Unannounced Primary Inspection

Name of Establishment:	**St James' Lodge Care Home**
Establishment ID No:	**11245**
Date of Inspection:	**16 September 2014**
Inspector's Name:	**Bridget Dougan**
Inspection No:	**IN017134**

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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1.0 General Information

Name of Home:	St James' Lodge Care Home
Address:	15 - 17 Coleraine Road Ballymoney BT53 6BP
Telephone Number:	028 2766 8212
E mail Address:	frank.mckenna@stjameslodge.co.uk
Registered Organisation/ Registered Provider:	St James' Lodge Limited Mr Francis Donal McKenna
Registered Manager:	Ms Bronagh Barker
Person in Charge of the Home at the time of Inspection:	Ms Bronagh Barker
Registered Categories of Care and number of places:	NH-I, NH-DE, RC-I 44
Number of Patients/Residents Accommodated on Day of Inspection:	43
Scale of charges (per week)	NH - £609
Date and time of this inspection:	16 September 2014: 12.00 – 18.00 hours
Date and type of previous inspection:	13 February 2014 Primary Announced

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 a primary announced inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were met.

3.0 Purpose of the Inspection

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

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

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

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

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

4.0 Methods/Process

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

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

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

- analysis of pre-inspection information
- discussion with the registered manager

- examination of records
- consultation with stakeholders
- tour of the premises
- evaluation and feedback.

Any other information received by RQIA about this registered provider has also been considered by the inspector in preparing for this inspection.

5.0 Consultation Process

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

Patients	**30**
Staff	**8**
Relatives	**5**
Visiting Professionals	**0**

Questionnaires were provided, during the inspection, to patients, their representatives and staff to seek their views regarding the service. Matters raised from the questionnaires were addressed by the inspector in the course of this inspection.

Issued To	**Number issued**	**Number returned**
Patients	**3**	**3**
Relatives / Representatives	**5**	**5**
Staff	**5**	**5**

6.0 Inspection Focus

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

The criteria from the following standards are included;

- Management of Nursing Care – Standard 5
- Management of Wounds and Pressure Ulcers –Standard 11
- Management of Nutritional Needs and Weight Loss – Standard 8 and 12
- Management of Dehydration – Standard 12

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

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

The 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

St James' Lodge Care Home is a 44 bedded nursing home with patient accommodation on two floors.

It is situated in its own pleasant grounds, located in Ballymoney. The home is within easy reach of local bus routes and Ballymoney town centre.

The home is divided, with the ground floor supporting the needs of 20 patients with a diagnosis of dementia and the first floor will support the care of 23 frail elderly patients and one patient within the category of terminally ill.

All patient bedrooms are single and provide ensuite facilities. Each has been furnished to a very high standard with a profiling bed, and there is a range of furniture providing storage for patients' personal processions. All bedrooms are decorated to a high specification.

Communal living areas, activity lounges and dining rooms are available on both floors to meet the needs of the patients. A hairdressing room is provided on each floor.

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) accurately reflected the categories of care and was appropriately displayed in a prominent position of the home.

8.0 Summary of Inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to St James' Lodge Care Home. The inspection was undertaken by Bridget Dougan on 16 September 2014 from 12.00 to 18.00 hours.

The inspection was facilitated by Ms Bronagh Barker, Registered Manager, who was joined by Mr Frank McKenna, Registered Provider for verbal feedback 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 patients’ human rights during this inspection. The requirements and recommendations made as a result of the previous inspection were also examined.

Prior to the inspection, the responsible individual completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible individual in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

Analysis of pre inspection activity confirmed that any accidents, incidents or complaints were managed in accordance with legislation and the previous Quality Improvement Plan (QIP) was completed and returned within the agreed timescales.

During the course of the inspection, the inspector met with the majority of patients, staff and five relatives. Feedback on the quality of care and services provided was generally very positive. One member of staff and one relative expressed some concerns regarding the numbers of staff on duty to care for the patients. Staffing issues were discussed with the registered manager and the registered provider and assurances were given that this was being addressed.

Staff were observed to treat the patients with dignity and respect and all patients appeared comfortable in their surroundings.

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

The home was comfortable and all areas were maintained to a high standard of hygiene.

