Announced Primary Inspection

Name of Establishment:	**Ardlough Care Home**
Establishment ID No:	**1166**
Date of Inspection:	**01 September 2014**
Inspector's Name:	**Heather Moore**
Inspection No:	**16513**

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544

1.0 General information

Name of establishment:	Ardlough Care Home
Address:	2 Ardlough Road Drumahoe Londonderry BT47 5SW
Telephone number:	028 7134 2899
Email address:	ardlough@fshc.co.uk
Registered organisation/ registered provider:	Four Seasons Health Care Mr James McCall
Registered manager:	Mrs Martina Mullan
Person in charge of the home at the time of inspection:	Mrs Martina Mullan
Registered categories of care and number of places:	NH-DE NH-MP NH-MP(E) 44
Number of patients accommodated on day of inspection	NH-DE 14 NH-MP NH-MP(E) 28
Scale of charges(per week)	£581.00
Date and time of this inspection:	01 September 2014: 08.25 hours - 16.00 hours
Date and type of previous inspection:	05 March 2014 Secondary Unannounced

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:

- Review of any notifiable events submitted to RQIA since the previous inspection
- Analysis of pre-inspection information
- Discussion with the regional manager
- Discussion with the registered manager

- Discussion with patients individually and with others in groups
- Consultation with patients/'relatives/representatives
- Consultation with staff
- Observation of care delivery and care records
- Examination of records
- Tour of the premises
- Evaluation and feedback.

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

5.0 Consultation process

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

Patients	**10 individually and with others in groups**
Staff	**10**
Relatives	**1**
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	**6**	**6**
Relatives / Representatives	**1**	**1**
Staff	**10**	**9**

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

The home, which is purpose built, is situated in its own tastefully landscaped and well-maintained grounds on the Ardlough Road, Drumahoe, Co. Londonderry. It is a two storey building with access to the first floor via a through floor lift and stairs.

Accommodation comprises:

- 42 single and one double bedroom
- A choice of six sitting rooms
- Two dining rooms
- An Activity Lounge
- Two Smoking Lounges
- Laundry
- Kitchen
- Toilet / Washing Facilities
- Staff accommodation

The home is registered to care for up to 44 patients requiring nursing care in the following categories of care:

Nursing Care

MP - Mental Disorder excluding Learning Disability
MP (E) - Mental disorder excluding Learning Disability over 65 years of age
DE – Dementia
Mrs Martina Mullan is the Registered Manager
Ardlough Care Home is owned and operated by Four Seasons Health Care Ltd
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 a primary inspection (announced) to Ardlough Care Home. The inspection was undertaken by Heather Moore on 01 September 2014 from 08.25 hours to 16.00 hours.

Mrs Martina Mullan, Registered Manager was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Mrs Louisa Rea, Regional Manager Four Seasons Health Care and to the registered manager 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. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See Appendix one.

During the course of the inspection, the inspector met with patients, staff and one visiting relative. The inspector 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.

Questionnaires were issued to patients, staff and one relative during the inspection.

The inspector spent a number of extended periods observing staff and patient interaction. Discussions and questionnaires are unlikely to capture the true experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience.

These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool is designed to help evaluate the type and quality of communication which takes place in the nursing home. A description of the coding categories of the Quality of Interaction Tool is appended to the report at Appendix Two.

As a result of the previous inspection conducted on 05 March 2014, three requirements and three recommendations were issued. These requirements and recommendations were reviewed during this inspection. The inspector evidenced that one requirement had been complied with, one requirement had been substantially complied with and one requirement was not compliant and has been stated for the second time. Four recommendations were addressed. 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**

The inspector examined three patients care records

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 patients' needs was evidenced to inform the care planning process.

However inspection of two patients care records revealed that a number of care plans were not reviewed on a monthly basis. A requirement is made in this regard.

Examination of two patients care records also revealed that an identified patient's bedrail risk assessment was not reviewed monthly a requirement is made that this is addressed. A recommendation is made that audits of patients care records are undertaken monthly.

