Unannounced Primary Care Inspection

Name of establishment:	**Edgewater Lodge (Orlock and Seaview Suites)**
RQIA number:	**1080**
Date of inspection:	**21 October 2014**
Inspector's name:	**Linda Thompson**
Inspection number:	**20117**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of establishment:	Edgewater Lodge
Address:	Orlock and Seaview Suites 4 Sunnydale Avenue Donaghadee BT21 0LE
Telephone number:	028 91888044
Email address:	edgewater.lodge.m@fshc.co.uk
Registered organisation/ Registered provider / Responsible individual	Four Seasons Health Care Mr James McCall
Registered manager:	Tiago Moreiro home manager (registration pending)
Person in charge of the home at the time of inspection:	J Basuel registered nurse initially then Mr Tiago Moreiro
Categories of care:	NH-DE, RC-DE
Number of registered places:	Orlock Suite - 21 Seaview Suite – 17
Number of patients / residents accommodated on day of inspection:	17 patients in Orlock Suite 16 residents in Seaview Suite
Scale of charges (per week):	Orlock Suite - £581 Seaview Suite - £461
Date and type of previous inspection:	13 March 2014, secondary unannounced inspection
Date and time of inspection:	21 October 2014 08.30 – 12.30 hours
Name of inspector:	Linda Thompson

2.0 Introduction

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

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

3.0 Purpose of the inspection

The purpose of this inspection was to consider whether the service provided to patients/residents 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 the preliminary assessment of achievement by the Provider of the DHSSPS Nursing Homes Minimum Standards 2008.

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

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

- review of any notifiable events submitted to RQIA, in accordance with Regulation 30 of the Nursing Homes Regulations (NI) 2005, since the previous inspection
- analysis of pre-inspection information submitted by the registered person/s

- discussion with the home manager
- review of the returned quality improvement plan (QIP from the previous care inspection conducted on 13 March 2014
- observation of care delivery and care practices
- discussion with staff on duty at the time of this inspection
- examination of records pertaining to the inspection focus
- consultation with patients individually and with others in groups
- tour of the premises
- evaluation and feedback.

5.0 Consultation process

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

Patients/Residents	30
Staff	10
Relatives	3
Visiting professionals	0

Questionnaires were provided (by the inspector), during the inspection, to patients / residents, their representatives and staff to seek their views regarding the quality of the service

Issued to	**Number issued**	**Number returned**
Patients / residents	5	5
Relatives / representatives	2	2
Staff	10	8

6.0 Inspection focus

The theme for the inspection year April 2014 – March 2015 is: 'Nursing Care'

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 regular reviewed. (Standard 5)

Under the 'Nursing Care' theme, inspection will focus on three areas of practice:

- management of wounds and pressure ulcers (Standard 11)
- management of nutritional needs of patients and weight loss (Standard 8 & 12)
- management of dehydration (Standard 12).

Only selected criteria from each of the four standards will be inspected across nine areas and incorporated into the Provider's Self-Assessment.

The inspector will also consider the management of patient's human rights during this inspection.

The inspection theme and focus for the 2014 – 2015 inspection year was outlined by RQIA at the annual Provider Roadshow in February 2014 and the self-assessment was made available on the RQIA website.

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

Edgewater Lodge Nursing home is situated on the outskirts of Donaghadee in a residential area. It is a purpose built facility with all patient accommodation at ground level. The home consists of two suites each registered separately**.**

This report refers to the Orlock and Seaview Suites. The Orlock Suite is a 21 bedded suite currently registered to provide Nursing care for patients under the following categories of care;

Nursing care

De Dementia

Seaview Suite is a 17 bedded suite registered to provide care for residents under the following categories of care;

Residential care

De Dementia

Within both units which are separated by double doors, there are an adequate number of sitting/dining rooms and toilet/bathroom/shower facilities appropriately located throughout the home.

A centrally located kitchen and laundry provide services to the home. Car parking facilities are available within the grounds of the home.

