Unannounced Primary Inspection

Name of establishment:	**Dunlady House**
Establishment ID No:	**1078**
Date of inspection:	**17 June 2014**
Inspector's name:	**Carmel McKeegan**
Inspection No:	**16821**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of home:	Dunlady House
Address:	18 Dunlady Road Dundonald Belfast BT16 1TT
Telephone number:	028 90481002
E mail address:	dunladyhouse@o2.co.uk
Registered organisation/ Registered provider / Responsible individual	Dunlady House Ltd Mr William Hugh Wilson
Registered manager:	Ms Lilian Jane O'Neill
Person in charge of the home at the time of inspection:	Ms Lilian Jane O'Neill
Categories of care:	NH-I ,NH-PH ,NH-PH(E) ,NH-TI
Number of registered places:	68
Number of patients accommodated on day of inspection:	65
Scale of charges (per week):	£581.00
Date and type of previous inspection:	25 July 2013, Primary unannounced inspection
Date and time of inspection:	17 June 2014 10.00 – 16.00
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

- 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	8
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	6	6
Relatives / Representatives	6	6
Staff	10	6

6.0 Inspection Focus

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

Criteria from the following standards are included;

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

An assessment on the progress of the issues raised during and since the previous inspection was also undertaken.

The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.

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

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

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

7.0 Profile of service

Dunlady Nursing home is situated approximately one mile from the Ulster Hospital near to the village of Dundonald.

The nursing home is owned and operated by Mr William Hugh Wilson, Dunlady House Limited.

The current registered manager is Ms Lilian O Neill.

This home is a two-storey building with single and double rooms, some of which are en suite. Access to the first floor is via a passenger lift and stairs.

There are two large day rooms and a dining room on the ground floor, and a small dining and lounge area on the first floor. The accommodation is bright and spacious and designed to a high standard.

A seated patio area is provided at the front of the building and is easily accessible for all patients.

The home also provides for catering and laundry services on the ground floor.
A number of communal sanitary facilities are available throughout the home.

There are adequate car parking spaces at the front of the premises.

The home is registered to provide care for a maximum of 68 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 Dunlady House Nursing Home. The inspection was undertaken by Carmel McKeegan on 17 June 2014 from 10.00 to 16.00 hours.

The inspector was welcomed into the home by Ms Lilian O'Neill, registered manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Ms O'Neill and Mr Paul Wilson, company director, at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. This self-assessment was received by the Authority on 24 April 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. There were no concerns raised with the inspector.

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 25 July 2013, two requirements and eight recommendations were issued. These were reviewed during this inspection.

The inspector was able to confirm that one requirement was compliant. One requirement made in relation to the provision of a report prepared by the registered person in respect of the monthly unannounced monitoring visits in accordance with Regulation 29 was not compliant and is stated for a third time. The inspector was unable to verify that a recommendation relating to the content of the regulation 29 report and a recommendation to ensure that patients and their representatives are made aware of the availability of the Regulation 29 Report were compliant. Both recommendations are stated for a second time. The inspector observed that other six recommendations had been fully complied with.

At the conclusion of this inspection Mr Wilson was made fully aware that enforcement action would be taken should compliance with Regulation 29 not be fully achieved within the required timeframe. It is required that the Regulation 29 monthly monitoring reports are submitted to RQIA until notified otherwise.

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 Dunlady House Nursing Home.

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

Review of two patients' care records, who had recently been admitted to the home, evidenced that in general 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.

It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 15 (2) that pain assessment is utilised for any patient prescribed regular or occasional analgesia, it is also required in accordance with regulation 16 (2) (b) that care plans on pain management are put in place for these patients, care plans should be reviewed to show that pain management is evaluated in a timely manner.

One patient's fall assessment and bedrail risk assessments had been signed but not dated; therefore the inspector was unable to establish when the risk assessments

had been undertaken. It is recommended that all entries in patient's records are dated and signed.

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

Aside from these issues, the inspector was able to verify in other records reviewed that 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.

One patient's wound care record stated the patient had a "superficial wound", in accordance with best practice; each wound should be graded using an evidenced based classification system. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 16 (2) (b) that wound assessment should include an evidence based classification system.