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 staff training, inductions, supervision, ‘nurse in charge’ competency assessments, recruitment processes and staffing levels.

The inspector reviewed and validated the home’s progress regarding the two requirements and two recommendations made at the last inspection on 13 February 2014 and confirmed compliance outcomes as follows: One requirement and two recommendations had been fully complied with and one requirement had not been complied with.

Post inspection

This inspection resulted in a formal meeting held with the registered manager and the registered provider. Areas for improvement were discussed (see sections 9.0, 10.0 and 11.0 of this report) and assurances were given that these issues would be addressed within the agreed timescales.

RQIA will continue to monitor the quality of service provided in St James’ Lodge Care Home and will carry out an inspection to assess compliance with these standards.

Conclusion

As a result of this inspection, five requirements and six recommendations were made; one requirement has been stated for the second time. 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, management, staff and relatives for their assistance and co-operation throughout the inspection process.

The inspector would also like to thank the patients, relatives and staff who completed questionnaires.

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

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	20 (3)	The registered person shall ensure that at all times a nurse is working at the nursing home and that the manager carries out a competency and a capability assessment with any nurse who is given the responsibility of being in charge of the home for any period of time in her absence. **Reference: Standard 16.3**	The inspector reviewed the personnel records of 10 registered nurses who were left in charge of the home in the absence of the registered manager and was unable to evidence that a competency assessment had been completed for any of these nurses. This requirement will be stated for the second time.	**Not compliant**
2	13 (1) (a)	The registered person shall ensure that the nursing home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. **Reference: Standard 5.3**	Review of a sample of food and fluids and repositioning charts evidenced that this requirement had been met.	**Compliant**

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	5.6	The manager must ensure that 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. **Reference: Standard 5.6**	The inspector reviewed a sample of four patients care records and evidenced that this recommendation had been met.	**Compliant**
2	26.1	It is recommended that the home manager develops a Palliative Care operations policy and procedure in accordance with statutory requirements. **Reference: Follow up on previous issues**	The inspector can confirm that this recommendation had been met.	**Compliant**

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

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated minimum standards, it will review the matters and take whatever appropriate action is required; this may include an inspection of the home. Please also refer to section 11.5 of the report.

Since the previous care inspection on 13 February 2014, RQIA have received one notification of safeguarding of vulnerable adult (SOVA) incidents in respect of St James' Lodge Care Home. RQIA is satisfied that the registered manager has dealt with SOVA issues in the appropriate manner and in accordance with regional guidelines and legislative requirements.

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 four patients care records which evidenced those patients individual needs were established on the day of admission to the nursing home, through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that 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, pain, infection control and continence were also completed on admission. Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure ulcer/wound and if required, the specific care plans regarding the management of the pressure ulcer/wound. Review of four patients care records evidenced that an assessment of the patients care needs was completed within 11 days of the patients admission to the home. In discussion with the registered manager, she demonstrated a good awareness of the patient who required wound management intervention for a wound and the number and progress of patients who were assessed as being at risk of weight loss and dehydration.

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

Section B – Standard 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Standard 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Standard 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Standard 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration** **Standard 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.**
The inspector observed that a named nurse 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 four patients care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Records also evidenced discussion with patients and/or their representatives following changes to the plans of care. Discussion with the registered manager and review of four patients care records confirmed that where a patient was assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention and treatment programme. This included the specific type of pressure reducing / relieving equipment and the frequency of repositioning the patient in accordance with assessed need. A daily repositioning and skin inspection chart was in place for the patient with the wound and also for patients who were assessed as being

at risk of developing pressure ulcers. Review of a sample of these records evidenced that patients were repositioned in accordance with their care plans and their skin was inspected at each positional change while in bed.

Policies and procedures were in place for staff on making referrals to the tissue viability specialists and dietician. These included indicators of the action to be taken and by whom. All nursing staff spoken with were knowledgeable regarding the referral process and of the action to take to meet the patients/residents' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

The patients weights were recorded on admission and on at least a monthly basis or more often if required.

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

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

Review of care records for one patient evidenced that the patient was referred to the dietician and the speech and language therapist in a timely manner. There was also evidence that the patient's care plan had been reviewed to incorporate the recommendations made by the other professionals.