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

Mr Tiago Moreiro is the Home Manager for the home and his registration with RQIA is pending

8.0 Executive summary

The unannounced primary care inspection of 21 October 2014 was undertaken by Linda Thompson between the hours of 08.30 and 12.30 hours. The inspection was facilitated by registered nurse J Basuel who was the nurse in charge at the commencement of the inspection. Mr Moreiro home manager joined the inspection shortly afterwards. Mr Moreiro facilitated the inspection throughout the day and was available for feedback of findings at the conclusion of the inspection.

The theme for the 2014 – 15 inspection year is 'Nursing Care' (Standard 5) and the inspection focused on three areas of practice related to:

- management of wounds and pressure ulcers (Standard 11)
- management of nutritional needs of patients and weight loss (Standard 8 & 12)
- management of dehydration (Standard 12).

The inspector also considered the management of patient's/resident's human rights during this inspection. The requirement made as a result of the previous inspection was also examined.

Prior to the inspection, the responsible person/home manager completed a self-assessment using the standard criteria outlined in the theme inspected. This self-assessment was received on 19 September 2014. The comments provided by the responsible individual/home manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

The inspector examined the content of the returned pre inspection documentation. The inspector can confirm that the document was professionally completed and contained sufficient comprehensive information to inform the self-assessment process.

The inspector can confirm that at the time of this inspection, the delivery of care to patients/residents was evidenced to be of a good standard and patients/residents were observed to be treated by staff with dignity and respect.

Refer to section 11.0 for further details about patients and residents.

The inspector, following examination of the staff duty rota, after observation of delivery of care, and having reviewed the comments received from staff questionnaires can confirm that staffing levels on the day of the inspection were appropriate to meet the needs of the patients/residents. The home manager assured the inspector that staffing levels were kept under regular review and would be adjusted as required by the needs of the patients/residents.

The inspector can confirm that the home was clean and fresh throughout the building. No malodours were noted. Refurbishment work was ongoing to bedrooms and the nurse call system was being updated to minimise the noise disturbance of alarms sounding from other areas of the home.

The home is commended on this refurbishment work.

There were systems and processes in place to ensure the effective management of the standards inspected. However, areas for improvement were identified in relation to;

- the management of food thickeners (Orlock Suite)
- the need for proactive management of one identified patient's bowel regime (Orlock Suite)
- updating of the monthly review of Malnutrition Universal Screening Tool (MUST) (Seaview Suite)
- the recording of time of entry of record in daily progress records (Seaview Suite).

The inspector reviewed and validated the home's progress regarding the one requirement made at the last inspection on 13 March 2014 and confirmed compliance has been fully achieved.

Verbal feedback of the inspection outcomes was given to the registered nurse in charge of Orlock and Seaview Suites throughout the inspection and to the home manager at the end of the inspection.

Conclusion

As a result of this inspection, one requirement and three recommendations were made;

Details can be found under Section 10.0 in the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients/residents, patient representatives, the home 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 secondary unannounced care inspection conducted on 13 March 2014

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
1.	13 (7)	In the interest of infection prevention and control it is required that • the source of the malodour is established and the malodour eliminated in the bedroom identified to the home manager. • the crash mattress should have an intact surface that can be effectively cleaned and decontaminated.	The inspector can confirm that there were no malodours evident throughout the home. The fall out mattress had been appropriately repaired.	Compliant

9.1 Follow up on any issues/concerns raised with RQIA since the previous inspection such as whistle blowing, 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 RQIA is notified of a breach of regulations or associated standards, it will review the matter and take

Since the previous inspection in 13 March 2014, RQIA have not been notified by the home of ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues.

