Announced Primary Inspection

Name of Establishment:	**Meadowbank**
Establishment ID No:	**1186**
Date of Inspection:	**6 May 2014**
Inspector's Name:	**Teresa Ryan**
Inspection No:	**17125**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Home:	Meadowbank
Address:	11A Trench Road Derry BT47 2DT
Telephone Number:	028 7134 7281
E mail Address:	deborah.macartney@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Healthcare Mr James McCall
Registered Manager:	Mrs Louise McCloskey, currently acting manager of the home; registered manager of a sister home, Four Seasons Health Care.
Person in Charge of the Home at the time of Inspection:	Mrs Louise McCloskey
Categories of Care:	NH-LD,NH-LD(E)
Number of Registered Places:	35 patients
Number of Patients and Residents Accommodated on Day of Inspection:	31
Scale of Charges (per week):	£567.00 - £610.00
Date and type of previous inspection:	12 February 2014 Secondary Unannounced
Date and time of inspection	06 May 2014 08.15 hours - 17.00 hours
Name of Lead Inspector:	Teresa Ryan

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 Mr John Coyle Peripatetic Manager

- discussion with the registered manager
- discussion with staff
- 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	**Five patients individually and to others in groups**
Staff	**16**
Relatives	**3**
Visiting Professionals	**-**

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

Issued To	**Number issued**	**Number returned**
Patients / Residents	**5**	**5**
Relatives / Representatives	**6**	**3**
Staff	**15**	**15**

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 registered persons and the inspector have rated the home's compliance level against each criterion of the standard and also against each standard.

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

Meadowbank is situated in a quiet residential area, a short distance from the centre of Londonderry.

The nursing home is owned and operated by Four Seasons Healthcare. Mrs Louise McCloskey is the current acting manager of the home.

The home is divided into two units, “Oakwood” and “Cedar wood” and comprises of 31 single bedrooms (one en-suite) and two double bedrooms (one en-suite), a choice of five sitting rooms, a main kitchen, two dining rooms, toilet/washing facilities, staff accommodation, office and laundry facilities.

A secure garden is provided at the back of the home. The grounds around the home were well maintained and the manager informed the inspector that arrangements were in place to provide a sensory garden for the patients. Adequate car parking facilities are provided at the front of the home.

The home is registered to provide care for a maximum of 35 patients under the following categories of care:

Nursing care
LD – Learning disability
LD (E) - Learning disability over 65 years

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary announced inspection to Meadowbank Private Nursing Home. The inspection was undertaken by Teresa Ryan on Tuesday 06 May 2014 from 08.15 hours to 17.00 hours.

The inspector was welcomed into the home by Mrs Louise McCloskey, Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was provided to Mr John Coyle, Peripatetic Manager, Four Seasons Healthcare and Mrs McCloskey.

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. This self- assessment is appended to this report at Appendix One.

During the course of the inspection, the inspector met with patients, staff and three visiting 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 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 12 February 2014 two requirements and two recommendations were issued. These were reviewed during this inspection. The inspector evidenced that the requirements and 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**

There was evidence of comprehensive and detailed assessment of patient needs from the 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. However there were no infection control assessments undertaken for patients and a recommendation is made that this be addressed. In making this recommendation it is acknowledged that care plans on infection control were in place for patients. The assessment of patient needs was evidenced to inform the care planning process.

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

- **Management of Wounds and Pressure Ulcers – Standard 11**

On the day of inspection the manager informed the inspector that there were currently no patients in the home who required wound management intervention for wounds/pressure ulcers. However there were a number of patients in the home who had been assessed as being at risk of developing pressure ulcers/wounds. Review of two of these patients' care records revealed preventative care plans were in place. These care plans were reviewed on a monthly or more often basis as required. Care plans for the management of risks of pressure ulcers were maintained to a professional standard.

- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**

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. A recommendation is made that the menu planner be reviewed to address all choices available for patients including for patients on therapeutic diets. Choices provided for snacks should be varied.

- **Management of Dehydration – Standard 12**

The inspector also examined the management of dehydration during the inspection. The home was evidenced to identify fluid requirements for patients and records were maintained of the fluid intake of those patients assessed at risk of dehydration.

Concern was raised however that the fluid intake records for one identified patient were not completed over the night duty period. This omission to record fluid intake for night time hours means that the total fluid intake cannot be accurately reconciled. This issue has been raised as a requirement in the quality improvement plan.