Discussion with staff and review of training records evidenced that training in relation to pressure area care and the prevention of pressure ulcers had not yet been provided for all nurses and care staff. Registered nurses had not yet received tissue viability training in the management of wounds/pressure ulcers. A recommendation has been made in this regard.

A recommendation is also made for all staff to have update training in relation to the care associated with patients who have swallowing difficulties. While training records evidenced that some staff had received this training, the registered person must ensure that this training is provided for all staff relevant to their role. Catering staff should also receive update training in nutrition.

Patients' moving and handling needs were assessed and addressed in their care plans. There was evidence that equipment such as a hoist was used to minimise the risk of friction. There were no issues identified during the inspection regarding moving and handling practices.

The registered nurse informed the inspector that pressure ulcers if present were 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	**Moving towards compliance**

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 four patients care records evidenced that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care for each patient. Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. Review of care records also evidenced that nutritional care plans for patients were reviewed monthly or more often as deemed appropriate. The evaluation process included the effectiveness of any prescribed treatments, for example prescribed analgesia. There was evidence that care records were audited on a monthly basis and 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 criterion assessed	**Substantially compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**

Section D – Standard 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Standard 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Standard 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Homes Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**
The inspector examined four patients care records which evidenced the completion of validated assessment tools such as; • The Roper, Logan and Tierney assessment of activities of daily living • Braden pressure risk assessment tool • Nutritional risk assessment such as Malnutrition Universal Screening Tool (MUST). The inspector also evidenced that the following research and guidance documents were available in the home for staff to access: • 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). Discussion with the registered manager confirmed that she had a good awareness of these guidelines and was knowledgeable regarding the individual dietary needs and preference of patients and the principles of providing good nutritional care. Three care staff consulted were knowledgeable regarding the specific support required by patients with regard to eating and drinking. The cook was also aware of patients who had specific dietary requirements.

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

Section E – Standard 5.6

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

Standard 12.11

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

Standard 12.12

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

A policy / procedure relating to nursing records management was available in the home. Review of this policy evidenced that it reflected The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance, however requires review.

The registered nurses on duty were aware of their accountability and responsibility regarding record keeping.

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

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

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

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

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

Review of a sample of fluid balance charts for 21 patients provided evidence of the following:

- patients/residents were offered fluids on a regular basis throughout the day
- the total fluid intake for patients/residents over 24 hours
- an effective reconciliation of the total fluid intake against the fluid target established
- action to be taken if targets were not being achieved
- a record of reconciliation of fluid intake in the daily progress notes.

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 – Standard 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.**
Please refer to criterion examined in Section C & E. In addition the review of four 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 criterion assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**

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

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 – Standard 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Standard 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.**
A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance. There was a four weekly menu planner in place. The registered manager informed the Inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home. It was confirmed by staff and patients that individual dietary preference and choice is accommodated. The inspector discussed with the registered manager and the cook the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients (see section E).

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

The inspector discussed the dietary needs of the patients with the registered manager, care staff and the cook. As identified in section B, review of the self – assessment (see appendix) and from discussion with the registered manager and care assistants, it was indicated that staff training had been completed in relation to assisted feeding techniques. However, it is recommended that all staff receive update training in the care associated with patients who have swallowing difficulties. Discussion with registered manager and cook confirmed that meals were served at appropriate intervals throughout the day in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes. The registered manager and cook confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered mid-morning, afternoon and at supper times. The inspector observed that a choice of fluids to include fresh drinking water were available and refreshed regularly. Staff were observed offering patients fluids at regular intervals throughout the day. Staff spoken with were knowledgeable regarding pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care.

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

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Substantially 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 confirmed that the required records were maintained in the home.

11.2 Patients 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 accommodated at the time of inspection in the home who were subject to guardianship arrangements.

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

The inspector discussed the Human Rights Act and Human Rights Legislation with the registered nurses and care staff. Staff demonstrated an awareness of these documents and how they impact on care delivery and copies of the documents were available in the home on the day of inspection.

The inspector also discussed the Deprivation of Liberty Safeguards (DOLs) with the registered manager including the recording of best interest decisions on behalf of patients. The registered manager demonstrated an awareness of this document, and a copy of DOL's was available in the home on the day of inspection.