There was evidence that the referring HSC Trust maintained appropriate reviews of the patient's satisfaction with the placement in the home and the quality of care delivered.

The inspector can confirm that based on the evidence reviewed, presented and observed: that the level of compliance with this standard was assessed as moving towards compliance.

- **8.1.2 Management of Wounds and Pressure Ulcers –Standard 11 (Selected criteria)**

The inspector examined one patient's care record in regard to wound management. There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment.

Examination of the patient's care record confirmed the absence of a care plan on pain management; inspection also confirmed the absence of a pain assessment.
A requirement and a recommendation are made in regard to the maintenance of the patient's care record.

Discussion with one relative confirmed that registered nurses had undertaken discussions with her in regard to planning and agreeing nursing interventions however there was no written evidence in one patient's care record that discussions with the patient's relative had taken place. A recommendation is made in this regard.

The inspector can confirm that based on the evidence reviewed, presented and observed that the level of compliance with this standard was assessed as moving towards compliance.

- **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 GP's, speech and language therapists and or dieticians being made as required.

However inspection of one patient's care record confirmed that the patient's MUST (Malnutrition Universal Screening Tool) assessment was not recorded monthly or more often if deemed appropriate. A recommendation is made in this regard.

The inspector also observed the serving of the lunch meal and can confirm that the patients were offered a choice of meal and that the meal service was well delivered.

It was observed during the meal that the daily menu was not displayed in the Evergreen Unit so that patients and their representatives know what is available at each meal time. A recommendation is made that be addressed.

Patients were observed to be assisted with dignity and respect throughout the meal.

The inspector can confirm that based on the evidence reviewed, presented and observed: that the level of compliance with this standard was assessed as substantially compliant.

- **Management of Dehydration – Standard 12 (Selected criteria)**

The inspector examined the management of dehydration during the inspection which evidenced that fluid intake details for patients at risk of dehydration were recorded daily however inspection of one patient's daily fluid charts confirmed the on two occasions there was no fluid intake recorded after 16.00 hours and 18.00 hours it was also confirmed that there were shortfalls in totalling the patient's daily fluid intake over a 24 hour period.

Inspection of the identified care records also revealed that the patient's daily fluid intake was not identified in the patient's care plans. These issues have been raised as two requirements in the quality improvement plan.

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 water /various cordials were available to patients in lounges, dining rooms and bedrooms.

The inspector can confirm that based on the evidence reviewed, presented and observed: that the level of compliance with this standard was assessed as moving towards compliance.

Patients, their representatives and staff questionnaires

Some comments received from patients

- "Very happy here."
- "Happy with everything."
- "Staff reassure me and make me feel better."
- "I am happy enough."
- "The food is good."
- "This is a good home."

Some comments received from a patient's representative.

- "I have no complaints."
- "I am very happy with the standard of care in this home."

Some comments received from staff

Examples of staff comments were as follows:

- "I had an induction when I commenced work."
- "I enjoy working here; I believe we have a very good delivery of care here."
- "I believe the care here is second to none."
- "The care assistants work very hard here to provide the high quality of care that is given with our home."
- "We work well as a team in both the Autumn and Evergreen units."
- "The carers attitude and attention to detail are exemplary."
- "Staff always go the extra mile."
- "There are always plenty of opportunities for training."
- "Good team work here."
- "Good practice carried out on a daily basis."
- "High standard of care here."

8.3 A number of additional areas were also examined

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

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

Conclusion

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

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

However areas for improvement are identified. Five requirements, two restated requirements and four recommendations are made. These requirements and

recommendations are addressed throughout the report and in the Quality Improvement plan (QIP).