Staff were observed offering fluids to patients at regular intervals throughout the day.

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

Patients / their representatives and staff questionnaires

Some comments received from patients and their representatives;

"Wonderful this is a good home"
"Staff treat me and my belongings with respect"
"Staff are aware of the help I need with eating and drinking"
"I feel safe in the home, I am happy"
"Very pleased with the standard of care provided in Meadowbank"
"I feel confident to express my views on how my relative is being cared for in the home".

Some comments received from staff;

"I had induction when I commenced work"
"The quality of care in the home is very good and staff treat the patients very well"
"The home is at its best at the moment with regard to personal care and the provision of activities to patients"
"The standard of care is at the possible highest standard, staff work as part of a team and patients are happy due to the provision of additional activities".

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 *and visiting professionals*
- environment

One requirement is made in regard to the high dusting in the home and one is made in regard to a malodour in an identified patient's bedroom.

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 patients were observed to be treated with dignity and respect. However areas for improvement are identified. Three requirements and two 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, peripatetic manager, manager, deputy manager, registered nurse 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 (1) (2)	It is required that patients' care records be reviewed and updated in order to ensure that care plans fully reflect the patients' assessed needs.	Review of a sample of patients' care records revealed that these had been reviewed and updated since the previous inspection. The patients' care plans reflected their assessed needs.	Compliant
2	15 (2) (a) (b)	The registered person shall ensure that the assessment of the patient's needs is kept under review and revised at any time when it is necessary to do so having regard to any change of circumstances, and in any case not less than annually.	The manager informed the inspector that all patients' assessment of needs had been reviewed and updated since the previous inspection. Review of four patients' care records revealed that these patients' assessment of needs had been reviewed and updated.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	5.3	It is recommended that the roles and responsibilities of named nurses be outlined in the Patient's Guide.	Review of the Patient's Guide revealed that this recommendation had been addressed.	Compliant
2	5.4 5.6 5.7	It is recommended that monthly reviews of patients' care plans and supplementary assessments fully address the care prescribed in care plans and the outcome of assessments. It is recommended that the daily evaluations of care and treatment provided fully reflect the care prescribed in patients' care plans. It is recommended that all entries and additions to care records be dated, timed and signed.	Review of four patients' care records revealed that all elements of this recommendation were being addressed.	Compliant

10.0 Inspection Findings

Section A

Standard : 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**

Standard 5.2

- **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission**

Standard 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**

Standard 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.**

Inspection Findings:

Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

The inspector reviewed four patients' care records which evidenced that patients' individual needs were established on the day of admission to the nursing home through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks.

Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, pain, Bristol stool chart and continence were also completed on admission. However infection control assessments were not undertaken for these patients. A recommendation is made that this shortfall be addressed. In making this recommendation it is acknowledged that care plans on infection control were in place for patients.

Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure ulcer/wound and if required, the specific care plans regarding the management of the pressure ulcer/wound. The manager informed the inspector that there were currently no patients in the home who required wound management intervention for a wound / pressure ulcer.

Review of four patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 11 days of patient's admission to the home.

In discussion with the manager and deputy manager they demonstrated a good awareness of the number and progress of patients who were assessed as being at risk of weight loss and dehydration.

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

Section B

Standard 5.3

- **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.**

Standard 11.2

- **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.**

Standard 11.3

- **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.**

Standard 11.8

- **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration**

Standard 8.3

- **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.**

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

Review of four patient's care records and discussion with patients, three visiting relatives and staff evidenced that patients as appropriate and their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Records also evidenced discussion with patients and/or their representatives following changes to the plans of care.

The manager informed the inspector that there were currently no patients in the home who required wound management intervention for a wound/pressure ulcer. However there were a number of patients assessed as being at risk of developing wounds/pressure ulcers. Review

of two of these patients' care records revealed the following;

- Body mapping charts were completed for the patients on admission. These charts were reviewed and updated when any changes occurred to the patients' skin condition.

- Care plans were in place which specified the pressure relieving equipment in place on the patients' beds and also when sitting out of bed.

- The type of mattresses in use was based on the outcome of the pressure risk assessments. The specialist mattresses in use were being safely used and records were available to reflect they were appropriately maintained.

- Daily repositioning and skin inspection charts were in place for the patients. Review of a sample of these charts revealed that patients' skin condition was inspected for evidence of change at each positional change. It was also revealed that patients were repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention.