Aside from the above issue, care plans for the management of risks of developing pressure ulcers and wound care were maintained to a professional standard and provided evidence that pressure risk management was provided in a timely manner and kept under review by the registered manager and deputy manager.

- **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.

The registered manager advised that the nursing home is participating in a Nutritional Research Project being undertaken by the Southern Eastern Health and Social Care Trust, discussion with staff members confirmed that they were knowledgeable of the nutritional needs and preferences of the patients accommodated in the nursing home.

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

The inspector also observed the serving of the lunch time meal and can confirm that patients were offered a choice of meal and that the meal service was well managed and supervised by registered nurses. Patients were observed to be assisted with dignity and respect throughout the meal. The home provides additional staff at meal times; dietary assistants are employed, whose primary function is to assist patients who require support with their meals and drinks. This is good practice.

The inspector spoke with several patients in the dining room, none of whom were aware of the meal choices for that day. One patient informed the inspector that staff are very willing to provide whatever meal choices and accompaniments patients need and provided an example of their personal experience. Patient's comments indicated that they were satisfied with meal choices provided in Dunlady House.

It is recommended that the daily menu is displayed to inform patients and their relatives of the meals planned for that day.

- **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.

Patient/resident, representatives and staff questionnaires

Some comments received from patients and their representatives:

"We as a family are very pleased with the care provided in this nursing home, we can visit any time and treat it just like home from home".
"The nurses are very good at keeping us informed of any changes in XXX's care, and always have time for a chat when we visit".

“I visit every day, so I know what the home is like and I am very pleased with the care and attention provided not just to my relative but to all the other patients as well”.
“It is a very caring, friendly home and I have recommended it to lots of my friends

Some comments received from staff:

“Proud to be one of the staff at Dunlady House”.
“Often too busy to chat to residents”
“Each individual resident on their arrival will be helped to complete a ‘getting to know you/all about you” information pack which will allow all staff to learn more about them and their history, likes and dislikes. I feel this helps provide a better person centred approach”.
“I am very happy to be working in this nursing home and believe we provide very good care.”

A number of additional areas were also examined.

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

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

Therefore, one requirement is stated for the third time, and two recommendations are now stated for the second time. Two requirements and three recommendations are made from this inspection process. These requirements and recommendations are detailed throughout the report and in the quality improvement plan (QIP).

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

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 25 July 2013

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1.	29 (1) (2) & (3)	It is required that a report is prepared by the registered person in respect of the monthly unannounced monitoring visits in accordance Regulation 29.	The inspector requested to review reports prepared by the registered person in respect of the monthly unannounced monitoring visits in accordance Regulation 29 (Regulation 29 reports), dating from September 2013. There was no report available for January 2014 and April 2014. Reports available in the home are in need of improvement in terms of providing sufficient information in order to meet the requirement that a written report on the conduct of the nursing home is provided. Further detail is provided in Section 11.1 This requirement is assessed as not compliant and is now stated for a third time.	Not compliant

2.	14 (2) (b)	A bed mattress should not be used as crash' or 'fall out' mattress' as they are not designed to be used in this way. Staff should be made aware of the risks they take if they use equipment outside of its purpose /use.	Discussion with the registered manager and two registered nurses indicated that an authentic crash mattress are used as a 'crash' or 'fall out' mattress'. Observations made on the day of the inspection confirmed that bed mattresses were no longer used for this purpose. 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.	25.2	A policy and procedure should be developed which outlines the purpose, content and process of the Regulation 29 unannounced visits and be reflective of the statutory requirements contained therein.	The inspector was able to confirm that a policy was developed which outlines the purpose, content and process of the Regulation 29 unannounced visits. This recommendation is assessed as compliant.	Compliant
2.	25.12	It is recommended that Regulation 29 reports are further developed to also provide evidence that the registered person had: • evidenced that deficits were identified and an action plan developed to address the deficits • evidenced that previous action plans issued had been reviewed to ensure deficits previously identified were addressed or improved • evidenced that where deficits had not been	The Review of seven Regulation 29 reports revealed the following; • reports for September, October and December 2013 did not contain sufficient information to constitute a monitoring report. • reports for February, March and May 2014 did not provide an action plan, nor was there any information to show why an action plan was not needed. The inspector discussed the deficits with the registered manager and Mr Paul Wilson, company director. This recommendation is not compliant and is now stated as a requirement.	Not compliant