11.4 Quality of interaction schedule (QUIS)

The inspector undertook two periods of observation in the home which lasted for approximately 35 minutes each.

The inspector observed the lunch meal being served in the dining room and in the interactions between patient and staff in the sitting room. The inspector also observed care practices in general throughout the home during the inspection.

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

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

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

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

11.5 Complaints

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

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

11.6 Patient finance questionnaire

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

11.7 NMC declaration

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

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC.

11.8 Questionnaire findings

Staffing/Staff Comments

The inspector examined duty rotas spanning a four week period (weeks commencing 01, 08, 15 and 22 September 2014). Review of duty rotas indicated that the staffing arrangement fell below RQIA's recommended minimum staffing guidance for nursing homes for the number of patients currently in the home. The inspector evidenced a deficit of one nurse in the general nursing unit between 08:00 and 14:00 hours. This was discussed with the registered manager who confirmed that there had been a shortage of nurses; however this had not been resolved. The registered manager also confirmed that she had frequently been included in the duty rotas as a registered nurse to provide care on the floor. Duty rotas should identify the number of hours spent by the registered manager on management duties and the hours spent on clinical duties. The registered provider must ensure that the registered manager been allocated sufficient hours to enable her to undertake her management responsibilities.

A requirement has been raised in accordance with Regulation 20 (1) (a) of The Nursing Homes Regulations (Northern Ireland) 2005.

During the inspection the inspector spoke with eight staff individually. On the day of inspection five staff also completed questionnaires. The following are examples of staff comments during the inspection and from the questionnaires;

- “I am in daily contact with the patients and the quality of care in my opinion is of a high standard.”
- “We do not always have the time to spend discussing or listening to residents. We have very little time to spend doing enjoyable activities with residents.”

The provision of activities was discussed with the registered manager. The inspector was informed that an activities co-ordinator was employed by the home to provide activities for patients on two or three days per week. The registered manager must ensure that the duty rotas include a record of all staff employed in the home.

Patients’ comments

During the inspection, the inspector spoke with the majority of patients individually. Three of these patients responded to the questions in the questionnaires. Some patients were unable to verbally express their views on the quality of care provided due to the frailty of their condition. All those patients who were able to provide feedback indicated that they were content living in the home.

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

- “I am glad to be here. All the staff are very helpful and friendly.”
- “The quality of care I receive is good.”
- “Happy living here.”

Patient representatives’ comments

During the inspection, the inspector spoke with five patients’ relatives. These relatives also completed questionnaires. The following are examples of relatives’ comments:

- “I have been very impressed with the staff of St James’ Lodge. They have achieved so much in such a short time since my aunt was admitted a few weeks ago.”
- “From 8 – 10 pm the staff are really pushed. They can be rushed off their feet.”
- “Very satisfactory; excellent in every way; all patients are well cared for.”
- “My experience of this home and all its staff is entirely positive. Without exception, they are professional and above all extremely kind and affectionate to all those in their care.”

11.9 Environment

As part of the inspection process, the inspector observed the general environment in the nursing home. This included viewing a random sample of bedrooms, lounges, dining rooms, and bathroom / toilet facilities. The home was comfortable and all areas were maintained to a high standard of hygiene.

11.10 Inductions

The inspector reviewed a sample of nine staff personnel records and was unable to evidence that an induction had been provided for eight staff members. A requirement has been made accordingly.

11.11 Mandatory training

Review of staff training records evidenced a deficit in mandatory training as follows:

- Safeguarding Vulnerable Adults
- COSHH
- Infection prevention and control.

One requirement and one recommendation have been made regarding mandatory training.

11.12 Staff supervisions

The inspector reviewed a sample of nine personnel records and was unable to evidence that any staff had received supervision. A requirement has been raised in this regard.

11.13 Recruitment procedures

The inspector reviewed the personnel records of nine staff and evidenced that two written references were not on file for two members of staff and there was evidence of only one written reference for a third member of staff. One requirement has been made with regard to recruitment practices.