10.0 Inspection findings

Section A – On admission a registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Standard criterion 5.1, 5.2, 8.1 and 11.1 examined.
Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance. The inspector reviewed three patient's/resident's care records which evidenced that patient's/resident's individual needs were established on the day of admission to the nursing home, through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks. Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart and continence were also completed on admission. Information received from the care management team for the referring Trust confirmed if the patient/resident 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 patient's/resident's care records evidenced that a comprehensive holistic assessment of the patient's/resident's care needs was completed within 11 days of the patient's/resident's admission to the home. The registered nursing staff confirmed there were no patients/residents currently in the home requiring wound care.

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

Section B –A registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Care records evidence involvement of the patient and /or their representative and that care planning and delivery reflect the recommendation from relevant health professionals. Referrals to healthcare professionals are made as required and in a timely manner. Standard criterion 5.3, 11.2, 11.3, 11.8 and 8.3 examined.

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

Review of three patient's/resident's care records and discussion with patients/residents 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/residents and/or their representatives following changes to the plans of care.

Patient's/resident's care records revealed that the pressure relieving equipment in place on beds and when sitting out of bed, was addressed in the care plans on pressure area care and prevention.

The inspector was able to confirm that pain assessments were appropriately used for these patients/residents.

The home manager informed the inspector that there were currently no patients in the home who required wound management.

The inspector however can confirm the following;

- Body mapping charts are completed for all patients/residents on admission. This chart was reviewed and updated when any changes occurred to the patient's/resident's skin condition
- care plans are established which specified the pressure relieving equipment in place on the patient's/resident'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
- A daily repositioning and skin inspection chart was in place for any patient/resident requiring frequent change of position to minimise risk of pressure damage.
- Review of a sample of these charts revealed that patient's/resident's skin condition was inspected for evidence of change at each positional change. It was also revealed that patients/residents were repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention.

Discussion with the home manager and one registered nurse and a review of three patient's/resident's care records, confirmed that where a patient/resident 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 home manager and registered nurse 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 the registered nurse evidenced that she was knowledgeable of the action to take to meet the patient's/resident's needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

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

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

The patient's/resident's nutritional status was also reviewed on at least a monthly basis or more often if required in Orlock Suite.
The inspector examined one resident's care records in Seaview Suite which evidenced that the MUST assessment was not updated on a monthly basis as required. A recommendation is raised.

Daily records were maintained regarding the patient's/resident'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 for one patient evidenced that the patient was referred for a dietetic assessment in a timely manner. This patient was also referred to the speech and language therapist.

The inspector raised concerns regarding the bowel management of one identified patient with a history of constipation. The nursing care records of this patient failed to record bowel function between 9/10/14 and 20/10/14. This lack of recording was not identified by the registered nursing team as a possible constipation issue. Toileting records also did not record bowel function.

A recommendation is raised to ensure that bowel function is actively managed to minimise the risks of developing constipation rather than reacting to constipation.

Discussion with the home manager, registered nurse, care staff and review of the staff training records, revealed that staff were trained in wound management and pressure area care and prevention. Staff were also trained in the management of nutrition.

Patients/resident's 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/resident's appropriately.

The home manager and registered nurses informed the inspector that pressure ulcers if present would be graded using an evidenced based classification system.

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

Section C - Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans. Standard criteria 5.4 examined.
Review of three patient's/resident's 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/resident. The inspector evidenced in care records of residents in Seaview Suite that the time of the entry into daily progress records was not consistently recorded. A recommendation is raised. Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. Review of care records also evidenced that nutritional care plans for patients/residents were reviewed monthly or more often as deemed appropriate. The evaluation process included the effectiveness of any prescribed treatments, for example prescribed analgesia. Discussion with one registered nurse and a 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 criteria assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criteria assessed	**Substantially Compliant**

Section D – All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. Standard criterion 5.5, 8.4 and 11.4 examined.
The inspector examined three patient's/resident's 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 home manager and registered nurses confirmed that they had a good awareness of these guidelines. Review of patient's/resident's care records evidenced that registered nurses implemented and applied this knowledge. Registered nursing staff were found to be knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients/residents and the principles of providing good nutritional care. All staff consulted could identify patients/residents who required support with eating and drinking.