		addressed, in a timely manner, appropriate follow up action had been taken.		
3.	25.6	The registered person should ensure that patients and their representatives are made aware of the availability of the Regulation 29 monthly monitoring report.	The inspector was unable to observe any notification system in the home to inform patients and their representatives of the availability of the Regulation 29 monthly monitoring report. This recommendation is not compliant and is now stated for a second time.	Not compliant
4.	25.13	It is recommended that an annual quality report for the home is completed in format suited to the needs of the patients accommodated and that a copy is held in the home and made available to all relevant persons.	The inspector was able to confirm that an annual quality report for the home was completed in format suited to the needs of the patients accommodated and that a copy is held in the home and made available to all relevant persons. This recommendation is assessed as compliant.	Compliant

5.	16	The induction programme for care staff should be further developed to provide written evidence that awareness raising and training on the recognition, recording and reporting of abuse has taken place.	The inspector was able to verify that the induction programme for care assistants has been updated to evidence that awareness raising and training on the recognition, recording and reporting of abuse has taken place. This recommendation is assessed as compliant.	Compliant
6.	10.7	It is recommended that the policy and procedure for the management of restraint is further developed to also include guidance on the use of sensor mats and in general, be reflective of the RCN guidelines “Let’s Talk About Restraint”.	Review of the restraint policy confirmed that the policy was updated as recommended and also reflected risk assessment in the best interest of the patient with reference to the European Convention of Human Rights This recommendation is assessed as compliant.	Compliant
7.	5.3	It is recommended that where a patient is assessed as requiring a hoist and/or sling, the type of hoist and the type and size of the sling should be recorded in the patient’s moving and handling risk assessment and associated care plan.	Review of three patient’s care records confirmed that this detail was provided. This recommendation is assessed as compliant	Compliant

8.	11.2	The wound management policy should be updated to reference current best practice documents and also state the notification procedure where a patient has a pressure ulcer of Grade 2 or above.	Review of the wound management policy confirmed that the policy referenced the NICE guidelines, EPUAC and the EHSSB Tissue Viability Handbook (2011). The policy also stated the required notification ad referral procedure where a patient has a pressure sore of Grade 2 or above.	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 25 July 2013, RQIA have received nil notifications of safeguarding of vulnerable adult (SOVA) incidents in respect of Dunlady House Nursing Home.

10.0 Inspection Findings

Section A

Standard 5.1

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

Standard 5.2

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

Standard 8.1

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

Standard 11.1

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

Inspection Findings:

Policies and procedures relating to patients' admissions were available in the home. It is recommended that the 'Admission Policy' is further developed to include the following;

- The manager ensures that risk assessment and care records providing all necessary information are provided from the referring Health and Social Care Trust prior to admission, documents for the referring Trust should be dated and signed when received.
- The arrangements to respond to any unplanned admission
- The arrangements to respond to self-referred patients.

Review of two patients' care records, who had recently been admitted to the home, evidenced that in general 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.

The following areas were identified;

Patient A (identity known to the registered manager)

- the fall risk assessment was signed but not dated
- the bedrail risk assessment was signed but not dated
- other specific risk assessments were dated to show they were completed on the day of admission
- a pain assessment had not been undertaken for this patient
- the patient's mobility assessment stated "requires full assistance"; more accurate detail is needed to clearly state if the patient requires the assistance of one or two persons.
- documents from the referring Trust had not been dated and signed when received

Patient B (identity known to the registered manager)

- general nursing needs assessment and risk assessments were evidenced to have been completed on the day of admission however despite information obtained on admission informing that the patient has a history of pain and was prescribed regular analgesia; a pain assessment had not been completed until 7 days post admission date.

It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 15 (2) that pain assessment is utilised for any patient prescribed regular or occasional analgesia, it is also required in accordance with regulation 16 (2) (b) that care plans on pain management are put in place for these patients, care plans should be reviewed to show that pain management is evaluated in a timely manner.

It is recommended that any documents from the referring Trust are dated and signed when received. As stated previously, one patient had two risk assessments that were signed but had not been dated; therefore the inspector was unable to establish when the risk assessments had been undertaken. It is recommended that all entries in patient's records are dated and signed.