Serious concerns were raised with regard to the overall management and control of operations of the home and these were discussed with the registered manager and the registered provider at the conclusion of the inspection.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Bronagh Barker, Registered Manager and Mr Frank McKenna, Registered Provider 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:

Bridget Dougan
The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS

Appendix 1

<table>
<tr><th colspan="2">Section A</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>A pre-admission assessment is carried out on each Resident prioir to admission to ensure the Home is equipped to meed to assessed needs of each Resident. Care Plans are received via the care management team to ensure accurate information is received. Within 11 days of admission a further assessment is completed on each Resident to include: MUST, falls risk, moving and handling, Oral, Braden and continence assessments. This allows staff to make a clinical judgement and encorporate their findings into an agreed plan of care for each Resdient. These assessments are evaluated monthly or more frequently if required.</td><td>Compliant</td></tr>
</table>

<table>
<tr><th colspan="2">Section B</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>A names nurse system is in place within the Home. Each Resident is allocated a nurse who has responsibility for planning and implementing assessed needs and plans of care. Referrals are made appropriately to various members of the multidisiplinary team who have more specific and required expertise in various areas including: T.V.N, podiatary, dietician. Any advice and guidance given from the team is incorportaed into the Resident's plan of care and</td><td>Compliant</td></tr>
</table>

releveant staff informed of same to ensure this is carried out. Braden scales are used on every Resident to determine whether they are at risk of developing pressure ulcers. If a risk is identified a care plan to minimise this risk is put in place to incorporate each individual needs.	
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**
All assessments are evaluated at least on a monthly basis. Staff review Resdient's on a daily basis and if required assessments are evaluated more frequently and if appropriate a change in the plan of care may be necessary	Substantially compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursign interventions are completed and carried out based on guidance and research to try to ensure all standards are of the highest possible. A validated grading tool is used to determine the severity of any wounds/ulcers. Advice is saught from T.V.N or podiatrist when required. Nutritional guidelines and relevant informtaion regarding skin care and the prevention of wounds/pressure ulcers is available within each nurses' station.	Substantially compliant

<table>
<tr><th colspan="2">Section E</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>All nursing records are recorded within an epic care computer system. This system has been adapted and reviewed since the Home opened to try to ensure it meets the individual needs of the Home and our Residents. Care plans are also inputted into this system, evaluated and reviewed to ensure assessed need is identified, a plan of care is developed and outcomes are recorded. Food and fluid charts are also completed via the epic care system including any refused nutritional intake and what has been offered to the Resdient. MUST scores are assessment monthly or more frequently if required and referrals made to dietician if appropriate.</td><td>Compliant</td></tr>
</table>

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**
Nursing progress noted are completed daily basis and any change identified docuemnted as reuqired. Care management reviews take place approximately 2-3 weeks following admission to the Home and routinely annually thereafter. This, however can be carried out more frequently if the Home, the Resdient or their representaive feels it is appropriate. Any outcome from these reviews are recorded onto the epic care system. A paper copy of meeting minutes is also held within the Resident's file.	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**
All Residents are encouraged to participate in their plan of care to ensure their wants, needs and wishes are taken into account and where appropriate incorporated into their plan of care. Residents are also encouraged to attend any review meetings held regarding their care. Any reviews held are fully documented and changes made to care plans or action plans are put in place to meet an identified need.	Compliant

<table>
<tr><th colspan="2">Section H</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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)</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>We offer a 4 weekly menu which takes into account recent guidelines and advice saught by diatetic team to ensure a nutritious and varied diet is offered daily. Families and Residents have been consulted on what items they would like to see incorporated into the menu. Two choices are available for Residents to choose from although if they do not want what is available an alternative can be requested. Special diets including puree, soft, minced etc are offered choices also. Seasonal menus are also available.</td><td>Compliant</td></tr>
</table>

<table>
<tr><th colspan="2">Section I</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>Assisting Resident's with nutritional and fluid intake is covered within the staff induction process. Training has been provided for some staff on dysphsia and this will be on-going for all staff. Resdients who have been assessed by SALT have the directions incorporated into their plan of care and kitchen staff made aware of all assessed needs. Meals are provided at conventional times, and hot and cold drinks are available throughout the day. There is always adequate staff available to offer supervision and supprt throughout meal times. Fresh drinking water is available in</td><td>Substantially compliant</td></tr>
</table>

communial areas throughout the Home at all times.	