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

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

9.0 Follow-up on previous issues

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
1	20 (1) (a)	The registered person shall 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. This requirement is made in regard to the shortfall of one registered nurse from 8am-2pm.	Inspection of two weeks staff duty rotas confirmed that registered nurses staffing levels were in line with the RQIA's recommended staffing guidelines.	**Compliant**
2	20 (1) (c) (i)	The registered person shall ensure that staff as appropriate are trained in cardio pulmonary resuscitation.	Inspection of staff training records confirmed that one registered nurse was trained in cardio pulmonary resuscitation. Discussion with the registered manager revealed that the registered nurse had been nominated to train additional staff in the home. However this training has as yet not been undertaken. **Restated**	**Substantially Compliant**
3	16 (2)	The registered person shall ensure that patients care plans are reviewed monthly or more often if deemed appropriate.	Inspection of three patients care records confirmed that a number of identified patients care plans were not reviewed monthly or more often if deemed appropriate. **Restated**	**Not Compliant**

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's validation of compliance
1	20.1	It is recommended that the Resuscitation Guidelines 2010 are accessible to staff to enable them to become familiar with the content of these guidelines.	Inspection of records confirmed that the Resuscitation Guidelines were accessible to staff in both units of the home.	**Compliant**
2	20.2	It is recommended that the emergency resuscitation equipment is checked daily (unless otherwise recommended by the manufacturer's instructions).	Inspection of the records of the emergency resuscitation equipment confirmed that the resuscitation equipment was checked daily.	**Compliant**
3	20.4	It is recommended that the home's first aider is highlighted on the staff duty roster for each shift for the 24 hour period.	Inspection of the staff duty rosters confirmed that the home's first aider was highlighted appropriately.	**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 is required: This may include an inspection of the home.

There were no outstanding issues regarding safeguarding of vulnerable adults (SOVA) incidents or complaints on the day of inspection.

11.0 Additional areas examined

11.1 Documents required to be held in the nursing home

Prior to the inspection a checklist of documents required to be held in the home under regulation 19(2) schedule 4 of The Nursing Homes Regulations (Northern Ireland) was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required documents were maintained in the home and were available for inspection. The inspector reviewed the following records:

- The home's statement of purpose
- The patient's guide
- Sample of reports of unannounced visits to the home under regulation 29
- Sample of staff duty rosters
- Record of complaints
- Sample of incident/accidents
- Record of food provided for patients
- Statement of the procedure to be followed in the event of a fire
- Sample of the minutes of patients/relatives and staff meetings.

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. During the inspection there were no patients in the home who were subject to a guardianship order.

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

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

11.4 Quality of interaction schedule (QUIS)

The inspector undertook a number of periods of observation in the home which lasted approximately 20 minutes each.

The inspector observed the patients' lunch meal which was served in the dining rooms. The inspector also observed care practices in the sitting rooms following the lunch meal.

The observation tool used to record these observations uses a simple coding system to record interactions between staff, patients' and visitors.

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

A description of the coding categories of the Quality of Interaction Tool is appended to the report at Appendix 2.

The staff were observed seating the patients in preparation for their lunch in an unhurried manner.

The staff explained to the patients their menu choice and provided adequate support and supervision. Staff were also noted assisting patients with their meal and patients were offered a choice of fluids.

Observation of care practices during these periods of observation revealed that staff were respectful in their interactions with the patients.

Overall the periods of observations were positive.

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.

11.6 Patient finance questionnaire

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

11.7 NMC declaration

Prior to the inspection the 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 manager were registered with the NMC.

11.8 Staffing /staff comments

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

The inspector spoke to 10 staff members during the inspection process and nine staff completed questionnaires.

Examples of staff comments were as follows:

- "I had an induction when I commenced work."
- "I enjoy working here; I believe we have a very good delivery of care here."

- “I believe the care here is second to none.”
- “The care assistants work very hard here to provide the high quality of care that is given with our home.”
- “We work well as a team in both the Autumn and Evergreen units.”
- “The carers attitude and attention to detail are exemplary.”
- “Staff always go the extra mile.”
- “There are always plenty of opportunities for training.”
- “Good team work here.”
- “Good practice carried out on a daily basis.”
- “High standard of care here.”

