

## **Unannounced Primary Care Inspection**

**Name of establishment:** Carlingford Lodge Care Home

**RQIA number:** 11102

**Date of inspection:** 2 October 2014

**Inspector's name:** Donna Rogan  
Karen Scarlet

**Inspection number:** IN017252

**The Regulation And Quality Improvement Authority**  
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**1.0 General information**

<b>Name of establishment:</b>	Carlingford Lodge Care Home
<b>Address:</b>	76 Upper Dromore Road Warrenpoint Co Down BT34 3PN
<b>Telephone number:</b>	02841759200
<b>Email address:</b>	karenmcelherron@priorygroup.com
<b>Registered organisation/ Registered provider / Responsible individual</b>	Mrs Caroline Denny Priory (Warrenpoint) Ltd
<b>Registered manager:</b>	Mrs Karen McElherron
<b>Person in charge of the home at the time of inspection:</b>	Mrs Karen McElherron
<b>Categories of care:</b>	NH-I, NH-DE
<b>Number of registered places:</b>	75
<b>Number of patients accommodated on day of inspection:</b>	38 NH-I 33 NH -DE
<b>Scale of charges (per week):</b>	£587 and this incorporates a third party top up of £20.00 per week £650 – private rate
<b>Date and type of previous inspection:</b>	12 February 2014 Secondary Unannounced
<b>Date and time of inspection:</b>	2 October 2014 09.30 to 18.05 hours
<b>Name of inspectors:</b>	Donna Rogan and Karen Scarlet

## 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 registered manager.
- Discussion with staff.
- Examination of records pertaining to staffing.
- Review of a sample of policies and procedures.
- Review of a sample of staff training records.
- Review of a sample of staff duty rotas.
- Evaluation and feedback.

## 5.0 Consultation process

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

Patients/Residents	<b>20</b>
Staff	<b>12</b>
Relatives	<b>2</b>
Visiting professionals	<b>0</b>

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.

<b>Issued to</b>	<b>Number issued</b>	<b>Number returned</b>
Patients / residents	<b>2</b>	<b>2</b>
Relatives / representatives	<b>0</b>	<b>0</b>
Staff	<b>5</b>	<b>3</b>

## 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:

<b>Guidance - Compliance statements</b>		
<b>Guidance - Compliance statements</b>	<b>Definition</b>	<b>Resulting Action in Inspection Report</b>
<b>0 - Not applicable</b>		A reason must be clearly stated in the assessment contained within the inspection report
<b>1 - Unlikely to become compliant</b>		A reason must be clearly stated in the assessment contained within the inspection report
<b>2 - Not compliant</b>	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
<b>3 - Moving towards compliance</b>	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
<b>4 - Substantially compliant</b>	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
<b>5 - Compliant</b>	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

Carlingford Lodge Care Home is a new purpose built two-story nursing home. The home is situated in a quiet rural area in close proximity to Warrenpoint town. The local community, shopping areas, and community services are located nearby.

The home offers bright and spacious accommodation for a maximum of 75 patients.

The bedrooms are all single rooms with ensuite shower facilities and are of varying sizes. Each bedroom is furnished with a profiling bed, a range of furniture providing storage for patients' personal possessions. Six electrical sockets are available in each bedroom as well as a television aerial socket and telephone point and a call bell is available from which patients may summon assistance.

In addition assisted bathrooms and shower facilities are available on both floors of the home ensuring that bathing facilities are available to meet all patients' needs. A range of clearly identified communal toilets are also located throughout both floors of the home.

Day lounges of various sizes are available on each floor. The lounges throughout the home are comfortably furnished and decorated with a wide range of seating including recliner chairs.

Each floor has dining rooms available for patient use. To encourage socialization between patients round tables have been provided. Half of the dining chairs are fitted with ski wheels for ease of movement. It was encouraging coloured crockery has been provided to assist patients with dementia. Facilities for making a cup of tea or a snack are also available.

The main kitchen, which is well laid out and equipped is located on the ground floor.

A central treatment room is located on the ground floor and each floor has two clinical rooms.

A well-equipped laundry is also available.

A passenger lift ensures that facilities on the first floor are accessible to all patients and visitors.

An enclosed garden which can be accessed by patients is also provided.

The home is registered to provide care for seventy five patients under the following categories of care:

### Nursing Care

I	Old age not falling into any other category (maximum 41 patients).
DE	Dementia care (maximum 34 patients).