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)

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

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

References

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

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

Quality Improvement Plan

Unannounced Primary Inspection

St James' Lodge Care Home

16 September 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Ms Bronagh Barker, Registered Manager and Mr Frank McKenna, Registered Provider, 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.

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

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	20 (3)	The registered person shall ensure that at all times a nurse is working at the nursing home and that the manager carries out a competency and a capability assessment with any nurse who is given the responsibility of being in charge of the home for any period of time in her absence. **Reference: Follow up on previous issues**	Two	A nurse is working in the home at all times and where a nurse has the responsibility of being in charge a compenency and capability assessment is undertaken. All complete.	Within one week from the date of this inspection
2	20 (1) (a)	The registered person shall, 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. Ensure that the acting manager has been allocated sufficient hours to enable her to undertake her management responsibilities. **Reference: Section 11.8**	One	The home employs based upon the statement of purpose the number of patients in the home, their dependency and the Nursing Home Regulations and Standards suitably qualified and competent staff in sufficient numbers. The Nurse Manager's hours have been reviewed and sufficient allocated hours are allocated for managerial responsibilities.	From the date of this inspection
3	20 (1) (c)	The registered person shall, having regard to the size of the nursing home, the statement of purpose and the number and	One		From the date of this inspection

		needs of patients – Ensure that the persons employed by the registered person to work at the nursing home receive: Appraisal, mandatory training and other training appropriate to the work they are to perform. **Reference: Section 11.11**		Staff Appraisals have been commenced and are ongoing for all staff. Mandatory Training and identified appropriate training has been completed for existing staff and is ongoing for new staff	
4	20 (2)	The registered person shall ensure that persons working at the nursing home are appropriately supervised. **Reference: Section 11.12**	One	A program of supervision for all staff has been commenced and is ongoing.	From the date of this inspection
5	21 (1) (b)	The registered person shall ensure not employ a person to work at the nursing home unless subject to paragraph (5), he has obtained in respect of that person the information and documents specified in paragraphs 1 to 7 of Schedule 2. **Reference: Section 11.13**	One	Pre employment references are now in place for the three identified staff members	From the date of this inspection

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	12.10	The registered person should ensure that all staff have update training in relation to the care associated with patients who have swallowing difficulties. **Reference: Section B**	One	Dysphasia Training has been completed on Tuesday the 11th of November 2014 for staff and further dates booked.	Within one month from receipt of this report
2	11.3	The registered person should ensure that all relevant staff have update training in relation to pressure area care and the prevention of pressure ulcers. **Reference: Section B**	One	Pressure area care and wound management training has been scheduled for Friday 21st November 2014 and Thursday 11th December 2014	Within one month from receipt of this report
3	11.7	The registered person should ensure that all registered nurses receive tissue viability training in the management of wounds/pressure ulcers. **Reference: Section B**	One	Wound management training for nurses has been scheduled for Friday 21st November and Thursday 11th December 2014	Within one month from receipt of this report
4	12.1	The registered person should ensure that catering staff receive update training in nutrition. **Reference: Section B**	One	Local dietetic department has been contacted and will contact us with suitable dates and times.	Within two months from receipt of this report
5	30.6	The registered person must ensure that staff duty rotas include a record of all staff working	One	The home's rostered off-duty is retained and records the	From receipt of this report

		over a 24 hour period and the capacity in which they were working. The hours worked by the activities co-ordinator should be included in the duty rotas. Duty rotas should also clearly identify the hours worked by the registered manager in clinical duties and those worked in managerial duties **Reference: Section 11.8**		names of all staff working in the home and the capacity in which they work The hours of the home's activity co-ordinator are included in the home's staff roster. The staff roster clearly identifies the hours worked by the Nurse Manager and identifies Clinical duties and Managerial Duties.	
6	28.1	The registered person must ensure that staff who are newly appointed, agency staff and students are required to complete a structured orientation and induction. **Reference: Section 11.10**	One	Newly appointed staff, agency staff and students are required to complete a structured orientation and induction program prior to commencing duty within the home.	From the date of this inspection

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

Name of Registered Manager Completing Qip	Bronagh Barker
Name of Responsible Person / Identified Responsible Person Approving Qip	Frank McKenna

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	B. Dougan	13/11/14
Further information requested from provider			