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The manager and deputy manager confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local healthcare Trust. Staff spoken with were knowledgeable regarding the referral process. Discussion with one registered nurse evidenced that this nurse was knowledgeable of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient. A tissue viability link nurse was employed in the home which is commendable.

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

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

Daily records were maintained regarding the patients' daily food and fluid intake

Policies and procedures were in place for staff on making referrals to the dietician. These included indicators of the action to be taken and by whom. All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment.

Review of four patients' care records evidenced that two of these patients were referred for a dietetic assessment in a timely manner. The patients' care plans were reviewed and updated to address the dietician's recommendations.

Discussion with the manager, deputy manager, registered nurse, care staff and review of the staff training records revealed that staff were trained in wound management and pressure area care and prevention during the previous 12 months. Staff were also trained in the management of nutrition. Seventeen staff were trained in the use of the Malnutrition Universal Screening Tool (MUST) on 30 April 2014. Seventeen staff were trained in diabetes care in September 2013.

Patients' moving and handling needs were assessed and addressed in their care plans. There was evidence that manual handling aids were used to minimise risk of friction. Staff consulted confirmed there was sufficient nursing equipment available to move and handle patients' appropriately.

The manager, deputy manager and registered nurse informed the inspector that pressure ulcers were graded using an evidenced based classification system.

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

Section C

Standard 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 Homes Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**
Review of four patients' care records evidenced that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care for each patient. Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. As previously stated there were currently no patients in the home who require wound management intervention for wounds/pressure ulcers. Discussion with the manager and deputy manager and review of governance documents evidenced that a number of care records were audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

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

Section D

Standard 5.5
- **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.**

Standard 11.4
- **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.**

Standard 8.4
- **There are up to date nutritional guidelines that are in use by staff on a daily basis.**

Nursing Homes Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)

The inspector examined four patients' care records which evidenced the completion of validated assessment tools such as;

- the Roper, Logan and Tierney assessment of activities of daily living
- Braden pressure risk assessment tool
- Nutritional risk assessment - Malnutrition Universal Screening Tool (MUST)

The inspector confirmed the following research and guidance documents were available in the home;

- DHSSPS 'Promoting Good Nutrition' A Strategy for good nutritional care in adults in all care settings in Northern Ireland 2011-16
- The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.
- The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care
- The European Pressure Ulcer Advisory Panel (EPUAP)
- RCN/NMC guidance for practitioners.

Discussion with the manager, deputy manager and registered nurse confirmed that they had a good awareness of these guidelines. Review of patients' care records evidenced that the deputy manager and registered nurses implemented and applied this knowledge.

Registered nursing staff were found to be knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care.

Ten staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held in the kitchen/ dining room for easy access by staff**.** This is commendable practice.

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

Section E

Standard 5.6

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

Standard 12.11

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

Standard 12.12

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

A policy and procedure relating to nursing records management was available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

Registered nurses spoken with were aware of their accountability and responsibility regarding record keeping.

The manager confirmed that staff had received training on the importance of record keeping commensurate with their roles and responsibilities in the home.

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

Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patients' status or to indicate communication with other professionals/representatives concerning the patients. Entries were noted to be dated, timed and signed with the signature accompanied by the designation of the signatory.

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

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

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

Review of a sample of fluid balance charts for one identified patient revealed that there was evidence that the patient was not offered fluids from 20.00 hours to 09.30 hours the following morning. There was evidence that the patient was offered fluids on a regular basis throughout the day. This omission to record fluid intake for night time hours means that the total fluid intake cannot be accurately reconciled. The patients' recommended daily fluid intake was addressed in the patients' care plan.

A requirement is made that the registered person shall ensure that food and fluids are provided in adequate quantities and at appropriate intervals.

Staff spoken with were evidenced to be knowledgeable regarding patients' nutritional needs.

Staff had attended training in the management of nutrition during the previous 12 months.

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

Section F

Standard 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.**
Please refer to criterion examined in Section E. In addition the review of three patients' care records evidenced that consultation with the patient and/or their representative had taken place in relation to the planning of the patient's care. This is in keeping with the DHSSPS Minimum Standards and the Human Rights Act 1998.

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

Section G

Standard 5.8

- **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate**

Standard 5.9

- **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.**

Prior to the inspection a patients' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that all the patients in the home, with one exception had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014. The manager informed the inspector that arrangements were being put in place for this care review to be undertaken.