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

Section E – 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 criterion 5.6, 12.11 and 12.12 examined.

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 patient's/resident's care records revealed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient. Care staff in the residential care unit recorded similar daily progress records. These statements reflected skin care and nutritional management intervention for patients/residents as required.

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

Entries were noted to be timed and signed with the signature accompanied by the designation of the signatory. Review of one resident's care records in Seaview Suite revealed that a number of entries were not timed appropriately.

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

The inspector reviewed the care records of two 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.

There was evidence that patients/residents were offered fluids on a regular basis throughout the day.

Staff spoken with were evidenced to be knowledgeable regarding patient's/resident's nutritional needs.

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

Section F – 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. Standard criteria 5.7 examined.

Please refer to criterion examined in Section E. In addition, the review of 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 criteria assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criteria assessed	**Compliant**

Section G – The management and involvement of patients and/or their representatives in review of care. Standard criterion 5.8 and 5.9 examined.
Prior to the inspection, a patient's/resident's 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 home manager informed the inspector that patient's/resident's 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/resident's named nurse attends each care review. A copy of the minutes of the most recent care review was held in the patient's/resident's care record file. The inspector viewed the minutes of two care management care reviews which evidenced that, where appropriate, patients/residents and their representatives had been invited to attend. Minutes of the care review included the names of those who 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 criterion assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**

Section H – Management of nutrition including menu choice for all patients. Standard criterion 12.1 and 12.3 examined.
A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance. There was a three weekly menu planner in place. The home manager informed the inspector that the menu planner had been updated recently and it was noted that the home is actively seeking the opinion of the patients/residents, their representatives and staff on the level of satisfaction of the new menu. This consultation is commended. The inspector discussed the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients/residents with the home manager and a number of staff. Staff spoken with were knowledgeable regarding the individual dietary needs of patients/residents and their likes and dislikes. Discussion with staff and review of the record of the patient's/resident's meals confirmed that all were offered choice prior to their meals. Staff spoken with was 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. From a review of the menu planner and records of patient's/resident's choices and discussion with a number of patients/residents, registered nurses and care staff, it was revealed that choices were available at each meal time. The home manager confirmed choices were also available to patients/residents who were on therapeutic diets.

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

Section I – Knowledge and skills of staff employed by the nursing home in relation to the management of nutrition, weight loss, dehydration, pressure area care and wounds. Standard criterion 8.6, 11.7, 12.5 and 12.10 examined.

The inspector discussed the needs of the patients/residents with the home manager and one registered nurse. It was determined that a number of patients had swallowing difficulties.

Review of training records revealed that staff had attended training in dysphagia awareness during the previous three years and further training was being delivered during the inspection visit.

Discussion with home 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 home manager and registered nursing staff 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/residents 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. All staff consulted could identify patients/residents who required support with eating and drinking.

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

The inspector raised concerns regarding the communal use of food thickeners in Orlock Suite. The inspector discussed the management of food thickeners with the registered nurse in charge and the home manager. A requirement is raised to ensure that all staff recognised that food thickeners are a prescribed medicine and each patient should be administered the thickener from their own individual stock.

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

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

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

11.0 Additional areas examined

11.1 Records required to be held in the nursing home

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

11.2 Patients/residents under Guardianship

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

There were no patients/residents accommodated at the time of inspection in the home who were subject to guardianship arrangements.

11.3 Quality of Interaction Schedule (QUIS)

The inspector undertook two periods of enhanced observation in the home which lasted for 20-30 minutes.

The inspector observed the breakfast being served in Orlock Suite and the activity session mid-morning in Seaview Suite.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area. A description of the coding categories of the Quality of Interaction Tool is appended to this report.

Total number of observations	
Positive interactions	18
Basic care interactions	0
Neutral interactions	0
Negative interactions	0

The inspector evidenced that the quality of interactions between staff and patients was observed to be positive. No basic, neutral or negative interactions were observed. Staff were observed to be knowledgeable of patients/residents likes and dislikes and there was a relaxed, friendly and warm atmosphere evidenced in the home.