11.9 Patients comments

The inspector spoke to ten patients /residents individually and with others in groups. Six patients/residents completed questionnaires.

Examples of their comments were as follow:

- “Very happy here.”
- “Happy with everything.”
- “Staff reassures me and makes me feel better.”
- “I am happy enough.”
- “The food is good.”
- “This is a good home.”

11.10 Relatives’ comments

The inspector spoke to one relative and this relative completed a questionnaire.

An example of the relative’s comments is:

- “I have no complaints.”
- “I am very happy with the standard of care.”

11.11 Environment

The inspector undertook an inspection of the home and viewed a number of patients’ bedrooms, communal facilities, toilet and bathroom areas.

The premises presented as generally clean, warm, and comfortable with a friendly and relaxed ambience.
However during a tour of the home it was revealed that an identified armchair in the Evergreen day room presented as stained with food debris. A requirement is made that the identified chair be deep cleaned.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Louise Rea, Regional Manager and Mrs Martina Mullan, 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:

Heather Moore
The Regulation and Quality Improvement Authority
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Tyrone & Fermanagh Hospital
Omagh
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Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Prior to admission to the home, the Home Manager or Senior Nurse visits the potential client in their current environment to carry out a pre-admission assessment. This also involves care plans from the referring Care Manager/Social Worker. Where the client comes from their own home, the GP provides an up to date list of medical history and list of medications in advance of the admission. Where the referral is for an emergency admission, the referrer must provide an up to date care plan including Braden, current mobility status, nutritional needs including type of diet and a full up to date list of medications. Only when the manager is satisfed that the relevant information is	Compliant

available will a decision be made to admit. On admission the identified nurse completes the inital assessments using a patient centred approach. The nurse communicates with the resident and/or representative, refers to the pre-admission assessment and all other information to assist them as far as possible. In addition to this, the nurse will complete, on admission, Braden, Body Map, MUST, Moving & Handling Risk Assessment, Falls Risk assessment, Bed Rail assessment if required and initial wound assessment if required. The resident/representative will sign consents for photographs and restraint where required. The Home Manager will audit the file one week after admission to ensure that the relevant documentation is of the required standard. The Regional Manager will also randomly audit these files during her Regulation 29 visit.	

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

to account and incorporated in to the care plan. Registered Nurses in the home are fully aware of the referral processes. They refer to the Wound Link Nurse in the home for preliminary advice and refer to the Trust TVN at the earliest opportunity. The Podiatrist is also sent a referral if required. The Home Manager completes a Wound Analysis each month and forwards to the Regional Manager. The Regional Manager will also randomly select wounds and supporting documentation as a theme to her Regulation 29 visits to further quality assure the care plans and assessments. Where a resident is at risk of developing pressure sores, a PMAP or Pressure Management Action Plan is commenced and this assists in devising the care plan. The equipment is reviewed and additional equipment purchased where necessary. Where the admission is emergency and the home does not have a suitable pressure relieving mattress, the admission would only go ahead if the Trust provides a mattress in the interim until the new mattress is in place. The Registered Nurse refers a resident to the dietician based on the MUST score and their own clinical judgement. All dietician forms are held in the care file. These are faxed to the Dietician but telephone advice can be sought in the interim. The care plan will be further devised on consultation with the professional advice. The Regional Manager will randomly select Nutrition as part of her Regulation 29 audit and will view residents at high risk/with recent weight loss.	

