses office, the TVN details are also held in this file, name address and telephone number. Once the form has been sent, then followed up by a telephone call to the TVN whee advice can be given prior to their visit. 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 GP, TVN or podiatrist. Where a resident is assessed at being at risk at developing 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 other relevant members of the MDT. The regional manager is informed via monthly report and during The Reg 29 visit. The Registered Nurse makes a decision to a refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Diectician referral forms are held within the home. These forms can be completed by staff and faxed directly to the Dietician for referral. The Dietician is also available via the telephone for advice until she is able to visit the resident. All advice, treatment or recommendations are recorded 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 MBT are kept informed of any changes.	

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 minumum 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 changs 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.	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 referring to planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for all 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 system. 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 the 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 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, 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 relation to nutritional care, diabetic care, care of Subcuteanous fluids and care of Percutanaous Endoscopic Gastrostomy (PEG).	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**
Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are contemporaneous 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 NMC guidelines - Record Keeping guidance for Nurses and Midwives. Records of the meals provided for each resident at each meal time are recored on the daily menu choice form, the catering manager also keeps records of the food served and includes any specialist dietary needs Residents who are assessed as being at risk of malnutrition, dehydration or eating excessively have all their food and fluids recored in detail on a daily basis using a FSHC food record booklet or fluid record booklet. These charts are recored over a 24 hr period with the fluid intake totalled at the end of the 24 hr period. The nurse utilises the	Compliant

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 residents care plan is discussed with them 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 discfussed duringt supervision sessions with each nurse as necessary.	

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 care plan or more fequently if there is a change in the residen't condition or if there are recommendations made by a member of the MDT. Residents and/or their representatives are involved in this evaluation process.	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 6-8 weeks post admission and then annually. Reviews can also be arranged in response to changing needs, expressions with dissatisfaction with care or at the request at the resident/representative. The Trust are responsible for organising these reviews and inviting the resident and their representative with a copy held in the residents file. Any recommendations made are actioned by the Home with care plans reviewed to reflect the changes. The resident/representative is kept informed of the progress towards the agreed goals.	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 residents dietary needs on admission and review on an ongoing basis. The care plans reflects type of diet, any special dietary needs, personal preferences in regard to likes and dislikes and any specialist equipment required, If the resident is independent or requires some level of assistance and recommendations made by the Dietician or Speech and Language Therapist. The care plan is evaluated on a monthly basis or more often if necessary. The home has a four week menu which is reviewed on a 6 montly basis taking into account seasonal foods. The menu is compiled following consoltation with residents/representatives, residents meetings, one to one meetings and food questionnaires. The PHA document - Nutritional and Menu checklist for Residential and Nursing Homes is to ensure 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 diet notification forms which informs the kitchen of each residents specific dietary needs.	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. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room, with the 4 week menu displayed in a menu display folder.	

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**
Training for Dysphagia and feeding techniques has been arranged for registered nurses for may 14 who will then link in with all care staff and provide further training. The Speech and Language Therapist 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	Compliant

Food Texture Descriptions. All recommendations made by the Speech and Language Therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for feeding, equipement to use and assistance required. Special diets are displayed on awhiteboard in the kitchen. Meals are served at the following times: Breakfast 9am -1030am Morning tea 11am Lunch 1pm Afternoon tea 3pm Dinner 5pm onwards Supper 8.15pm onwards There are variations to above if a resident requests to have their meals outside of these times. Hot and cold drinks are available throughout the day and night on request. There are foods available outside of these times for those residents who require modified or fortified diets. Cold drinks are available at all times in the lounges and bedrooms. Any matters concerning a residents eating and drinking are detailed on each individual care plan including for example likes and dislikes, type of diet, consistency of fluid, any specialist equipment is 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. Appropriate aids such as plate guards and specialised cutlery are available as necessary and as indicated in the care plan. Each nurse has completed an education e-learning module on Pressure Ulcer prevention. The Home has a link nurse 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 to give additional support. All nurses within the home have a competency assessment completed. Competency assessments have a quality assurance element built into the process.	

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

Comber Care Home

12 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 Mrs Anne Robertson, registered manager, either during or after the inspection visit.

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

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

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

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	20(1)(c)(i)	The registered persons must ensure that recorded individual formal supervision of staff is fully established and that the supervision planner is up to date. **This requirement is now raised for the third and final time. Further non-compliance with result in enforcement action.** **Ref: Follow-up on previous issues**	Three	Home Manger has completed a time table as to when staff will have their individual supervisions. Supervisions are now in progress. The manager is being assisted by her deputy and Team Leader.	31 December 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.	16.3	It is recommended that: • that the registered manager confirms that the competency and capability assessment template for registered nurses taking charge of the home in the absence of the registered manager includes a section in relation to safeguarding vulnerable adults **Ref: Follow-up on previous issues**	Two	The Nurse in Charge Competency document has been revised. Home Manager will complete supervisions with the nurses in the meantime to ensure that their understanding is full.	30 November 2014
2.	5.3	It is recommended that: • the responsibilities of named nurses are outlined in the Service User Guide. **Ref: Follow-up on previous issues**	Two	Information now available in the Service User Guide as to the role of the named nurse	30 November 2014

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	Anne Robertson
Name of Responsible Person / Identified Responsible Person Approving Qip	Jim McCall Carol Cousins CAROL COUSINS DIRECTOR of OPERATIONS

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable			
Further information requested from provider			

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	yes	Linda Thompson	20/10/14
Further information requested from provider			