11.4 Complaints

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 RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

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 discussed the management of complaints with the home manager and reviewed the complaint record. This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements.

11.5 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'/residents' monies were being managed in accordance with legislation and best practice guidance.

11.6 NMC declaration

Prior to the inspection the home 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 home manager, were appropriately registered with the NMC.

11.7 Questionnaire findings

11.7.1 Staffing levels and staff comments

Discussion with the home manager and review of the nursing and care staff duty roster for week commencing 13 October 2014 and 20 October 2014 evidenced that the registered nursing and care staffing levels were in keeping with the RQIA's recommended minimum staffing guidelines for the number of patients/residents accommodated in the home during the inspection.

Staff were provided with a variety of training, including mandatory training, since the previous inspection. Attendance at mandatory training was well managed.

Review of records, discussion with the home manager and staff evidenced that this attendance level was achieved by proactively managing staff development and training through regular supervision sessions and annual appraisal. The home manager and staff are to be commended for their efforts in this area.

During the inspection the inspector spoke with all staff. The inspector was able to speak to a number of these staff individually and in private. Seven staff completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

Some comments received from staff are detailed below;

“I am very happy working here”
“This is one of the better homes I have worked in and I always look forward to coming here”
“I feel the patients are well cared for”
“We have a very good team of staff here”

11.7.2 Patients/residents and relatives comments

During the inspection the inspector spoke with 30 patients/residents individually and with the majority of others in smaller groups.

Whilst most patients / residents were unable to independently complete the questionnaires due to their medical frailty the inspector completed the questionnaires for them from discussion responses.

Patients spoken with and the questionnaire responses confirmed that patients were treated with dignity and respect, that staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home.

Some patient/resident comments received are detailed below;

“I am happy here”
“The staff are very good”
“I am happy with the food and always have enough to eat”

The inspector spoke with three relatives during the inspection and two questionnaires were returned at the end of the inspection.

Some relative comments received are detailed below;

“My ……. has been here for some time. I feel the staff are very good and he is very well cared for”
“I am offered my meal her with my husband and I am made to feel very welcome”
“I visit very regularly and am always welcomed”
“If I was worried I know I can talk to any of the staff”

11.7.3 Professionals’ comments

There were no professionals available during the inspection period.

11.8 Record keeping

In accordance with Regulation 19 (2) Schedule 4, a number of records are required to be kept in a nursing home. Prior to this inspection the registered person/s completed and returned a declaration to confirm that these documents were available in the home. If the document was not available an explanation was required.
The returned declaration for Schedule 4 documents confirmed that all documents listed were available in the home. The inspector sampled a number to confirm this as follows:

- staff duty rota
- staff training records
- patient/resident food and fluid records
- complaints records

Review of three patient care records evidenced that generally a good standard of record keeping was maintained. However, a number of areas for improvement were identified as follows:

Seaview Suite

- The MUST assessment of one identified resident was not completed for a number of months.
- the daily progress records failed to record the time of every entry made

Recommendations are issued. See quality improvement plan (QIP).

12.0 Quality Improvement Plan

The details of the quality improvement plan appended to this report were discussed with Mr Tiago Moreiro, home manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider / home 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:

