Announced Primary Inspection

Name of Establishment:	**Culmore Manor Care Centre**
Establishment ID No:	**1172**
Date of Inspection:	**25 June 2014**
Inspector's Name:	**Heather Moore**
Inspection No:	**16499**

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

Name of Home:	Culmore Manor Care Centre
Address:	39 Culmore Road Londonderry BT48 8JB
Telephone Number:	028 7135 9302
E mail Address:	ciaran.burke@larchwoodni.com
Registered Organisation/ Registered Provider:	Larchwood Care Homes (NI) Ltd Mr Ciaran Sheehan
Registered Manager:	Mr Ciaran Burke
Person in Charge of the Home at the time of Inspection:	Mr Ciaran Burke
Registered Categories of Care and number of places:	NH-I, NH-PH 56
Number of Patients Accommodated on Day of Inspection **Scale of charges(per week)**	54 £581.00 - £624.00
Date and time of this inspection:	25 June 2014: 08.15 hours - 16.00 hours
Date and type of previous inspection:	08 January 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:

- 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	**6**
Staff	**10**
Relatives	**3**
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	**3**	**3**
Staff	**10**	**8**

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

Culmore Manor Care Centre is situated in its own landscaped grounds off the Culmore Road on the outskirts of Derry city. The home runs adjacent to the Foyle Bridge and is conveniently accessible to the public.

The home is registered to provide care in the following categories:

Nursing Care

- NH I - Old age not falling within any other category
- NH - PH - Physical disability other than sensory impairment

Facilities are provided over two floors with bedroom accommodation on both floors. The home now operates single occupancy bedrooms some with ensuite facilities. Access to the first floor is via a passenger through floor lift and stairs.

Dining room and day room facilities are provided on both floors of the home.

Laundry and sluicing facilities are also available and the home is well maintained and features many home comforts.

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 Culmore Manor Care Centre. The inspection was undertaken by Heather Moore on 25 June 2014 from 08.15 hours to 16.00 hours.

The inspector was welcomed into the home by Mr Ciaran Burke, Registered Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given 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 three relatives. 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 three relatives 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 08 January 2014, two requirements and two recommendations were issued. These requirements and recommendations were reviewed during this inspection. The inspector evidenced that one requirement was addressed one requirement was substantially addressed and two recommendations had been fully complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

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

Standard 8: Nutritional needs of patients are met. (Selected criteria)
Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)
Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria)

Inspection Findings:

- **Management of Nursing Care – Standard 5**

The inspector can confirm that at the time of the inspection there was evidence to validate that patients receive safe and effective care in Culmore Manor Care Centre. 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.

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

A recommendation is made that care records are dated timed and signed appropriately.

There was also 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.

COMPLIANCE LEVEL : Compliant

- **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.

A recommendation is made that the patients' pressure relieving equipment in use on patients' beds and when sitting out of bed be addressed in patients' care plans on pressure area care and prevention.

Inspection of an identified patient's care record confirmed the absence a care plan on pain management. A requirement is made in this regard.

Examination also confirmed the absence of a patient's pain assessment. A recommendation is made that this be addressed.

Discussion with three relatives confirmed that registered nurses had undertaken discussions with them in regard to planning and agreeing nursing interventions however there was no written evidence in this regard. A recommendation is made in this regard.

Inspection of staff training records revealed that registered nurses required to be trained in care planning. A requirement is made that this be addressed.

COMPLIANCE LEVEL: Moving to 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. 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. Patients were observed to be assisted with dignity and respect throughout the meal.

COMPLIANCE LEVEL: Compliant

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

The inspector examined the management of dehydration during the inspection which evidenced that fluid requirements and intake details for patients were recorded and maintained for those patients assessed at risk of dehydration.

Patients were observed to be able to access fluids with ease throughout the inspection, staff were observed offering patients additional fluids throughout the inspection.

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

COMPLIANCE LEVEL: Compliant

Patients / their representatives and staff questionnaires

Some comments received from patients:

- “I am able to get pain relief when I need it.”
- “I have no problems here.”
- “Sometimes it is very short staffed.”
- “I feel that the home could have its own transport to take those who are able out more.”
- “Some residents are very noisy and shout especially at night it is very disturbing.”
- “The staff are very good and kind.”

Some comments received from patients’ representatives:

- “My recent experience is that the home is good / very good.”
- “I have no problems the staff are all very good.”
- “I feel that the staff are rushed of their feet they are too busy.”

Some comments received from staff;

- “Some staff goes above and beyond their duties to residents to ensure a friendly atmosphere with in the home.”
- “Staff doesn’t always have time to talk to the residents on a one to one basis.”
- “Home is very clean and friendly, recent improvements to the home are very appealing.”
- “Sometimes it’s very demanding some of the patients are very challenging.”
- “I have worked here for 11 years with a great team I think dependency levels of patients are not taken into account when sorting out staffing levels.”