## 8.0 Summary of inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Carlingford Lodge Care Home. The inspection was undertaken by Donna Rogan and Karen Scarlet on 2 October 2014 from 09 30 to 18 05 hours.

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

The inspectors were welcomed into the home by registered nurse manager Karen McElherron. Operations director Mr Gavin O'Hare Connolly joined the inspection in the afternoon. Verbal feedback of the issues identified during the inspection was given to Mrs McElherron and Mr O'Hare Connolly at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. This self-assessment was received by the Authority in July 2014 and the inspector has been able to evidence that the level of compliance achieved with the standards inspected was accurately measured by the home manager.

The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

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

The inspectors spent two extended periods observing staff and patient interaction. Discussions and questionnaires are unlikely to capture the true experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience. These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool was designed to help evaluate the type and quality of communication which takes place in the nursing home.

As a result of the previous inspection conducted on 12 February 2014 ten requirements and five recommendations were issued. These were reviewed during this inspection and the inspector evidenced that all requirements with the exception of one have achieved compliance and all five recommendations have been fully complied with. Details can be viewed in the section immediately following this summary.

### **Standards inspected:**

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed. (Selected criteria)



Standard 8: Nutritional needs of patients are met. (Selected criteria)

Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)

Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria).

## **8.1 Inspection findings**

### **8.1.1 Management of nursing care – Standard 5**

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

Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis and as and when 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.

There were no requirements or recommendations made in relation to this standard.

**Compliance Level: Compliant**

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

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

There was evidence of appropriate assessment of the risk of development of pressure ulcers which demonstrated timely referral to tissue viability specialist nurses (TVN) for guidance and referral to the HSCT regarding the supply of pressure relieving equipment if appropriate.

Care plans for the management of risks of developing pressure ulcers and wound care were maintained. The overall management of wounds and pressure ulcer care was in keeping with best practice.

There were no requirements or recommendations made in this regards to this standard.

**Compliance Level: Compliant**

### **8.1.3 Management of nutritional needs and weight loss – Standard 8 and 12 (selected criteria)**

The inspector reviewed the management of nutrition and weight loss within the home.

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

The inspector also observed the serving of the 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 meal served was well presented and appeared appetising.

There were no requirements or recommendations made in regards to this standard.

**Compliance Level: Compliant**

### **8.1.4 Management of dehydration – Standard 12 (selected criteria)**

The inspector examined the management of dehydration during the inspection which evidenced that the fluid requirements and fluid 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.

There were no requirements or recommendations made in regards to this standard.

**Compliance Level: Compliant**

## **8.4 A number of additional areas were also examined.**

- Records required to be held in the nursing home.
- Human Rights Act 1998 and European Convention on Human Rights (ECHR).
- Patient and staff quality of interactions (QUIS).
- Complaints.
- Patient finance pre-inspection questionnaire.
- NMC declaration.
- Staffing and staff comments.
- Comments from representatives/relatives.
- Review of care records.
- Environment.

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

The home's general environment was well maintained and patients were observed to be treated with dignity and respect.

Overall, areas for improvement were identified in relation to the environment, laundry and the dementia unit.

There were four requirements and nil recommendations made as result of this inspection. The requirements made are detailed throughout the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients and their representatives, the home manager, the operations director, 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 primary unannounced care inspection conducted on 12 February 2014**

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
1	15 (2)	<p>The registered manager must ensure the assessment process of patients' needs is on-going and timescales are set to reassess the patients' needs in keeping with best practice guidelines</p> <ul style="list-style-type: none"> <li>• Ensure initial risk assessments are completed on admission.</li> <li>• Ensure agreed plans of care to meet this patient's immediate care needs are put in place on admission</li> <li>• Ensure waterlow and braden risk assessments are not used concurrently.</li> <li>•</li> </ul>	<p>The inspectors reviewed four care records. All care records reviewed evidenced that initial risk assessments have been completed on admission.</p> <p>Agreed plans of care were in place to meet patients immediate care needs on admission.</p> <p>Braden risk assessments were the only pressure risk assessments in use.</p> <p>There was evidence that patients' risks assessments were completed following re admission to the home.</p> <p>The care records reviewed contained body maps which were completed on admission.</p> <p>There was evidence in patients' care records that the assessment of wounds were supported by photographic evidence.</p>	Compliant