The inspector was able to evidence that 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 patients who required wound management intervention 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	**Substantially compliant**

Section B

Standard 5.3
- **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.**

Standard 11.2
- **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.**

Standard 11.3
- **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.**

Standard 11.8
- **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration**

Standard 8.3
- **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.**

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

Reviewed of a further two patient's care records (long term care) 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 evidenced that the pressure relieving equipment in place on the patients' beds and when sitting out of bed was addressed in each patients' care plans on pressure area care and prevention.

The inspector spoke with three registered nurses on duty, each of whom was knowledgeable of the patient's need for which they were responsible. The inspector reviewed one patient's who was receiving treatment for a wound, the following observations were made;

- A body mapping chart was completed showing location of the wound site. This chart was reviewed and updated when any changes occurred to the patient's skin condition.

- A wound management care plan was in place, which stated the patient had a "superficial wound", in accordance with best practice; each wound should be graded using an evidenced based classification system.

- A pain assessment had been undertaken for this patient, two days post admission.

- A care plan was in place which specified the nursing intervention including daily repositioning and skin inspection regime for the patient and also stated the pressure relieving equipment in place on the patient's bed and also when sitting out of bed.

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

It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 16 (2) (b) that wound assessment should include an evidence based classification system.

Discussion with the registered manager and three registered nurses and 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 inspector observed that 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 evidenced that patients were repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention.

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 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 three 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. The home has a tissue viability link nurse, 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 inspector was able to evidence that;

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

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

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 mandatory training was provided for all staff, the staff training matrix is reviewed by the registered manager to ensure that all staff members attend training. Discussion with six staff members confirmed that they have received training in pressure care and prevention, management of nutrition and wounds. Staff indicated that training provided by the home was applicable and equipped them to fulfil their job responsibilities. Registered nurses confirmed that if they identified or requested additional training, they would be supported and facilitated by management to meet their personal training 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	**Substantially compliant**

Section C

Standard 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Homes Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**
Review of five 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 daily evaluation process should also include the effectiveness of any prescribed treatments, for example prescribed analgesia. Discussion with three registered nurses 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	**Substantially compliant**

Section D

Standard 5.5
- **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.**

Standard 11.4
- **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.**

Standard 8.4
- **There are up to date nutritional guidelines that are in use by staff on a daily basis.**

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

The inspector examined five 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.

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 available and 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. A review of the training records 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. In general, entries were noted to be timed and signed with the signature accompanied by the designation of the signatory , as previously

stated, two risk assessments in one patient's care record were not dated and a recommendation is made that this shortfall be addressed.

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.

On the day of the inspection, the inspector was unable to ascertain the menu on the day of the inspection, the menu board in the main dining room remained blank throughout the inspection and the planned three week rotational menu was not on display on any of the notice boards throughout the home. Discussion with staff confirmed that patients were consulted individually the previous day regarding their menu choices for the next day.

The inspector spoke at length with the cook and reviewed the three week rotating menu, a copy of which was held in the main kitchen. The cook was very knowledgeable of all patient's individual dietary requirements and culinary preferences. Discussions confirmed that there was effective communication between care and catering staff to ensure that patient's dietary requirements were met.

The inspector spoke with several patients in the dining room, none of whom were aware of the meal choices for that day. One patient informed the inspector that staff are very willing to provide whatever meal choices and accompaniments patients need and provided an example of their personal experience. Patient's comments indicated that they were satisfied with meal choices provided in Dunlady House. It is recommended that the daily menu is displayed in a suitable format and in an appropriate location, so that patients, and their representatives know what is available at each mealtime.

The inspector discussed with the registered manager and a 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 revealed that choices were available at each meal time. The registered manager confirmed choices were also available to patients who were on therapeutic diets.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**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 and review of training records 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. The home provides additional staff at meal times, dietary assistants are employed, whose function is to assist patients who require one to one support with their meals and drinks. This is good practice.

Discussion with the registered nurses clearly evidenced their knowledge in the assessment, management and treatment of wounds. Review of the template used to undertake competency and capability assessments for the registered nurses revealed that pressure ulcer/wound care was addressed.