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The care files are reviewed monthly or as condition changes. The plan of care would dictate the frequency of the reviews required. The resident is assessed daily and reported on the progress charts and care plan evaluation forms. Changes are reported on a 24 hour shift report and left for the Home Manager. The Home Manager and Regional Manager will audit Care Plans. The named person in the Trust will also be notified of any changes and will review the care plans during review or more frequently if there are significant changes	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**
The Home refers to up to date guidelines as defined by the professional bodies and national standards setting organisations. Guidelines from NICE, GAIN, RCN,NIPEC, HSPPS, PHA and RQIA are available to all staff to refer to. The pressure ulcer grading tool is the EPUAP. If a pressure ulcer is identified then an initial wound assessment is completed with a plan of care which includes the grade of the ulcer, dressing regime, frequency of repositioning, mattress type etc. An ongoing wound assessment is completed at each dressing change. The wound is photographed if consent has been given. Ongoing measurements are made and progress commented on. There are up to date guidelines available for all staff in respect of Nutrition. There is extensive information on Four Seasons Intranet on Nutrition. Where necessary, additional training would be sourced e.g in the event of the home having a resident with a PEG Percutaneous Endoscopic Gastrostomy.	Substantially compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are contemporaneous and are in accordance with the NMC guidelines. All care delivered includes an evaluation. Nurses have access to NMC guidelines and Nurses are given additional training in Care Planning and Person Centred Care. Records of the meals provided are recorded at each mealtime on a daily menu choice form. The Catering Manager retains records of food served and keeps up to date information on specialist dietary needs. Residents who are assessed as being at risk of malnutrition, dehydration or excessive eating have their food and fluids recorded in detail using the Four Seasons documentation. The fluid charts are totalled and the nurse comments /makes actions as required. Referrals will be made as necessary.	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The care provided is reflected in the daily statements made by the nurses. There will be a minimum of one entry during the day and one at night. The care plan is updated/re-written where necessary i.e if condition changes or if a visiting professional makes recommendations. The Residents/Representatives will read and sign the care plans to indicate their participation and agreement.	Moving towards complian

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care Management reviews are generally held within 6-8 weeks post admission and then annually thereafter. Emergency reviews will be arranged where the staff have identified persistent issues and difficulties. Where a resident/representative expresses dissatisfaction with the home then a review is generally called so that all parties can discuss concerns and devise action plan to rectify any issues. The Trust are responsible for arranging these reviews however where they are not held in a timely manner then the Home Manager arranges Home Reviews until the Trust review can take place. The Home receives the written report of the review from the Named Person in the Trust.	Substantially compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
On admission the residents needs and choices are established and documented in the care plan. The Catering staff are given written notification of each new admission and regular updates on existing residents when changes occur. The Catering staff meet regularly with the residents and records are kept of organised meetings. Relatives are kept informed at Relative Meetings of any proposed changes. Dietetic and Speech and Language instructions are kept in the residnets files and incorporated in to the care plan. The Catering Staff meet regularly with the Home Manager and the Regional Manager observes meals during her Regulation 29 visits. The Catering Staff have support from the Four Seasons Catering Managers to devise variations in menus and they also complete food questionnaires with the Residents. Residents are offered a choice of two meals and dessert at each meal time however where a resident refuses then an alternative is made available	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Staff have received training in Dysphagia and records are kept in the Training file. The Catering Team met with the Four Seasons Catering Manager in March 2014 and had training in thickening foods and pureed diets etc. All recommendations are incorporated in to the care plan. The Catering Staff retain an up to date list provided by the Nursing staff. The Care Staff have "Easy Guides" made out indicating type of diet/fluid/personal preferences for each resident and are located in the dining room. Staff are given training on how to deal with the choking resident through their Basic Life Support practical training and also have to complete e-learning in first aid. Each unit has a suction	Substantially compliant

machine and Registered Nurses are present at each mealtime. Meals are served as follows: Breakfast - 8.30am - 10.30am Morning Tea - 11am Lunch - 12.30pm - 1.30pm Afternoon Tea - 3pm Evening Tea - 4.30pm - 5.30pm Supper - 8.15pm - 9pm These are the usual times in the home but a resident can request outside of these times or if going out to an appointment or late back in from appointment. They are encouraged to use the dining room but can eat in their own bedroom if preferred. Drinks are available 24 hours per day and are refreshed as required. Residents have equipment provided as required in order to maintain independence and dignity. Registered Nurses have completed the Pressure Area care module on e-learning. The home has a Wound Care Link Nurse who is presently completing supervisions and competencies on the other nurses to ensure a consistent approach to wound care. Where the dressing is complex then the Tissue Viability Nurse from the Trust would give additional support and guidance and supervision.	