Linda Thompson
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
Before accepting any resident into the home, the Home Manager or a designated representative from the home carries out a pre admission assessment. Information gathered from the resident/representative (where possible), the care records and information from the Care Management Team informs this assessment. Risk assessments such as the Braden Tool are carried out, if possible, at this stage. Following a review of all information a decision is made in regard to the home's ability to meet the needs of the resident. If the admission is an emergency admission and a pre admission is not possible in the resident's current location then - a pre admission assessment is completed over the telephone with written comprehensive, multidisciplinary information regarding the resident being faxed or left into the home. Only when the Manager is satisfied that the home can meet the residents needs will the admission take place. On admission to the home an identified nurse completes initial assessments using a patient centred approach. The nurse communicates with the resident and/or representative, refers to the pre admission assessment and to information received from the care management team to assist her/him in this process. There are two documents completed within twelve hours of admission - an Admission Assessment which includes photography consent, record of personal effects and a record of 'My Preferences' and a Needs Assessment which includes 16 areas of need - the additional comments section within each of the 16 sections includes additional necessary information that is required to formulate a person centred plan of care for the Resident. In addidtion to these two documents, the nurse completes a series of hollistic risk assessments immedidiately on admission. Continence and Bowel assessments are completed within seven days of admission. Following discussion with the resident/representative, and using the nurse's clinical judgement, a care plan is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations. This can be evidenced in the care plan and consent forms.	Compliant

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

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
A named nurse completes a comprehensive and holistic assessment of the resident's care needs using the assessment tools as cited in section A, within 7 days of admission. The named nurse devises care plans to meet identified needs and in consultation with the resident/representative. The care plans promote the maximum independence and focuses on what the resident can do for themselves as well as what assistance he might require. Any recommendations made by other members of the mutidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable. Registered nurses in the home are fully aware of the process of referral to a TVN when necessary. There are referral forms held in a designated file in the nurse's office, the Tissue Viability Nurse's details are also held in this file. Once the form has been sent it, is then followed up by a telephone call to the TVN where advice can be given prior to their visit. Referrals are also made via this process in relation to residents who have lower limb or foot ulceration to either the TVN or a podiatrist. If necessary, a further referral is made to a vascular surgeon by the G.P, TVN or podiatrist. Where a resident is assessed as being 'at risk' of developing pressure ulcers, a Pressure Ulcer Management and Treatment plan is commenced. A care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. The care plan will take in consideration any advice received from other multidisciplinary members. The treatment plan is agreed with the resident/representative, Care Management and relevant members of the MDT. The Registered Nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Dietician referral forms are held within the home. These forms can be completed by staff in the home and are faxed to the GP for referral. The dietician is also available over the telephone for advice until she is able to visit the resident. All advice, treatment or recommendations are recorded on the MDT form with a subsequent care plan being compiled or current care plan being updated to reflect the advice and recommendations. The care plan is reviewed and evaluated on a monthly or more often if necessary	Compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The Needs Assessment, risk assessments and care plans are reviewed and evaluated monthly or more often if there is a change in the resident's condition. The plan of care dictates the frequency of review and re assessment, with the agreed time interval recorded on the plan of care. The resident is assessed daily with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the Home Manager's attention. The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
The home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to consult. The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading sysytem. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change or if there are any changes on the dressign regime or recommendation from TVN. There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', ' PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in relation to nutritional care, diabetic care, care of subcuteanous fluids.	Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are comtemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines - Record keeping:Guidance for nurses and midwives. Records of the meals provided for each resident at each mealtime are recorded on a daily menu choice form. The Catering Manager also keeps records of the food served and include any specialist dietary needs. Residents who are assessed as being 'at risk' of malnutrition, dehydration or eating excessively have all their food and fluids recorded in detail on a daily basis using a FSHC food record booklet or fluid record booklet. These charts are recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. The nurse utilises the information contained in these charts in their daily evaluation. Any deficits are identified with appropriate action being taken and with referrals made to the relevant MDT member as necessary. Any changes to the resident's plan of care is discussed with them and/or their representative. Care records are audited by the Manager with an action plan compiled to address any deficits or areas for improvement - this is discussed during supervision sessions with each nurse as necessary.	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care delivered is monitored and recorded on a daily basis on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan of care or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their represenatatives are involved in the evaluation process..	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care Management Reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust organises these reviews and invitesthe resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the resident's file. Any recommendations made are addressed by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The home follows FSHC policy and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs on admission and review on an ongoing basis. The care plan reflects type of diet, any special dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated monthly or more often if necessary. The home has a 3 week menu. The menu is compiled following consultation with residents and their representatives - residents meetings, one to one meetings and food questionnaires. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied. Copies of recommendations from the dietician and speech and language therapist are made available to the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs.	Compliant

Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything from the daily menu an alternative meal of their choice can be provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. Various ondiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room, with the 3 week menu displayed when entering the home and available in the kitchen for consult if so requested.	

