Secondary Unannounced Care Inspection

Name of Service and ID:	**Woodmount (1195)**
Date of Inspection:	**11 February 2015**
Inspector's Name:	**Heather Moore**
Inspection ID:	**IN016531**

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544

1.0 GENERAL INFORMATION

Name of Home:	Woodmount
Address:	15 Melmount Road Strabane BT82 9ED
Telephone Number:	028 7188 4234
E mail Address:	woodmountnhome@hotmail.com
Registered Organisation/ Registered Provider:	Mr Alfred Lindsay Woods Mrs Roberta Jillian Woods
Registered Manager:	Mr Thomas Monteith
Person in Charge of the home at the time of Inspection:	Mr Thomas Monteith
Categories of Care:	NH-I, NH-PH, NH-PH(E)
Number of Registered Places:	32
Number of Patients Accommodated on Day of Inspection:	29
Scale of Charges (per week):	£581.00
Date and type of previous inspection:	08 August 2014 Secondary Unannounced
Date and time of inspection:	11 February 2015: 8.35am to 1.40pm
Name of Inspector:	Heather Moore

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 are required.

This is a report of an inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being 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.

The Regulation and Quality Improvement Authority aims to use inspection to support providers in improving the quality of services, rather than only seeking compliance with regulations and standards. For this reason, annual inspection involves in-depth examination of a limited number of aspects of service provision, rather than a less detailed inspection of all aspects of the service.

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

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

- Discussion with the registered provider
- Discussion with the registered manager
- Discussion with staff
- Discussion with patients individually and to others in groups
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- Review of a sample of care records
- Observation during a tour of the premises
- Evaluation and feedback.

5.0 Inspection Focus

The inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

STANDARD 5

Nursing Care: Patients receive safe, effective nursing care based on an 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.

Questionnaires were provided by the inspector, during the inspection, to patients / residents, their representatives and staff to seek their views regarding the quality of the service.

Issued to:	Number Issued	Number Returned
Patients /Residents	**5**	**5**
Relatives / representatives	**1**	**1**
Staff	**8**	**8**

The inspector has rated the home's Compliance Level against each criterion 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		
Compliance statement	**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.

6.0 Profile of Service

Woodmount Private Nursing Home is owned by Mr and Mrs Woods and provides care for up to 32 patients in the general nursing category of care and physical disability under and over 65 years of age.

The home is situated on the Melmount Road, a short distance from the centre of Strabane.

Mr Lindsay and Mrs Woods own and operate the home.

Mr Thomas Monteith is the Registered Manager.

The home comprises of 26 single and three double bedrooms (five with en-suite), three sitting rooms, a dining room, a main kitchen, washing/toilet facilities, launderette and staff accommodation/offices.

There are adequate car parking facilities at the rear of the home.

7.0 Summary

The unannounced inspection of Woodmount Private Nursing Home was undertaken by Heather Moore on 11 February 2015 from 8.35am to 1.40pm. The inspection was facilitated by Mr Thomas Monteith Registered Manager. Mrs Jill Woods Registered Provider was also available during the inspection process. Verbal feedback was given to the registered provider and to the registered manager at the conclusion of the inspection.

The focus of this inspection was Standard 5: Nursing care and to assess progress with the issues raised during and since the previous inspection on 8 August 2014. Two requirements and three recommendations were reviewed, one requirement and three recommendations were complied with, and one requirement was substantially compliant and was therefore restated.

Review of four patients care records revealed that there was an improvement in patients care records since the previous inspection, however examination of one patient's care record revealed that one care plan had not been reviewed since the 14 October 2014, the identified patient's Malnutrition Universal Screening tool (MUST) had also not been reviewed on a monthly basis. One requirement and one recommendation are made in regard to care records.

Repositioning charts were in place for patients who were at risk for patients who were assessed as being at risk of developing pressure ulcers. A review of a sample of patients repositioning charts revealed a small number of omissions in the recording of the patients charts. A recommendation is made that these charts are completed appropriately.

There was written evidence held in the care records inspected that patients and/or their representatives were involved in discussing, agreeing and planning care interventions.

Care reviews were held for patients post admission and more often thereafter.

From a review of the available evidence, discussion with relevant staff and observation, the inspector can confirm that the level of compliance with the standard inspected was substantially compliant.

Discussion with patients and two relatives revealed that patients and relatives were complimentary regarding the standard of care being provided. Patients and relatives comments are discussed in Section 6.2 (Additional Areas Examined)

The inspector can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a good standard and patients were observed to be treated with dignity and respect.