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 good standard. 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. Four requirements, one restated requirement 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 relatives, registered manager, registered nurses and staff for their assistance and co-operation throughout the inspection process.

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

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	16 (2)	The registered person shall ensure that patients' care plans and bedrail risk assessments are reviewed monthly or more often if deemed appropriate.	Inspection of three patients care records confirmed that patients' care plans and bedrails were reviewed monthly or more often if deemed appropriate.	Compliant
2	27 (2) (b)	The registered person shall ensure that the following environmental issues should be addressed: • Repaint toilet (Room 20) • Replace identified bedroom carpet • Replace worn chipped vanity units • Replace identified bedroom curtains • Replace curtains in dayroom (downstairs).	The inspector inspected the home environment and the following issues were addressed: • Toilet was repainted • Identified bedroom carpet was replaced • Worn chipped vanity units were not replaced • Identified bedroom curtains were replaced • Curtains in day room were not replaced. **Restated**	Substantially 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 2012 are accessible to staff to enable them to become familiar with the content of these guidelines.	The Resuscitation Guidelines were available in 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 checks of the emergency equipment confirmed that daily records were maintained.	**Compliant**

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

Since the previous inspection on the 18 January 2014, RQIA have received two notifications of safe guarding of vulnerable adult (SOVA) incidents in respect of Culmore Manor Care Centre.

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 30 minutes each.

The inspector observed the patients' lunch meal which was served in the dining rooms.

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.

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.

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 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/Staff Training

On the day of inspection registered nurses and care staff, staffing levels were satisfactory however the inspector examined a sample of staff duty rosters from the previous weeks.

Inspection confirmed that care staff, staffing levels for day and night duty were in accordance with the RQIA's recommended minimum staffing guidelines however examination of registered nurses staffing levels revealed a shortfall in one registered nurse from 8am-2pm. A requirement is made in this regard. In making this requirement it is acknowledged that the registered manager had made efforts to maintain registered nurses staffing levels however there was a turnover of registered nurses during this period.

Inspection of staff training records revealed that a small number of staff required training in Moving and Handling, and Fire Awareness. A requirement is made in this regard.

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

Examples of staff comments were for as follows:

- "Some staff goes above and beyond their duties to residents to ensure a friendly atmosphere with in the home."
- "Staff doesn't always have the time to talk to the residents on a one to one basis."
- "Home is very clean and friendly, recent improvements to the home are very appealing."
- "Sometimes it's very demanding some of the patients are very challenging."
- "I have worked here for 11 years with a great team I think dependency levels of patients are not taken into account when sorting out staffing levels."

11.9 Patients' Comments

The inspector spoke to six patients individually and with others in groups. Six patients completed questionnaires.

Examples of their comments were as follows:

- "I am able to get pain relief when I need it."
- "I have no problems here."
- "Sometimes it is very short staffed."
- "I feel that the home could have its own transport to take those who are able out more."
- "Some residents are very noisy and shout especially at night it is very disturbing."
- "The staff are very good and kind."

11.10 Relatives' Comments

The inspector spoke to three relatives and these relatives completed questionnaires.

An example of the relative's comments is:

- "My recent experience is that the home is good / very good."
- "I have no problems the staff are all very good."
- "I Feel that the staff are rushed of their feet they are too busy."

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 warm, generally clean and comfortable. However a requirement is restated in regard to the replacement of chipped, worn vanity units and also the replacement of curtains in the day room.

A requirement is also made that the identified patients' bedroom carpets are replaced.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr Ciaran Burke, 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
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Tyrone & Fermanagh Hospital
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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**
A pre admission assessment is carried and documented out prior to admission. This is informed by Care Management documentation including NISAT, medical, nursing and other relevant professionals reports. An agreed plan of care is drawn up to ensure immediate care needs are met. A comprehensive, holistic assessment is completed with 11 days of admission.Relevant risk assessments are completed including MUST, pressure ulcer risk incorporating nutritional, pain and continence assessments.	Compliant