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
Supervisions of the staff are carried out to ensure the knowledge regarding food textures and consistencies is up to date and aditional dysphagia is carried out when available either within the home or outside. The Speech and Language therapist and dietician give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document - 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language therapist are incorporated into the care plan and specify type of diet, consistency of fluids, position for feeding, equipment to use and assistance required.The kitchen receives and keeps a copy of the SALT's recommendations for reference by the kitchen. A weekly list of the residents weights and their fluctuations is updated and writen every Monday on a board in the kitchen. Meals are served at the following times:- Breakfast - 9:30am-10.30am Morning tea - 11am Lunch - 12.30pm-13.30pm Afternoon tea - 3pm Evening tea - 4.30pm Supper - 8pm-8.30pm There are variations to the above if a resident requests so. Hot and cold drinks and a variety of snacks are available all day and night. There are foods available outside of these times for those resident's who require modified or fortified diets. Cold drinks including are available at all times in the lounges and bedrooms, these are replenished on a regular basis. Any matters concerning a resident's eating and drinking are detailed on each individual care plan - including for eg. likes and dislikes, type of diet, consistency of fluid, any special equipment required and if assistance is required. A diet notification form is completed by the nurse for each resident and a copy is given to the kitchen.Meals are only served when a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Appropriate aids are available as necessary and as indicated in the plan of care. Each nurse has completed an education e-learning module on pressure area care. Central training on wound care	Compliant

related topics are arranged for nurses requiring additional support. All nurses within the home have a competency assessment completed. Competency assessments have a quality assurance element built into the process.	

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

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Primary Unannounced Care Inspection

Edgewater Lodge
(Orlock and Seaview Suites)

21 October 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 Mr Tiago Moreiro home 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.	13(4)(b)	The home manager must ensure that food thickeners are correctly recognised as prescribed items and therefore only administered to the patient for who they are prescribed. Communal use of food thickeners must cease immediately. **Ref 10.0, section I**	One	Supervision provided to all staff on each unit is being carried out by heads of departments regarding the appropriate use and storage of thickners. Storage for the thickners is already in place to ensure each resident has their own thickner in the dinning rooms hence stopping the communal usage of the prescribed thickners	From date of inspection and on going

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	5.3	It is recommended that the home manager review the management of bowel function of the identified patient in Orlock suite. Bowel management should be reviewed to ensure that; • action is taken as required to prevent constipation rather than waiting to treat and manage constipation that has already occurred. **Ref 10.0, section B**	One	The record of bowel motions is being done daily by CA on appropriate toileting chart that is now being checked and signed by the nurse on duty to ensure that constipation of resident is prevented by administering the prescribed PRN as needed.	From date of inspection and on going
2.	8.2	It is recommended that staff in Seaview Suite ensure that the MUST assessment is updated monthly as required. **Ref 10.0, section C**	One	Care Profile Audits are being carried out to ensure that all assessments are being done as required. Also a planner was put in place to ensure that assessments remain updated as required	By end November 2014
3.	6.2	It is recommended that staff in Seaview Suite ensure that all entries in daily progress records appropriately reflect the time that the entry was made. **Ref 10.0, section E**	One	Supervision carried out with all the senior staff in Seaview Suite regarding best practice of recording keeping and this is already in place. Spot checks will take place to ensure it	From date of inspection and ongoing

				continues as required.	

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:

NAME OF REGISTERED MANAGER COMPLETING QIP	Tiago Moreira
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall Carol Cousins CAROL COUSINS DIRECTOR of OPERATIONS

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes		18/12/14
Further information requested from provider			