		<ul style="list-style-type: none"> <li>• Ensure a re-assessment of patients' care takes place on re-admission to the home following a period of hospitalisation.</li> <li>• Ensure body maps are recorded on admission.</li> <li>• Ensure the assessment of wounds is supported by photographic evidence.</li> </ul>		
2	16 (1)	<p>The registered person shall ensure a written nursing plan is prepared by a nurse in consultation with the patient or patient's representative as to how the patient's needs in respect of his health and welfare are to be met.</p> <ul style="list-style-type: none"> <li>• Ensure all terminology used to describe patients' behaviour</li> </ul>	<p>Following a review of four care records there was evidence that there was a written care plan for each patient. The care plans contained terminology which described patients' behaviour using a person centred approach.</p> <p>A review of three patients with pressure ulcers/wounds contained relevant information which included the specific pressure relieving devices used whilst patients were in bed and whilst seated. The registered manager has also recently introduced 'skin bundle forms' which includes information regarding repositioning and relevant information regarding skin inspection. The forms were found to be informative and appropriately completed.</p>	Compliant

		<p>reflects a person centred approach</p> <ul style="list-style-type: none"> <li>• Ensure identified care plans are further developed in relation to the prevention of pressure ulcers by; stating the specific pressure relieving devices while the patient is in bed and when seated; putting a daily repositioning and skin inspection chart in place.</li> <li>• The practice of combining repositioning and skin inspection charts with the “bedrail use check-list” should cease. Records should also reflect the frequency of the repositioning schedule identified in the care plan.</li> </ul>	<p>Patients were observed to be seated using cushions appropriate to their assessed need whilst in seated in wheelchairs.</p> <p>The effect of prescribed analgesia was observed to be included in the care record.</p>	
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		<ul style="list-style-type: none"> <li>• Ensure all patients are seated on cushions appropriate to their assessed need while in wheelchairs.</li> <li>• The effect of prescribed analgesia for one identified patient should be documented in the daily progress notes</li> </ul>		
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3	20 (1) (c) (i)	<p>The registered person shall ensure that the persons employed to work at the nursing home receive appraisal, mandatory training and other training appropriate to the work they are to perform by</p> <ul style="list-style-type: none"> <li>ensuring all mandatory training is up to date</li> </ul>	A review of the mandatory training records evidenced that staff have received and updated their mandatory training.	Compliant
4	19 (2) 8	The registered person shall maintain a record of the nursing home's charges to patients, including any extra amounts payable for additional services not covered by those charges, and the accounts paid by or in respect of each patient.	The patient agreement has been updated and all relevant charges have been included.	Compliant



5	12 (1)	<p>The registered person shall ensure the treatment and other services provided to each patient meet his individual needs and reflect best practice. This requirement is in relation to</p> <ul style="list-style-type: none"> <li>patients' fluid intake recording.</li> <li>appropriate measures are taken when a patient refuses their meal.</li> </ul>	<p>A review of three patients who required their fluid intake to be recorded evidenced that they were recorded.</p> <p>Records were retained when patients refused their meal and staff had recorded the measures they had taken when a patient refused their meal.</p>	Compliant
6	13 (1)	<p>Ensure the issues raised regarding care practices are addressed in keeping with best practice in dementia care as follows;</p> <p>Ensure the patients' day is well structured in keeping with their individual care needs.</p> <p>Ensure activities are planned and</p>	<p>Formal training has been received by all staff currently working in the dementia unit. The training included up to date training in care practices. A formal activity programme is being implemented and on the day of inspection the individual care needs of patients were being met.</p> <p>Patients spoken with stated that they enjoy the activities organised.</p>	Complaint

		individualized and suited to the patients' for whom they are planned.		
7	14.4	<p>The registered person shall make arrangements by training staff or by other measures, to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse by ensuring that:</p> <ul style="list-style-type: none"> <li>all nursing staff are competent in reporting suspected, alleged or actual incidents of abuse to the relevant persons and agencies in accordance with procedures and in a timely way.</li> <li>all staff receive an annual update training in relation to Safeguarding Vulnerable Adults (SOVA)</li> </ul>	<p>Following discussion with staff on duty it was evident that they were competent in reporting suspected allegation of abuse. They were able to demonstrate to the inspectors the correct action to take in keeping with policies and procedures.</p> <p>The training records reviewed evidenced that staff have received up to date training in relation to safeguarding vulnerable adults.</p> <p>All the relevant guidance documents were available at the nurses' station. These guidance documents were included in the homes' policies and procedures.</p> <p>The inspectors observed the use of a key pad locking mechanism, which has recently been installed in the dementia unit of the home. A variation application should be submitted to RQIA to identify this change to the home's structure. The use of the key pad restricts patients' access to the use of the dining room.</p> <p>There is on-going works in the dementia unit to enhance the quality of life for patients. This is to be commended. However a formal application for any changes of use of rooms or any area should be submitted to RQIA prior to the changes being made in keeping with the Registration Regulations</p>	Substantially compliant