Inspection of the staff duty roster and observation on the day of inspection confirmed that staffing levels were satisfactory for the number of patients currently in the home.

The inspector undertook a tour of the home and viewed a number of patients' bedrooms, communal areas, dining room, and toilet and bathroom facilities. The home presented clean, warm and comfortable.

As a result of this inspection one restated requirement and two recommendations were made these are discussed in the report and in the quality improvement Plan. (QIP)

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

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

8.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	20 (1) (c) (i)	The registered person shall ensure that staff receive annual appraisal.	Inspection of staff appraisal records confirmed that staff had received appraisal since the previous inspection.	Compliant
2	15 (2) (b)	The registered person shall ensure that the assessment of need is 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.	Inspection of four patients care records confirmed that the patient's assessment of need was reviewed on an annual basis or more often if deemed appropriate.	Compliant
3	16 (2)	The registered person shall ensure that patients care plans are reviewed monthly or more often if deemed appropriate.	Inspection of four patients care records revealed that one patient's care plan had not been reviewed since the 14 October 2014. **Restated**	Substantially compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	6.2	It is recommended that alterations in patients care records are dated timed and signed.	Inspection of four patients care records confirmed that alterations in patients care records were recorded appropriately.	Compliant
2	5.3	It is recommended that written evidence is available in patients care records that indicate that consultation had taken place between the nurse/patient/and/or their representative in regard to nursing Interventions.	Inspection of four patients care records revealed that written evidence was available in patients care records that confirmed that consultation had taken place between the nurse/patient/and/or their representative in regard to nursing interventions.	Compliant

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

There were no issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

9.0 Inspection Findings

STANDARD 5- NURSING CARE **Patients receive safe, effective nursing care based on an 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 Assessed: 5.1 At the time of each patient's admission to the home, a nurse carries out and records an initial risk 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.	**COMPLIANCE LEVEL**
Inspection Findings:	
The registered manager confirmed that a pre-admission assessment is carried out on all patients prior to admission to the home, with the exception of those arranged as part of the emergency admission process. A review of four patients care records confirmed that the assessments of the patient's needs was completed using the Roper, Logan and Tierney model of nursing on admission. A nurse develops a plan of care from the assessment which specifies the interventions required to meet the patient's needs. Specific validated risk assessment tools such as the Braden Scale, MUST, Falls risk, Continence moving and handling were evidenced and used to direct the plan of care.	Compliant
Criterion Assessed: 5.2 A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of four patients' care records revealed that comprehensive holistic assessments of the patients care needs using validated assessment tools were completed within 11 days of the patient's admission to the home.	Compliant

STANDARD 5- NURSING CARE

Patients receive safe, effective nursing care based on an 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 Assessed: 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 professionals.	**COMPLIANCE LEVEL**
Inspection Findings:	
On admission a primary nurse is allocated to each individual patient and he/she has responsibility for assessing, planning, implementing and evaluating their care. The care plan is discussed and agreed with the patient (where possible) and their relative and the patient are encouraged to be independent as possible. Review of four patients care records confirmed that written evidence was available regarding the agreeing and planning of nursing interventions. Review of the care records also revealed that relatives' communication records were held and the evidence provided indicated that relatives were informed of changes to patients' conditions as appropriate. Care records inspected reflected advice provided by health care professionals such as dieticians, speech and language therapists. The promotion of independence including rehabilitation was addressed in the care plans inspected. Review of four patients care records confirmed that one patient's care plan was not reviewed since 14 October 2014. A restated requirement is made in this regard. Inspection also confirmed that the patient's Malnutrition Universal Screening Tool (MUST) was not reviewed monthly. A recommendation is made that patients MUST assessments are reviewed on a monthly basis or more often if deemed appropriate.	Moving Towards Compliance

Repositioning charts were in place for patients at risk of developing pressure ulcers. A review of a sample of repositioning charts revealed a number of omissions in recording the charts appropriately. A recommendation is made in regard to this shortfall.	
Criterion Assessed: 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.	**COMPLIANCE LEVEL**
Inspection Findings:	
As previously stated in Criterion 5.3, a requirement and a recommendation are made in regard to the review of patients care records.	Moving Towards Compliance
Criterion Assessed: 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.	**COMPLIANCE LEVEL**
Inspection Findings:	
Examination of four patients care records evidenced that validated assessment tools such as the Roper, Logan and Tierney assessment of activities of daily living. Validated skin risk assessment and the nutritional risk assessment were in place. The inspector observed that documents such as policies and procedures and other evidence based research were available to staff in the home.	Compliant
Criterion Assessed: 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.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of four patients' care records revealed that the outcome of care of care delivered was monitored and recorded at least daily and nightly and more often if required. As previously stated a restated requirement and a recommendation are made in regard to shortfalls in a patient's care record.	Moving Towards Compliance