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. The inspector reviewed the following records:

- the patient's guide
- sample of staff duty rosters
- record of complaints
- record of food and fluid provided for patients
- staff training matrix
- sample of incident/accident records
- Regulation 29 monthly monitoring reports

As stated in Section 9, a requirement was raised at the previous two inspections in relation to the provision of a report prepared by the registered person in respect of the monthly unannounced monitoring visits in accordance with Regulation 29. At the conclusion of this inspection Mr Wilson was made fully aware that enforcement action would be taken should compliance with Regulation 29 not be fully achieved within the required timeframe. It is required that the Regulation 29 monthly monitoring reports are submitted to RQIA until notified otherwise.
A recommendation is stated for a second time to improve upon the content provided in Regulation 29 reports, a report template for this purpose is provided on RQIA website.

11.2 Patients/residents under Guardianship

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

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

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

The inspector discussed the Human Rights Act and Human Rights Legislation with the 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 20 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 and dietary assistants were observed 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.

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 eight staff. The inspector was able to speak to a number of these staff individually. On the day of inspection six 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;

“Proud to be one of the staff at Dunlady House”.
“Often too busy to chat to residents”
“Each individual resident on their arrival will be helped to complete a ‘getting to know you/all about you” information pack which will allow all staff to learn more about them and their history, likes and dislikes. I feel this helps provide a better person centred approach”.
“I am very happy to be working in this nursing home and believe we provide very good care.”

Patients’ comments

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

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

“The staff are all very kind and caring, if you need something all you have to do is ask”.
“I feel very fortunate to be living in a good nursing home like this one”.
“I have no complaints, everyone is very good, the food is tasty and we are always given a great choice”.
This is well run home, the staff are very attentive, they all work very hard, but they make time for us all”.

Patient Representative/relatives’ comments

During the inspection the inspector spoke with three representatives/relatives. In addition, on the day of inspection, six representatives/relatives completed and returned questionnaires.

The following are examples of relatives’ comments during inspection and in questionnaires.

“We as a family are very pleased with the care provided in this nursing home, we can visit any time and treat it just like home from home”.
“The nurses are very good at keeping us informed of any changes in XXX’s care, and always have time for a chat when we visit”.
“I visit every day, so I know what the home is like and I am very pleased with the care and attention provided not just to my relative but to all the other patients as well”.
“It is a very caring, friendly home and I have recommended it to lots of my friends”

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Lillian O'Neill, 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**
5.1 On admission to Dunlady House, the named or designated nurse carries out an initial risk assessment of immediate care needs, using the Roper Logan & Tierney assessment tool. Information is gained from the pre-admission assessment carried out by the nurse manager prior to admission and the multidisciplinary assessment received from the care manager or social worker from hospital. This assessment should involve the resident or their representative to ensure the resident has a care plan that addresses their individual needs, wishes and preferences. The purpose of the assessment is to ensure that any immediate risks and care needs are identified and addressed from admission.	Compliant

5.2 At Dunlady House a holistic comprehensive assessment of the resident's needs is carried out within 48 hours of their admission to the home. The nurse uses all available sources of information for this assessment including referral letters, discharge summaries, vital signs, urinalysis and assessment information from other health care professionals. Assessment data is discussed with the resident and their representative. This assessment should comply with appropriate protocols identified in other policies including the use of identified risk assessment tools i.e. MUST assessment, Braden score, Manual Handling, Bedrail protocols and Falls assessment. The resident's GP will be informed of the resident's admission on the day of admission or the following day, if the resident arrives late in the evening. The resident's medication should be reviewed and prescribed on the medication kardex. The assessment information must be documented in the resident's record and a care plan written and agreed with the resident or their representatives 8.1 On admission a weight history is established if possible from the resident, their family, GP.or discharge letter from hospital. The MUST tool is used to identify residents who are malnourished, at risk of malnutrition or obese. All residents at risk have a written care plan implemented. Residents are referred to the dietican through their own GP. Residents are then weighed monthly or more often if required. In some cases of end of life care and pallative care MUST screening is not appropriate. 11.1 At pre-admission an assessment of all available information is sought and necessary equipment put in place. A baseline braden and MUST score is recorded. Dietary needs are recorded. Skin conditions and continence care is recorded. On admission a body map is completed detailing any pressure sores, skin breaks, brusing or other abnormalities. Wound charts are completed including measurement of all wounds. Tissue viability are involved if necessary.	