The manager informed the inspector that patients' care reviews were held post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff preferably the patient's named nurse attends each care review. The manager informed the inspector that she attends all patients' care reviews undertaken in the home. A copy of the report of the most recent care review was held in the patients' care records. Copies of the minutes of care reviews compiled by the referring HSC Trust were also held in the patients' care records.

The minutes of care reviews for a small number of patients were outstanding and these were received in the home on the day of inspection. The inspector viewed the minutes of four care management care reviews which evidenced that, where appropriate, patients and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended, an updated assessment of the patients' needs and a record of issues discussed. Care plans were evidenced to be updated post care review to reflect recommendations made where applicable.

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

Section H

Standard 12.1

- **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.**
  Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.

Standard 12.3

- **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.**
  A choice is also offered to those on therapeutic or specific diets.

A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance.

There was a four weekly menu planner in place. The manager informed the inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home.

The inspector discussed with the manager, deputy manager and a number of staff the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients.

Staff spoken with were knowledgeable regarding the individual dietary needs of patients to include their likes and dislikes. Discussion with staff and review of the record of the patient's meals confirmed that patients were offered choice prior to their meals.

Staff spoken with were knowledgeable regarding the indicators for onward referrals to the relevant professionals. eg. speech and language therapist and/ or dietician. Review of four patients' care records revealed that two of these patients had been seen by a speech and language therapist (SALT). This professional's recommendations were addressed in the patients' care plans on eating and drinking. Review of four patients' care records evidenced that two of these patients were referred for a dietetic assessment in a timely manner. The patients' care plans were reviewed and updated to address the dietician's recommendations. As previously stated under Section D relevant guidance documents were in place.

Review of the menu planner and records of patients' choices and discussion with a number of patients, manager, deputy manager, registered nurse and care staff revealed that choices were available at each meal time. These staff also confirmed choices were also available to patients who were on therapeutic diets. Review of the menu planner revealed that there was no variation to the choices recorded for the morning , afternoon and supper snacks. One choice was recorded for the dessert for the main meal of the day. However observation on the day of inspection and discussion with a number of patients and staff and review of a sample of food records for patients it was confirmed that there were a number of choices provided on a daily basis for the dessert. A recommendation is made that the menu planner be reviewed to address all choices available for patients including for patients on therapeutic diets. Choices provided for snacks should be varied.

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

Section I

Standard 8.6
- **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.**

Standard 12.5
- **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.**

Standard 12.10
- **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:**
  - **risks when patients are eating and drinking are managed**
  - **required assistance is provided**
  - **necessary aids and equipment are available for use.**

Standard 11.7
- **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.**

The inspector discussed the needs of the patients with the manager. It was determined that a number of patients had swallowing difficulties.

Review of training records revealed that 21 staff had attended training in dysphagia awareness during the previous12 months. First aid training was up to date for all staff. Catering staff were also trained in the preparation and presentation of pureed meals and the fortification of foods.

Review of two patients' care records evidenced that the recommendations made by the speech and language therapist were addressed. Discussion with the manager confirmed that meals were served at appropriate intervals throughout the day and in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.

The manager confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning, afternoon and at supper times.

The inspector observed that a choice of fluids to include fresh drinking water were available. Staff were observed offering patients fluids at regular intervals throughout the day.

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Ten staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held in the kitchen/ dining room for easy access by staff**.** This is commendable practice.

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

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

A tissue viability link nurse was employed in the home and registered nurses and care staff were trained in wound management and pressure area care and prevention..

Registered nurses were deemed competent in wound care through competency and capability assessments. The manager informed the inspector that all registered nurses competency and capability assessments were currently under review. The timescale for completion of this review was Friday 09 May 2014.

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

11.0 Additional Areas Examined

11.1 Records required to be held in the nursing home

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

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) DHSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspector discussed the Human Rights Act and Human Rights Legislation with the manager and a number of staff. The inspector can confirm that copies of these documents were available in the home. The manager and staff displayed an awareness of the details outlined in these documents. The manager informed the inspector that these documents will be discussed with staff during staff meetings and that staff will be made aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patients care and accompanying records. The inspector also discussed the Deprivation of Liberty Safeguards with the manager including the recording of best interest decisions on behalf of patients. A copy of DOLS was also 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 for approximately 30 minutes each. The inspector observed the lunch meal being served in the dining room and in the Cedar wood unit. The inspector also observed care practices during the provision of activities to patients. The observation tool used to record these observations was the Quality of Interaction Schedule (QUIS). This tool uses a simple coding system to record interactions between staff, patients and visitors.