		<ul style="list-style-type: none"> <li>guidance documents relevant to N Ireland are incorporated in the home's SOVA policy / procedures</li> <li>registered nurses are reminded of the evidence based guidance in relation to the management of restraint (as discussed)</li> </ul>	<p>(Northern Ireland) 2005. A requirement is made that the application if forwarded to RQIA without delay. The Statement of Purpose should also be updated and forwarded to RQIA.</p>	
8	30 (1) )d)	<p>The registered person must give notice to RQIA without delay of the occurrence of any event in the nursing home which adversely affects the wellbeing or safety of any patient including</p> <ul style="list-style-type: none"> <li>any safeguarding issue</li> <li>any pressure ulcers grade 2 or above</li> </ul>	<p>A review of the untoward incident in the home there was evidence that they were reported to RQIA in a timely way. This includes any safeguarding issue.</p> <p>Staff informed the inspectors that they were aware of their obligation to inform RQIA and the local healthcare trust if any patient develops a pressure ulcer of grade 2 or above.</p>	Compliant

9	19 (2) Schedule 4 (10)	The registered person must ensure that an up to date inventory is maintained of furniture and personal possessions brought into the home by patients	There was an inventory of the furniture and personal possessions brought in by patients retained in the home.	Compliant
10	20 (1) (a)	The registered person must, having regard to the size of the nursing home, the statement of purpose and the number and needs of patients-ensure that at all times suitably qualified, competent and experienced persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients	A review of the staff duty rotas evidenced that the numbers and skill mix of staff rostered were appropriate to meet the needs of the patients accommodated.	Compliant

No	Minimum Standard Ref.	Recommendations	Action taken – as confirmed during this inspection	Inspector's validation of compliance
1	5.1	It is recommended an assessment tool for patients who have a cognitive impairment be used in the dementia care unit.	A cognitive assessment tool was observed to be in use in the dementia care unit.	Compliant
2	28.1	It is recommended that the induction programme is reviewed so that there is evidence of competencies being achieved over a reasonable timeframe.	The induction forms reviewed were evidenced as being comprehensive and competencies were evidenced as being achieved over a reasonable timeframe.	Compliant
3	28.6	<p>It is recommended an accurate record is kept in the home of all training, including induction and professional development activities completed by staff.</p> <p>The registered manager agreed to advise RQIA when returning the QIP regarding the number of nurses and care assistants who have</p>	<p>A review of the training records evidenced that an accurate record of all training, including induction and professional development activities completed with staff was included.</p> <p>The inspector has received written confirmation that 11 registered nurses have received formal training in the management of pressure ulcer/wound care.</p> <p>45% of care staff have received pressure ulcer prevention training. The remaining care staff will have received this training by 30 October 2014.</p>	Compliant

		undertaken wound care training and the prevention and management of pressure ulcer training (as a percentage)		
4	26.1, 25.12 & 25.13	<p>It is recommended that:</p> <ul style="list-style-type: none"> <li>• a policy is developed pertaining to the arrangements for the Regulation 29 visit within one month.</li> <li>• greater engagement with patients is evidenced in the Regulation 29 reports.</li> <li>• the identity of relatives is redacted in the Regulation 29 reports.</li> <li>• information pertaining to the availability of the Regulation 29</li> </ul>	<p>There has been a policy developed pertaining to the arrangements for visits required under Regulation 29.</p> <p>There was evidence in the Regulation 29 reports of extensive engagement with patients.</p> <p>The identities of patients have been anonymised in Regulation 29 reports.</p> <p>There is a notice displayed regarding the availability of Regulation 29 reports and the annual quality reports to patients and their representatives.</p> <p>The annual quality report has been forwarded to RQIA.</p>	Compliant

		<p>visits and the annual quality report is provided to patients and their representatives.</p> <ul style="list-style-type: none"> <li>the annual quality report is submitted to RQIA on return of the QIP.</li> </ul>		
5	25.11	It is recommended that record keeping audits are further developed and any corrective action required must be addressed with the staff when deficits are identified.	The registered manager confirmed that record keeping audits have been further developed and any corrective action required is addressed with the staff should any deficits be identified.	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 the remit of RQIA to investigate complaints made by or on 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.