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**
5.3 The care planning process in Dunlady House involves the named nurse, the resident and/or their representative meeting to develop a plan of care. The care plan sets realistic and reasonable goals that are discussed and agreed by the resident. When a resident is unwilling or unable to contribute to the care plan, the named nurse seeks the views and observations of relatives and/or advocate to ensure a person centred plan that is individualised to the abilities,	Compliant

strengths, goals and needs of the resident. Specific care interventions are evidence based and comply with residents known wishes and in keeping with organisational policies and protocols affecting specific care domains. The named nurse will document the care plan and ensure it is communicated to all the healthcare members involved in the residents care. Referals are made when necessary to multidisciplinary team i.e. Occupational Therapist (OT), Speech and Language Therapist (SLT), Podiatry, Physio, Community Rehabilitation Nurse, Tissue Viability, Diabetes Specialist Nurse and Dietitian. Where a patient is at risk of developing skin damage a care plan is drawn up to meet the identified needs of the resident. A turning chart is put in place and the appropriate equipment is sourced etc appropriate mattress and cushion. 11.2 Referrals are made if required to tissue viability, podiatry, SLT, diabetic specialist nurse, physio, OT, lymphodoema specialist nurse, colorectal nurse specialist, continence care team and pallative care team as required. These members of the multidisplinary are contacted through call management or arranged via GP. Referrals are made to the pallative care team through the NI hospice having obtained consent from the GP, Advise and support is also sought from the nursing home support team. 11.3 If the patient is at risk of developing pressure ulcers for example poor mobility or bedbound a must score of 2, contractures of limbs, incontinent, diabetic or have a pallative care diagnosis. A care plan is drawn up in conjunction with the multisdisplinary team to meet the individual needs and comfort of the resident. Appropriate equipment is put in place. Bed cushion, mattress, hoist, turning disks, glide sheets, re-positioning charts. 11.8 Residents with lower limb or foot ulceration are referred to podiatry through call management. The assessment completed by podietry and recommendation made are incorporated in the residents care plan. Wound charts are completed as required. 8.3 If the MUST score indicates the resident requires a dietary assessment the GP is contacted to make a referral to dietician. Bloods and any other investigation ordered by the GP is undertaken. Where necessary a SLT assessment is also requested. If the patient is palliative care a palliative care team dietician may be involved.	

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**
Assessments of wounds are carried out at each dressing change and wound charts completed with evaluation and care plans updated as necessary. Pain charts are recorded. MUST scores are recorded monthly or weekly if a MUST score is 2. Turning charts are completed, checked daily and reviewed as necessary. Food and fluid charts are recorded and reviewed daily.	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**
5.5 At Dunlady House, medications are administered in line with the NMC guidelines for the administration of medicine, and the RQIA's guidelines on Control and Administration of Medicines in Nursing Homes. Consent and confidentiality are in keeping with the NMC Code of Professional Conduct standard for conduct performance and ethics. Records and record keeping are in line with the NMC guidelines for record and record keeping. Nutrition is assessed using the Malnutrition Universal Screening Tool (MUST). Wound management is in line with EPUAP/NICE guidelines. Palliative Care is in line with the Liverpool Care Pathway for the Dying. Pegfeeds and Diabetes protocols are managed using NICE Guidelines. Staff are supported and encouraged to keep up to date with in-house training opportunities and by attending external seminars. 11.4 EPUAP reference guide provides evidence based recommendations for the prevention and treatment of pressure ulcers.The EPUAP guide is also used for ulcer classification. Care plans and wound charts are then drawn up by the named nurse in collaboration with Tissue Viability team where necessary. 8.4 The Public Health Agency document "nutritional guidelines and menu checklist" is available and referred to by cook manager when drawing up menus. Referred to by nursing and dietary staff for guidelines to improve nutritional intake	Compliant

and food fortification for residents with a poor appetite or weight loss. Also for patients with nutrition related disorder,. dementia, diabeties, coeliac disease, obesity, dysphagia and palliative care. Nutritional guidelines for individual residents as recommended by dietican diabetic nurse specialist and other members of the multidisplinary team are incorporated into the residents individual care plans.	