Positive interactions	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 Two.

Observation of the lunch meal confirmed that meals were served promptly and assistance required by patients was delivered in a timely manner.

Staff were observed preparing and seating the patients for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients with their meal and patients were offered a choice of fluids. The staff explained to the patients their meal choice and provided appropriate assistance and support to the patients

Observation of care practices during the provision of activities to patients revealed staff initiated conversation with patients and listened to their views and was respectful in their interactions with them. Overall the periods of observation were positive in regard to the care of patients in the home.

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 during the inspection. This review revealed that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought. The manager informed the inspector that lessons learnt from investigations were acted upon.

11.6 Patient Finance Questionnaire

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

11.7 NMC declaration

Prior to the inspection the registered manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC). The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC.

11.8 Staffing/Staff Comments

Discussion with the manager and a number of staff, and review of a sample of staff duty rosters evidenced that the registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients currently in the home for day and night duty. Activity therapy staff were employed Monday to Friday for 60 hours per week. The manager informed the inspector that care staff also provide activities to the patients at weekends. Catering, laundry, administrative and maintenance staffing levels were found to be satisfactory. There was one housekeeper rostered on the day of inspection. In discussion with the manager and a number of staff it emerged that one of the housekeeping staff was off on special leave for a number of weeks and had not been replaced. In discussion with the manager she informed the inspector that bank staff covered this staff member's duties a number of

days per week and that arrangements were in place to roster two staff daily from Monday 12 May 2014.

Staff were provided with a variety of relevant training including learning disability awareness, enteral feeding systems and mandatory training since the previous inspection and this is commendable.

During the inspection the inspector spoke to16 staff. The inspector was able to speak to a number of these staff individually and in private. On the day of inspection 15 staff completed questionnaires. The following are examples of staff comments during the inspection and in questionnaires;

"I had induction when I commenced work"
"The quality of care in the home is very good and staff treat the patients very well"
"The home is at its best at the moment with regard to personal care and the provision of activities to patients"
"The standard of care is at the possible highest standard, staff work as part of a team and patients are happy due to the provision of additional activities"
"I think the home is a better place at present for patients and staff"
"I find a big change in the atmosphere in the home, patients seem more happy plus we are getting positive feedback for the patients' families"
"Meadowbank has drastically changed for the better, staff morale is better and staff seem happier"
"At present I am working on my own, finding it hard to get cover especially at weekends"
"I would rather have face to face training as opposed to training through e-learning"
"We would benefit from training on the application of wound care products".

11.9 Patients' Comments

Due to the category of care only a small number of patients were able to express their views. During the inspection the inspector spoke to five patients individually and to a number in groups. The patients consulted who were unable to express their views verbally expressed their satisfaction through positive gestures with the standard of care provided in the home. On the day of inspection three patients were assisted by staff in the completion of questionnaires. The following are examples of patients' comments during the inspection and in questionnaires.

"Wonderful this is a good home"
"Staff treat me and my belongings with respect"
"Staff are aware of the help I need with eating and drinking"
"I feel safe in the home, I am happy"
Staff can make me a snack and a cup of tea at any time"
"Staff are always polite to me, I am happy here"
Staff always respect my privacy and they always knock my door before entering"
"I feel safe in this home"
"My family member discusses my care".

11.10 Relatives' Comments

During the inspection the inspector spoke to three relatives. These relatives completed questionnaires. The following are examples of relatives' comments during inspection and in questionnaires;

"Very pleased with the standard of care provided in Meadowbank"
"I feel confident to express my views on how my relative is being cared for in the home"
"Staff provide me with sufficient information in regard to the care of my relative"
"Staff make me feel welcome in the home"
"Could not be better I am very pleased".