There have been notifications to RQIA regarding incidents since the previous inspection. The incidents were being managed in accordance with best practice guidelines and The Nursing Home Regulations (Northern Ireland) 2005.



## 10.0 Additional areas examined

### 10.1 Records required to be held in the nursing home

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

### 10.2 Patients/residents under guardianship

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

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

The inspector discussed the Human Rights Act and Human Rights Legislation with the registered manager and two of the registered nurses. All three were knowledgeable regarding Human Rights Act 1998. However as stated in the previous requirements, section 9.0 of this report, the management of a newly added key padded locking mechanism is required to be reviewed to allow patients in the dementia to use the dining area outside of mealtimes. As discussed a variation application should be made to RQIA without delay of how the key pad area will be managed and how this area shall be accessible to patients. A requirement is made in this regard.

### 10.4 Quality of interaction schedule (QUIS)

The inspector undertook two periods of observation in the home which lasted for approximately 10 minutes each.

The inspector observed the interactions between patient and staff during the serving of lunch in both dining rooms.

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	8
Basic care interactions	0
Neutral interactions	1
Negative interactions	0

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

## 10.5 Complaints

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

The inspector reviewed the complaints records. This review evidenced that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought.

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

## 10.6 Patient finance questionnaire

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

## 10.7 NMC declaration

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

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

## 10.8 Questionnaire findings

### 10.8.1 Staffing/staff comments

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

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

During the inspection the inspectors spoke with twelve staff. The inspector was able to speak to a number of these staff individually and in private. On the day of inspection, three staff completed questionnaires. The following are examples of staff comments during the inspection and in questionnaires;

*"I am very satisfied that patients are treated with dignity and respect"*

*"I have received training of the identification of patients at risk of pressure damage"*

*"I have received training in the identification of patients at risk of malnutrition and the management of dehydration"*

*"I have received training in the use of MUST (Malnutrition Universal Screening Tool)"*

*"I am very satisfied that care is provided is based on individual needs and wishes of patients".*

### **10.8.2 Patients' comments**

During the inspection the inspectors spoke with 20 patients individually and with a number in groups. In addition, on the day of inspection, 2 patients completed questionnaires.

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

*"Staff will give me the time to do the things I need to do without rushing"*

*"Generally everything is very good"*

*"I always have access to a buzzer"*

*"When I use the buzzer staff come and help me"*

*"I enjoy the food I am given in the home"*

### **10.8.3 Patient representative/relatives' comments**

During the inspection the inspectors spoke with two representatives/relatives/visitors. The following are examples of relatives' comments during inspection and in questionnaires;

*"I believe my relative to is getting the best care possible"*

*"Everyone is so pleasant; we have no complaints or worries"*

*"Mum has settled well in the home and the staff are so kind and considerate"*

## **10.9 Review of care records**

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

Wound care/pressure ulcer care records were examined for three patients. The inspectors assessed the records to be robust and evidenced that wound care/pressure ulcer was being managed in keeping with best practice and records were reflective of the care delivery.

The following was accurately recorded;

- Up to date body map.
- Up to date Braden pressure risk assessment.
- Initial wound assessment.
- On-going wound assessment.
- Care plan detailing the care to be delivered.
- Correspondence and guidance from the tissue viability nurse.

- Up to date MUST assessment tool.
- Up to date pain assessment.
- daily progress regarding the on-going management of wounds and pressure ulcers.

There were no requirements or recommendations made in relation to wound care/pressure ulcer care.

## **10.10 Environment**

The home was well presented, and the environment was welcoming clean and free from malodours. The following areas were discussed with the registered manager and are required to be addressed;

- Tidy and reorganise the store beside lift zone 4.
- Ensure all items are safely stacked in storage areas, storage areas should be maintained clear to ensure the door can be opened.
- Repair the door leading into the kitchen.
- The linen store on the ground floor should be reorganised to ensure storage is maintained in keeping with best practice.

### **10.10.1 Laundry**

The laundry room is required to be reorganised to ensure safe and effective laundering. Items of unclean laundry were observed to be on the floor. Suitable laundry receptacles should be supplied to accommodate this.