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**
5.6 In Dunlady House, strict records are kept of the medication that has been administered, refused or discarded and includes any action taken to resolve issues incurred. Written Care Planning, daily evaluations take account of any changes or outcomes of care provided. These care plans are updated monthly and as necessary e.g. when care needs change. Wound Charts, Pain Assessments, Risk Assessments, Fluid Balance Charts, Food Charts, Turning Charts, Blood Sugar Monitoring (BM) Records, Vital Signs and Rescusitation Status are all used as necessary and are handwritten using black ink only, no tippex or corrector fluid is permitted. All residents records are stored in keeping with the Data Protection Act and NMC Guidelines on Record and Record Keeping. A multidisciplinary (MD) record sheet is kept for each resident and is filled in by any members of the MD team visiting. 12.11 A three week rotating menu is available for all residents in the home including choice of menu for residents with	Compliant

swallowing difficulties or modified diets. Charts that include food and fluid intake is recorded for all residents. Charts identify food and fluids offered and type of food. The total and type of fluids offered and actually taken is also recorded. The nurse in charge each day assesses the contents of these charts. 12.12 All food offered and refused is recorded on the daily food and drinks intake and output charts. This is monitored by the named nurse and relevant referrals are made to dieticians, diabetic nurse specialist or pallative care team after discussion with the resident or relative. A care plan is drawn up to implement any changes to the diet that are recommended.	

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**
5.7 In Dunlady House, daily evaluations are carried out that include any outcomes that take place. Care plans are reviewed once a month and updated as necessary to help provide holistic patient centred care. Regular audits are carried out of accidents, complaints and untoward incidents. Reviews of assessments by other professionals involving the residents i.e. Care management reviews, are carried out 6 weeks after admission and yearly thereafter. Quality Assurance Audits are also carried out yearly involving residents and relatives. Queens University Belfast carry out regular audits in Dunlady House regarding students training.	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**
5.8 Dunlady House carried out quality assurance audits that include residents relatives. The relatives also participate in care management reviews. The GP visits the residents annually to carry out medicine reviews and reviews of dementia care. The multidisciplinary team including OT, SLT, Podiatry, Physio, Community Rehabilition Nurse, Tissue Viability, Diabetes Specialist Nurse and Dietitian review residents as required. Eye Testing and Retinal Screening are carried out annually on each resident. Medical care plans are completed for a large number of residents by their GP's. 5.9 Results of reviews are recorded on Multidisciplinary sheets. Outcomes of all reviews are communicated to all staff on the team. Changes to care plans are made with consultation and agreement from resident and their representative. Referrals are made to MDT as required, residents and their representative are kept informed of progress.	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**
12.1 Residents have the option to choose from a three week rotating menu with two choices for each main meal. If they are unable to choose from the menu an alternative meal will be provided by the cook. These menus are drawn up by the cook and nurse manager who refer to "nutritional guidelines and menu checklist for residential and nursing homes as published by the public health agency". The NICE guidelines for nutrition support in adults are also referred to when necessary. All recommendations from dietican, nurse specialists, pallative care specialists and SLT. are incorporated into the residents individual care plans and adhered to. 12.3 There is a three week menu for residents to choose from. This menu is updated and revised at least twice a year. The quality assurance audits also reflect the suitability of the menu. If the resident is unable to find a suitable choice on the menu an alternative meal can be requested from the catering staff. Menus are also suitable for residents requiring modified diets and special diet e.g. gastric, diabetic or renal are also offered a choice. Drinks and snacks are available at all times for residents on request.	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
8.6 Annual update training is provided by Medicare on dysphagia and use of thickening agents. This training is available to all staff. Other training sessions are provided by Nutilis and trained staff have all had an update on Percutaneous Endoscopic Gastroscomy training and the insertion of PEG tubes. Instruction from the SLT are always included in the residents files and the named nurse incorporates the SLT findings in the residents care plan.	Compliant