11.11 Environment

During the inspection the inspector undertook a tour of the premises and viewed the patients' bedrooms, sitting areas, dining room, laundry, bath/shower and toilet facilities. During this tour it was revealed that the high dusting especially the tops of patients' wardrobes requires to be addressed. There was a malodour in one of the patients' bedrooms and this also requires to be addressed. Two requirements are made in this regard. In making these requirements the improvements in the environment standards are acknowledged.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr John Coyle, Peripatetic Manager, Four Seasons Healthcare and Mrs Louise McCloskey, 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:

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Tyrone and Fermanagh Hospital
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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 a designated representative from the home carries out a pre admission assessment. Information gleaned from the resident/representative (where possible), the care records and information from the Care Management Team informs this assessment. Risk assessments such as the Braden Tool are carried out, if possible, at this stage. Following a review of all information a decision is made in regard to the home's ability to meet the needs of the resident. If the admission is an emergency admission and a pre admission is not possible in the resident's current location then - a pre admission assessment is completed over the telephone with written comprehensive, multidisciplinary information regarding the resident being faxed or left into the home. Only when the Manager is satisfied that the home can meet the residents needs will the admission take place.	Substantially compliant

On admission to the home an identified nurse completes initial assessments using a patient centred approach. The nurse communicates with the resident and/or representative, refers to the pre admission assessment and to information received from the care management team to assist her/him in this process. There are two documents completed within twelve hours of admission - an Admission Assessment which includes photography consent, record of personal effects and a record of 'My Preferences' and a Needs Assessment which includes 16 areas of need - the additional comments section within each of the 16 sections includes additional necessary information that is required to formulate a person centred plan of care for the Resident. In addidtion to these two documents, the nurse completes risk assessments immedidiately on admission. These include a skin assessment using the Braden Tool, a body map, an initial wound assessment (if required), a moving and handling assessment, a falls risk assessment, bed rail assessment, a pain assessment and nutritional assessments including the MUST tool, FSHC nutritional and oral assessment. Other risk assessments that are completed within seven days of admission are a continence assessment and a bowel assessment, Following discussion with the resident/representative, and using the nurse's clinical judgement, a plan of care is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations. This can be evidenced in the care plan and consent forms. The Home Manager and Regional Manager will complete audits on a regular basis to quality assure this process	

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**
named nurse completes a comprehensive and holistic assessment of the resident's care needs using the assessment tools as cited in section A, within 7 days of admission. The named nurse devises care plans to meet identified needs and in consultation with the resident/representative. The care plans demonstrate the promotion of maximum independence and focuses on what the	Substantially compliant

resident can do for themselves as well as what assistance is required. Any recommendations made by other members of the mutidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable. Registered nurses in the home are fully aware of the process of referral to a TVN when necessary. There are referral forms held in a designated file in the nurse's office, the Tissue Viability Nurse's details are also held in this file - name, address and telephone no. Once the form has been sent it, is then followed up by a telephone call to the TVN where advice can be given prior to their visit. Referrals are also made via this process in relation to residents who have lower limb or foot ulceration to either the TVN or a podiatrist. If necessary, a further referral is made to a vascular surgeon by the G.P, TVN or podiatrist. Where a resident is assessed as being 'at risk' of developing pressure ulcers, a Pressure Ulcer Management and Treatment plan is commenced. A care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. The care plan will give due consideration to advice received from other multidisciplinary members. The treatment plan is agreed with the resident/representative, Care Management and relevant members of the MDT. The Regional Manager is informed via a monthly report and during the Reg 29 visit. The Registered Nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Dietician referral forms are held within the home. These forms can be completed by staff in the home and faxed directly to the dietician for referral. The dietician is also available over the telephone for advice until she is able to visit the resident. All advice, treatment or recommendations are recorded on the MDT form with a subsequent care plan being compiled or current care plan being updated to reflect the advice and recommendations. The care plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in the home and other members of the MDT are kept informed of any changes.	

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**
he Needs Assessment, risk assessments and care plans are reviewed and evaluated at a minimum of once a month or more often if there is a change in the resident's condition. The plan of care dictates the frequency of review and re assessment, with the agreed time interval recorded on the plan of care. The resident is assessed on an ongoing daily basis with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the Home Manager's attention. The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.	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 professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to. The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading sysytem. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime or if the condition of the pressure ulcer changes. There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', ' PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in relation to nutritional care, diabetic care, care of subcuteanous fluids and care of percutaneous endoscopic gastrostomy (PEG)..	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 comtemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines - Record keeping:Guidance for nurses and midwives. Records of the meals provided for each resident at each mealtime are recorded on a daily menu choice form. The Catering Manager also keeps records of the food served and include any specialist dietary needs. Residents who are assessed as being 'at risk' of malnutrition, dehyration or eating excessively have all their food and fluids recorded in detail on a daily basis using a FSHC food record booklet or fluid record booklet. These charts are recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. The nurse utilises the information contained in these	Substantially compliant

charts in their daily evaluation. Any deficits are identified with appropriate action being taken and with referrals made to the relevant MDT member as necessary. Any changes to the resident's plan of care is discussed with them and/or their representative. Care records are audited on a regular basis by the Manager with an action plan compiled to address any deficits or areas for improvement - this is discussed during supervision sessions with each nurse as necessary.	