### **10.10.2 Dementia unit**

A review of the dementia unit environment evidenced significant improvements in order to enhance the quality of life with patients accommodated who have a diagnosis of dementia. The home is observed to be spacious and bright, clean and fresh. Staff spoken with in the home were aware of how the environment impacts on patients daily life in the home. This is to be commended. However the following areas are required to be addressed;

- All orientation and menu boards should be kept up to date.
- Some items were observed in patients bedrooms which did not belong to them, such as eye glasses and wheelchairs.
- Call bell leads should be suitably placed to minimise the risk of tripping
- Where appropriate memory boxes should be used alongside bedroom door signage
- A variation application should be submitted to RQIA regarding the newly installed keypad locking mechanism and the change of usage from a bedroom into a café. A variation application regarding any structural changes to the environment should be made to RQIA prior to the works commencing as discussed.

## **12.0 Quality Improvement Plan**

The details of the quality improvement plan appended to this report were discussed with Karen McElherron 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:

**Donna Rogan**  
**The Regulation and Quality Improvement Authority**  
**9<sup>th</sup> Floor, Riverside Tower**  
**5 Lanyon Place**  
**Belfast**  
**BT1 3BT**

**Appendix 1**

<b>Section A</b>	
<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.</b>	
<b>Criterion 5.1</b> <ul style="list-style-type: none"> <li>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.</li> </ul> <b>Criterion 5.2</b> <ul style="list-style-type: none"> <li>A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.</li> </ul> <b>Criterion 8.1</b> <ul style="list-style-type: none"> <li>Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.</li> </ul> <b>Criterion 11.1</b> <ul style="list-style-type: none"> <li>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.</li> </ul>	
<b>Nursing Home Regulations (Northern Ireland) 2005 : Regulations 12(1) and (4); 13(1); 15(1) and 19 (1) (a) schedule 3</b>	
<b>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
<p>Preadmission assessments are completed on all residents prior to admission. At pre admission the residents care needs are identified. Information also received from the Care Management team used in assessment</p> <p>The Must Tool is used in the admission assessments along with any relevant SALT or dietician information that is provided, This is then reviewed monthly or more often if required.</p> <p>Braden is used to assess each resident's risk of developing pressure sores and reviewed monthly or more often if required.</p>	Compliant

Section B	
<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.</b>	
<p><b>Criterion 5.3</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>Criterion 11.2</b></p> <ul style="list-style-type: none"> <li>There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.</li> </ul> <p><b>Criterion 11.3</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>Criterion 11.8</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>Criterion 8.3</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1); 14(1); 15 and 16</b></p>	
<b>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
Each resident has a named nurse who is responsible for the development and review of each residents care plan, The named nurses are responsible for reviewing and updating at least monthly. Involvement from the MDT and family and resident are also used in the review of care plans.	Compliant

Referrals to the TVN are made directly to her from the trained staff, this is followed up either by a visit or telephone call from her to continue to offer support and guidance. She also devises a plan of care which the nurses must follow. Trained staff then will develop a care plan and wound care charts in line with the TVN plan of care and review and evaluate.

Referrals are made directly to podiatry for the residents who require any input in relation to lower limb or foot ulceration.

Referrals to the dietician are made through the GP from the trained staffs request based on their clinical assessment and judgement. Residents are seen by the dietician and plans of care are drawn up for trained staff to incorporate into their care plans and disseminate and review.

Each resident has a named nurse who is responsible for the development and review of each residents care plan, The named nurses are responsible for reviewing and updating at least monthly. Involvement from the MDT and family and resident are also used in the review of care plans.



Section C	
<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.</b>	
<b>Criterion 5.4</b> <ul style="list-style-type: none"> <li>Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.</li> </ul> <b>Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16</b>	
<b>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
The trained staff review the care delivered at least monthly intervals using the assessment tools and clinical records	Compliant

Section D	
<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.</b>	
<b>Criterion 5.5</b> <ul style="list-style-type: none"> <li>All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.</li> </ul> <b>Criterion 11.4</b> <ul style="list-style-type: none"> <li>A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.</li> </ul> <b>Criterion 8.4</b> <ul style="list-style-type: none"> <li>There are up to date nutritional guidelines that are in use by staff on a daily basis.</li> </ul>	
<b>Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)</b>	
<b>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
<p>All assessment tools and clinical assessments are based on evidence based tools, braden pressure assessment tool is used for all residents and updated monthly at least.</p> <p>Nutritional guidelines are available in the kitchen and on both floors and form the basis for the development of menus. Resident choice and dietician advise are also incorporated into menu choice.</p>	Compliant