If the recommendations are contrary to the residents wishes the SLT is consulted before any change to the care plan is made..3 12.5 Breakfast is served bewtween 7.00am - 10.30am. Lunch between 12 midday - 2.00pm. Evening meals between 4.30pm - 6.00pm. Supper 8.00pm - 10.00pm. Tea trolleys with a variety of hot and cold beverages is served 10am, 3pm, 7pm and 9pm. Drinks and snacks are available on request. Jugs of fresh chilled water and clear drink glasses are placed in each residents room on a daily basis. 12.10 On admission a care plan is written for each resident detailing their dietary requirements and swallowing assessment. This is written in conjunction with the multidisplinary assessments and recommendation from Speech & language therapist. Staff are trained to ensure recommendation are adhered to with regards to positioning of resident e.g upright and alert. The appropriate type of food, modified diet and correct thickening agent and consistency of fluids is adhered to as recommendion by SLT. Assistance for residents who require supervision, or full assistance is provided. Necessary aid and equipment is provided e.g. a range of feeding cups with darkened plates for visually impaired residents. A range of adapted cutlery for deformed hands. Plate guards to prevent food being pushed off the plate. 11.7 All RGN's employed have undertaken training in wound management that includes risk assessments that include the braden scale and MUST assessments. Skin inspection and body mapping. Skin care. The use of positioning and repositioning of residents. The use of appropriate equipment. Bed mattresses, cushions, glide sheets and hoists. RGN's are also experienced in pressure ulcer classification system to document the grade and type of tissue loss. Wound measurement. Monitor healing. Nutritional support and hydration. Pain assessment and management.	

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.

Quality Improvement Plan

Unannounced Primary Inspection

Dunlady House

17 June 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Ms Lilian Jane O'Neill, 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.	29 (1) (2) & (3)	It is required that a report is prepared by the registered person in respect of the monthly unannounced monitoring visits in accordance Regulation 29. **A copy of the monthly Regulation 29 report should be forwarded to the aligned inspector Linda Thompson, by the 10th of each subsequent month. This should continue until further notice.** **Ref: Section 9, Follow up on previous issues**	Three	Reports written and forwarded to lead Inspector.	31 August 2014
2.	15 (2)	The registered person shall ensure that the assessment of the patient's needs is (a) kept under review; and (b) revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually. • pain assessments must be utilised for any patient prescribed regular or occasional analgesia **Ref: Section A**	One	Pain assessment in place with daily updates. Audited to ensure full compliance	From the date of this inspection

3.	16 (2) (b)	The registered person shall ensure that – (b) The patient's plan is kept under review. • the effectiveness of analgesia should be regularly evaluated and recorded • wound assessment should include an evidence based classification system **Ref: Section A and Section B**	One	Evaluted daily and recorded. Ongoing audits. E.P.U.A.P. Pressure ulcer classification system in use.	From the date of this inspection

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.	25.12	It is recommended that Regulation 29 reports are further developed to also provide evidence that the registered person had: • evidenced that deficits were identified and an action plan developed to address the deficits • evidenced that previous action plans issued had been reviewed to ensure deficits previously identified were addressed or improved • evidenced that where deficits had not been addressed, in a timely manner, appropriate follow up action had been taken. **Ref: Section 9, Follow up on previous issues**	Two	Action plans are developed. Previous action plans are reviewed.	31 August 2014
2.	25.6	The registered person should ensure that patients and their representatives are made aware of the availability of the Regulation 29 monthly monitoring report. **Ref: Section 9, Follow up on previous issues**	Two	Notlce displayed at reception.	From the date of this inspection

3.	26.1	The 'Admission Policy' should be further developed to include the following; • The manager ensures that risk assessment and care records providing all necessary information are provided from the referring Health and Social Care Trust prior to admission, documents for the referring Trust should be dated and signed when received. • The arrangements to respond to any unplanned admission • The arrangements to respond to self-referred patients. **Ref: Section A**	One	Staff aware to sign and date all received documents. Emergency admission policy in place and reviewed. New policy written for self referred patients.	31 August 2014
4.	3.4	Any documents from the referring Trust should be dated and signed when received. **Ref: Section A**	One	Staff now auditing all documents to ensure full compliance.	From the date of this inspection
5.	6.2	All entries in patient's records should be dated and signed. **Ref: Section A**	One	All documents and care plans audited to ensure full compliance.	From the date of this inspection

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

Name of Registered Manager Completing Qip	Lilian O'Neill
Name of Responsible Person / Identified Responsible Person Approving Qip	Neil Wilson

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	Linda Thompson	27/8/14
Further information requested from provider			