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care delivered is monitored and recorded on a daily basis on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan of care or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their represenatatives are involved in the evaluation process.	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**
Care Management Reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the resident's file. Any recommendations made are actioned by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals. Reviews are ongoing at present and are being chaired by Caroline Bradley Team Leader with the Trust. We are still completing the reviews and we have some scheduled but still some to schedule. Care Manager is aware of same.	Moving towards compliance

Section H

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

Criterion 12.1

- **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.**
  Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.

Criterion 12.3

- **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.**
  A choice is also offered to those on therapeutic or specific diets.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
The home follows FSHC policy and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs on admission and review on an ongoing basis. The care plan reflects type of diet, any special dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if necessary. The home has a 4 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives - residents meetings, one to one meetings and food questionnaires. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied. Copies of instructions and recommendations from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs. Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything from the daily	Substantially compliant

menu an alternative meal of their choice is provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room, with the 4 week menu displayed in a menu display folder and on the wall outside the kitchen.	

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 on dysphagia on15/10/13. Further training on enteral feeding and feeding techiques is arranged for all care and kitchen staff for this month. Date to be confirmed. The Speech and Language therapist and dietician also give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document - 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for feeding, equipment to use and assistance required. The kitchen receive a copy of the SALT's recommendations and this is kept on file for reference by the kitchen. Special diets are displayed on a white board in the fridge room. Meals are served at the following times:-	Substantially compliant

Breakfast - 9am-10.30am Morning tea - 11am Lunch - 12.40pm-12.50pm Afternoon tea - 3pm Evening tea - 4.50pm Supper - 7.30pm-8pm There are variations to the above if a resident requests to have their meals outside of these times. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. There are foods available outside of these times for those resident's who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedrooms, these are replenished on a regular basis. Any matters concerning a resident's eating and drinking are detailed on each individual care plan - including for eg. likes and dislikes, type of diet, consistency of fluid, any special equipment required and if assistance is required. A diet notification form is completed for each resident with a copy given to the kitchen and one held in the care file. Meals are not served unless a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Appropriate aids such as plate guards and specialised cutlery are available as necessary and as indicated in the plan of care. Each nurse has completed an education e-learning module on pressure area care. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the home have a competency assessment completed. Competency assessments have a quality assurance element built into the process.	

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

Appendix Two

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

Meadowbank Private Nursing Home

Tuesday 06 May 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 John Coyle, Peripatetic Manager and Mrs Louise McCloskey, Manager during the inspection feedback.

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	Requirement carried forward from the previous inspection on 20 February 2013	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	27(2)(d)	The registered person shall, having regard to the number and needs of patients, ensure that all parts of the nursing home are kept clean and reasonably decorated. Ref. Section 11, point 11.11	One	At present recruiting domestic staff to cover long-term sick leave and bank list. All high dusting has been completed and refurbishment prgramme substantially completed.	Two weeks
2	18 (2)(j)	The registered person shall, having regard to the number and needs of patients, keep the nursing home free from offensive odours. Ref. Section 11, Point 11.11	One	Identified room with mal-odour has been deep cleaned and bed replaced. Will be re-decorated in due course	One week

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	12.3	It is recommended that the menu planner be reviewed and updated to address all choices available for patients including for patients on therapeutic diets. Choices available for all snacks should be varied. Ref. Section H	One	Menu has been reviewed and choices have been included for theraputic diets. Variety of choices are available for all snacks.	Two weeks
2	5.3	It is recommended that infection control assessments be undertaken for patients. Ref. Section A.	One	Infection control nurse in process of devising an infection control assessment tool.	Two weeks

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	Louise McCloskey
Name of Responsible Person / Identified Responsible Person Approving QIP	Jim McCall JR WATSON DIRECTOR OF OPERATIONS 9.6.2014

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes		15/7/14
Further information requested from provider			