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

where appropriate.Planned interventions promote maximum independence taking into account advice and recommendations from relevant professionals.Where appropriate referrals are made to relevant services such as Tissue Viability, Chiropody/Podiatry and Dieticians. Utilising advice and guidance from these services, a pressure ulcer prevention and treatment plan is drawn up, agreed and put in place.	
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 care plans, assesssments and interventions are reviewed and updated at least monthly or more frequently as required as part of the ongoing assessment process.	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**
All nursing interventions, activities and procedures are supported and guided by evidence based research as issued by professional bodies and national standard setting organisations eg NICE guidelines which are available for staff to reference at all times.Re A validated pressure ulcer grading tool is used i.e. Braden. Patients are screened and an appropriate treatment plan put in place.	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**
Records are maintained in accordance with NMC guidelines and these will include outcomes for patients. Meal details are recorded in sufficient detail to determine nutritional suitability. A daily record is kept of all food and drink taken and/or refused. Monthly weight records are recorded and actioned appropriately with other professionals.	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**
Care delivery outcomes are monitored and recorded daily. Care plans are reviewed at least monthly or more frequently as required.Formal care reviews are held involving Care Manager, resident/resident representative(s) and other professionals. These formal reviews take place at six weeks from admission, then after six months and thereafter annually.	Substantially 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**
Residents are encouraged and facilitated to participate in all care reviews including Trust arranged formal multidisciplinary review meetings. Where a resident is unable to attend in person his/her views are sought and relayed to the meeting as appropriate. Care review meeting documentation is completed prior to, during and at conclusion of meetings. These records are signed by all relevant parties and a written copy retained in care file. Agreed changes are made to care plans and residents and representatives updated on progress	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**
Residents are offered a varied, nutritious diet which meets individual needs and preferences and takes into account guidance from relevant documents.Special diets are also provided on individual basis e.g diabetic, gluten free, fat reducing, low sodium. Residents are offered a choice from menu at each mealtime and if this is not preferred an alternative meal is provided to residents preference.	Substantially 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**
Residents with swallowing difficulties have their needs fully documented in care plans. Care plans are devised, implemented and reviewed taking into consideration relevant knowledge and advice from relevant professionals. Instructions and guidance from speech and language therapists inform the care plan. Staff are trained in first aid measures including management of a choking incident. Meals are provided at regular intervals throughout each day with hot and cold snacks available on demand. Hot and cold drinks including fresh drinking water are available at all times. Meals are provided in staffed dining areas or individually in bedrooms/communal areas and are staffed according to assessed individual risk. Specialist aids and equipment are available for individual use. Residents individual eating and drinking requirements are fully detailed in care plans. Where a resident requires wound care nurses have the the expertise and skills required to enable effective wound management. This is informed via input from tissue viability specialist with advice and guidance received detailed within the care plan. Wound care training is facilitated and includes specialist training provided by professionals from suppliers of wound care products and dressings	Substantially compliant

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

Announced Primary Inspection

Culmore Manor Care Centre

25 June 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with **Mr Ciaran Burke, 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	16 (1)	The registered person shall ensure that a pain management care plan is maintained for patients who require wound care intervention. **Ref: Management of Wounds and Pressure Ulcers**	One	Documentation has been updated to include a pain management care plan where appropriate.	One Week
2	27 (2) (b) 13 (7)	The registered person shall ensure that the identified bedroom carpets are replaced. **Ref: Section11 point 11.12 (Additional Areas Examined)**	One	Programme to replace bedroom carpets has been initiated and shall aim to be completed within the stated timescale.	Three Months
3	27 (2) (b)	The registered person shall ensure that the following issues are addressed: • Replace chipped vanity units • Replace curtains in the day room **Ref: Section 11 point 11.12 (Additional Areas Examined)**	Two	Programme to replace vanity units and identified curtains has been initiated and shall aim be completed within the stated timescale.	Three Months
4	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,	One	Registerd nurse levels are as required including 4 registered nurses on duty each morning.	From the date of this inspection

		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. **Ref Section11 point 11.8 (Additional Areas Examined)**			
5	20 (1) (c) (i)	The registered person shall ensure that staff as appropriate are trained in the following areas: • Moving and Handling • Fire Safety • Care planning (registered nurses). **Ref Management of Wounds and Pressure Ulcers** **Ref: Section 11 point 11.8 (Additional Areas Examined)**	One	Moving and Handling has been completed. Fire Safety And Care Planning sessions are scheduled within the timescale.	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 the patients' pressure relieving equipment in use on patients' beds and when sitting out of bed be addressed in patients' care plans on pressure area care and prevention. **Ref: Management of Wounds and Pressure Ulcers**	One	Pressure relieving equipment is identified in care plans where appropriate.	One week
2	5.2	It is recommended that a pain assessment be maintained in patients' care records (if applicable). **Ref: Management of Wounds and Pressure Ulcers**	One	Pain assessments are maintained in care records where applicable	One week
3	5.3	It is recommended that written evidence is maintained in patients' care records to indicate that discussions had taken place with patients, and their representatives in regard to planning and agreeing nursing interventions. **Ref: Management of Wounds and Pressure Ulcers**	One	Written evidence is maintained to indicate discussion/agreement with residents/representatives in regard to care planning.	One week
4	6.2	It is recommended that all entries in case records are dated, timed and signed, and	One	Date entry format has been amended.	From the date of this

		made in such a way that the original entry can still be read. **Ref : Management of Nursing Care**			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	Ciaran Burke
Name of Responsible Person / Identified Responsible Person Approving Qip	Ciaran Sheehan

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	yes		19.8.14
Further information requested from provider			