<b>Section E</b>	
<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.</b>	
<p><b>Criterion 5.6</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>Criterion 12.11</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>Criterion 12.12</b></p> <ul style="list-style-type: none"> <li>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 and reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.</li> </ul> <p><b>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) &amp; (4), 19(1) (a) schedule 3 (3) (k) and 25</b></p>	
<b>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
<p>Progress notes are kept and updated at least twice daily on all residents; they are completed by trained staff. Trained staff also complete care plans, risk assessments and evaluate them at least monthly. After each meal a record is kept of what has been eaten/offered/refused for each resident. All residents when their care plan indicates, fluids are recorded and a daily target for 24hrs is recorded and the actual daily intake is recorded in the progress notes. Each identified residents care plan specifies the target fluid intake for 24hrs and where the target is not achievable, advice is sought from the MDT and utilized.</p>	Compliant

Section F	
<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.</b>	
<b>Criterion 5.7</b> <ul style="list-style-type: none"> <li>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.</li> </ul> <b>Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16</b>	
<b>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
<p>Each individual residents progress notes are updated at least twice within a 24hr period. Any changes, outcomes and care interventions are recorded by the nurse in charge.</p> <p>The care plans, risk assessments are evaluated monthly by the primary nurse and they are reviewed at patient care reviews along with the care manager, family and members of the MDT</p>	Compliant

<b>Section G</b>	
<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.</b>	
<b>Criterion 5.8</b> <ul style="list-style-type: none"> <li>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.</li> </ul> <b>Criterion 5.9</b> <ul style="list-style-type: none"> <li>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.</li> </ul>	
<b>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)</b>	
<b>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
Care reviews are attended by the primary nurse, caremanager, family, and where possible the resident. Care reviews are minuted and any actions identified are agreed at the meeting, A copy of the care review minutes is kept in te residents file and a copy sent to the patients NOK.	Moving towards compliance

Section H	
<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.</b>	
<b>Criterion 12.1</b> <ul style="list-style-type: none"> <li>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 dietitians and other professionals and disciplines.</li> </ul> <b>Criterion 12.3</b> <ul style="list-style-type: none"> <li>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.</li> </ul>	
<b>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) &amp; (4), 13 (1) and 14(1)</b>	
<b>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
<p>Following appropriate guidance documents ,Menus have been devised by a qualified cook. incorporating residents like/dislikes and specialised diets. Staff are aware and are pro active in providing alternatives, if a resident doesn't eat the prepared meal, this is recorded in the food/fluid intake record. Nutritional guidelines are available in the kitchen and on both floors</p>	<p>Compliant</p>

<b>Section I</b>	
<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.</b>	
<p><b>Criterion 8.6</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>Criterion 12.5</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>Criterion 12.10</b></p> <ul style="list-style-type: none"> <li>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:             <ul style="list-style-type: none"> <li>risks when patients are eating and drinking are managed</li> <li>required assistance is provided</li> <li>necessary aids and equipment are available for use.</li> </ul> </li> </ul> <p><b>Criterion 11.7</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20</b></p>	
<b>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
Nurses and carers have an ongoing training plan to ensure their knowledge and skills are maintained for assisting residents with swallowing difficulties. The SALT team regularly review the residents and complete a plan of care which the trained staff then incorporate into the care plans and disseminate to the care staff and catering staff. Trained staff also make professional judgement calls and ask for SALT to review clients they have concerns about and care plans are up dated accordingly.	Substantially compliant

Meals are provided at conventional times for the residents and additional snacks and hot cold drinks are always available, where residents are unable to verbalize a request staff use there non verbals cue to determine their request.

Staff are well updated and informed of any risks or changes to the eating and drinking needs of the residents, this is disseminated through handover, staff meetings and resident updates as changes may occur.

Trained staff have training in wound care management and are supported by the TVN for additional guidance and support. We also have a Wound Management Link Nurse who attends quarterly Trust updates.