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.

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Primary Inspection

Ardlough Care Home

01 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 **Mrs Louisa Rea, Regional Manager and Mrs Martina Mullan, Registered Manager** either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	20 (1) (c) (i)	The registered person shall ensure that staff as appropriate are trained in cardio pulmonary resuscitation. **Ref: Follow up to previous issues**	Two	Training has been arranged for the 17th October for the appropriate staff.	Two Months
2	16 (2) (b)	The registered person shall ensure that care plans are reviewed and updated monthly or more often if deemed appropriate. **Ref: Management of Nursing Care**	Two	Staff meeting was held on the 12th and 14th September, discussed care file documentation. A planner has been commenced with specific dates for individual residents care plans and assessments to be completed on a monthly basis or more often as needed. As part of the monthly audit process the home manager will review the bedrail assessments for compliance .	From the date of this inspection
3	16(2)(b)	The registered person shall ensure that patients' bed rail risk assessments are reviewed and updated monthly or more often as deemed appropriate. **Ref: Management of Nursing Care**	One		From the date of this inspection.
4	16 (1)	The registered person shall ensure that a specific care plan on pain management is maintained in care plans for patients who require wound care intervention. **Ref: Management of wounds and pressure ulcers**	One	A care plan for pain management has been put in place were resdents require wound care intervention. This is evaluated at least monthly or more often if required.	From the date of this inspection

5	16 (1)	The registered person shall ensure that patients recommended daily targets and the action to be taken if these targets are not being achieved be recorded in patients care plans on eating and drinking. **Ref: Management of dehydration**	One	This was discussed at the staff meetings on the 12th and 14th September. The nurse in charge is reviewing the charts regularly to ensure that targets have been met and recording in the care plans what action has been taken to address if this has not been met .	From the date of this inspection
6	12(4)(a)	The registered person shall ensure that food and fluids are prepared in adequate quantities and at appropriate intervals **Ref :Management of dehydration**	One	Food and fluids are available throughout the day and night for residents to access if required.	From the date of this inspection
7	27 (2) (d)	The registered person shall ensure that the identified chair in the Evergreen sitting room is deep cleaned. **Ref: Section 11 point 11.10 (Additional Areas Examined)**	One	The identified chair was removed from the home on the day of the inspection and replaced.	Two Months

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.3	It is recommended that written evidence is maintained in patients care records to indicate that discussions had taken place with patients and/or their representatives in regard to planning and agreeing nursing interventions. **Ref: Management of pressure ulcers and wound care**	One	This was discussed at the statt meetings held on the 12th and 14th September and staff were advised to record any discussions with relatives in relation to planned and agreed nursing interventions.	One Month
2	5.2	It is recommended that a pain assessment be maintained in patients care records. (if applicable) **Ref: Management of pressure ulcers and wound care**	One	Any resident who is prescribed analgesia now has a pain assessment in place.	From the date of this inspection
3	12.10	It is recommended that the daily menu is displayed in a suitable format and in appropriate location, so that patients, and their representatives, know what is available at each mealtime. **Ref: Management of Nutritional Needs and weight loss**	One	A daily menu display board has been ordered and awaiting the delivery of same.	From the date of this inspection

4	5.4	It is recommended that monthly audits of patients care records are undertaken in the home. **Ref: Management of Nursing Care**	One	Audits have been carried out on residents files and tthis will be completed regularly	One Week

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	Martina Mullan
Name of Responsible Person / Identified Responsible Person Approving Qip	Jim McCall J RICHARDSON DIRECTOR OF OPERATIONS 7.10.14

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

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Heather Moore	08 October 2014
Further information requested from provider			