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

**COMPLIANCE LEVEL**

Substantially compliant



**Appendix 2**

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

<b>Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.</b>	<b>Basic care: (BC) – basic physical care e.g. bathing or use of 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.</b>
<ul style="list-style-type: none"> <li>• 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).</li> <li>• Checking with people to see how they are and if they need anything.</li> <li>• Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task.</li> <li>• Offering choice and actively seeking engagement and participation with patients.</li> <li>• Explanations and offering information are <input type="checkbox"/> tailored to the individual, the language used easy to understand, and non-verbal used were appropriate.</li> <li>• Smiling, laughing together, personal touch and empathy.</li> <li>• Offering more food/ asking if finished, going the extra mile.</li> <li>• Taking an interest in the older patient as a person, rather than just another admission.</li> <li>• 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.</li> <li>• 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.</li> </ul>	<p>Examples include: Brief verbal explanations and encouragement, but only that the necessary to carry out the task.</p> <p>No general conversation.</p>

<b>Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.</b>	<b>Negative (NS) – communication which is disregarding of the residents' dignity and respect.</b>
<p><b>Examples include:</b></p> <ul style="list-style-type: none"> <li>• Putting plate down without verbal or non-verbal contact.</li> <li>• Undirected greeting or comments to the room in general.</li> <li>• Makes someone feel ill at ease and uncomfortable.</li> <li>• Lacks caring or empathy but not necessarily overtly rude.</li> <li>• Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact.</li> <li>• Telling someone what is going to happen without offering choice or the opportunity to ask questions.</li> <li>• Not showing interest in what the patient or visitor is saying.</li> </ul>	<p><b>Examples include:</b></p> <ul style="list-style-type: none"> <li>• Ignoring, undermining, use of childlike language, talking over an older person during conversations.</li> <li>• Being told to wait for attention without explanation or comfort.</li> <li>• Told to do something without discussion, explanation or help offered.</li> <li>• Being told can't have something without good reason/ explanation.</li> <li>• Treating an older person in a childlike or disapproving way.</li> <li>• Not allowing an older person to use their abilities or make choices (even if said with 'kindness').</li> <li>• Seeking choice but then ignoring or over ruling it.</li> <li>• Being angry with or scolding older patients.</li> <li>• Being rude and unfriendly.</li> <li>• Bedside hand over not including the patient.</li> </ul>

## 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**

**Primary Unannounced Care Inspection**

**Carlingford Lodge Care Home**

**2 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 Karen McElherron, registered manager during 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	32 (h)	<p>The registered person shall give notice in writing of any changes to the premises of the nursing home are significantly changes or altered in any way.</p> <p>An application for variation should be submitted to RQIA without delay of the changes made to the dementia unit. This includes the installation and management of the key coded locking mechanism installed and the changing a bedroom into a café. This application should be approved by RQIA prior to being used by patients.</p> <p><b>Ref Previous requirements and 10.10.2</b></p>	One	Variation form completed for proposed cahnge of use of x1 bedroom to x1 cafe/lounge area.	From the date of inspection
2	27	<p>Ensure the following areas are addressed;</p> <p>Tidy and reorganise the store beside lift zone 4.</p> <p>Ensure all items are safely stacked in storage areas, storage areas should be maintained clear to ensure the door can be opened.</p> <p>Repair the door leading into the kitchen.</p> <p>The linen store on the ground floor should be reorganised to ensure storage is maintained</p>	One	<p>Stock removed from store area,clear passage maintained.</p> <p>Kitchen door repaired</p> <p>Linen area re-organised and maintained</p>	From the date of inspection

		in keeping with best practice.  <b>Ref 10.10</b>			
3	13 (7)	The laundry room is required to be reorganised to ensure safe and effective laundering. Items of unclean laundry were observed to be on the floor. Suitable laundry receptacles should be supplied to accommodate this.  <b>Ref 10.10.1</b>	One	Laundry trolleys purchased.	From the date of inspection
4	12 (1) (b)	The following areas should be addressed in the dementia unit as discussed;  All orientation and menu boards should be kept up to date.  Some items were observed in patients' bedrooms which did not belong to them, such as eye glasses and wheelchairs.  Cbell leads should be suitably placed to minimise the risk of tripping.  Where appropriate memory boxes should be used alongside bedroom door signage.  <b>Ref 10.10.2</b>	One	Staff check orientation /menu boards daily to ensure up to date  Staff complete regular checks on bedroom areas and remove items appropriately.  Staff reminded of the hazards presented by call bells and reposition as required  Maintenance person currently repairing damaged memory boxes and replacing with more effective lock.	From the date of 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:

<b>NAME OF REGISTERED MANAGER COMPLETING QIP</b>	Karen McElherron
<b>NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP</b>	Caroline Denny

<b>QIP Position Based on Comments from Registered Persons</b>	<b>Yes</b>	<b>Inspector</b>	<b>Date</b>
Response assessed by inspector as acceptable	Yes	Donna Rogan	19/01/15
Further information requested from provider			