STANDARD 5- NURSING CARE **Patients receive safe, effective nursing care based on an 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 Assessed: 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.	**COMPLIANCE LEVEL**
Inspection Findings:	
All nursing interventions, treatment and care provided including activities participated in are recorded on the progress notes daily and discussed at handover times. Care plans are updated and evaluated in the agreed time frame by the named nurse. Care management reviews are held on a regular basis in conjunction with the patient, carer/family, home staff, relevant professional staff and the care manager. Minutes of care management reviews were available for inspection.	Compliant
Criterion Assessed: 5.8 Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multi-disciplinary review meetings arranged by local HSC Trusts as appropriate.	**COMPLIANCE LEVEL**
Inspection Findings:	
The registered manager informed the inspector that care management reviews are held annually and can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. The registered nurse in charge or the registered manage attends each review. A copy of the most recent review was held in the patient's care record.	Compliant

STANDARD 5- NURSING CARE **Patients receive safe, effective nursing care based on an 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 Assessed: 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.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector examined the minutes of four care management reviews which evidenced that, where appropriate patients and their representatives had been invited to attend. Minutes of the review included the names of those who had attended an assessment of the patient's needs and a record of issues discussed. Care plans were updated to reflect recommendations made at care management reviews where applicable.	Compliant

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

6.0 Additional Areas Examined

6.1 Care Practices

During the inspection the staff were noted to treat the patients with dignity and respect. Good relationships were evident between patients, and staff.

Patients were well presented with their clothing suitable for the season.

Staff were observed to respond to patients' requests promptly.

The demeanour of patients indicated that they were relaxed in their surroundings.

6.2 Patients' and Relative's Comments

During the inspection the inspector spoke to 10 patients individually and to others in groups. Five patients also completed questionnaires. These patients expressed high levels of satisfaction with the standard of care, facilities and services provided in the home. A number of patients were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home.

Examples of patients' comments were as follows:

- "I am very happy."
- "It's a lovely home."
- "Everyone is very kind."
- "I had a birthday party last week."
- "The food is very good."

The inspector spoke to two relatives during the inspection process, one relative also completed a questionnaire.

Example of the relatives' comments was as follows:

- "My mother was admitted to the home yesterday and everyone has been very kind."
- "I have no complaints, the care is very good."

6.3 Staffing/Staff Comments

On the day of inspection the number of registered nurses and care staff rostered on duty were in line with the RQIA's recommended minimum staffing guidelines for the number of patients currently in the home.

The inspector spoke to a number of staff during the inspection. Eight staff completed questionnaires. No issues or concerns were brought to the attention of the inspector.

Examples of staff comments were as follows:

- "We work well as a team, and provide a high standard of care."

- “We try to provide a good standard of care, all the residents are well looked after.”
- “I enjoy my work here.”
- “I have had training in safe guarding vulnerable adults.”
- “Yes I know how to report poor staff practice.”
- “I feel that the standard of care here is excellent.”

6.4 Environment

The inspector undertook a tour of the premises and viewed the majority of the patients’ and residents’ bedrooms, sitting areas, dining rooms, and laundry, kitchen, bathroom, and shower and toilet facilities.

The home was found to be clean warm and comfortable with a friendly and relaxed ambience.

The registered provider informed the inspector that a refurbishment programme is planned for the spring and a number of bedrooms and areas throughout the home shall be redecorated.

11.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Jill Woods, Registered Provider and Mr Thomas Monteith, Registered Manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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

Enquiries relating to this report should be addressed to:

Heather Moore
The Regulation and Quality Improvement Authority
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BT79 0NS

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Prior to each admission to the Home, the registered Manager completes a pre-assessment. Following admission a key worker/named nurse is identified who then completes a full assessment and develops a care plan. An integral aspect of this comprehensive care plan is the completeion of the MUST tool and assessment of pressure areas and incontinence.	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**
A full comprehensive care plan is completed for each patient following admission to the Home. Referrals are made where appropriate to the Tissue Viability Nurse (TVN), Dietician (SALT) etc for either advice or for further specialised assessment and treatment	Compliant

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**
Each care plan is updated on a daily basis by both day and night staff. Within the first 6 -8 weeks post admission, a care review iniated by Trust staff is carried out with the patient, staff from the home and relatives in attendance. This facilitates input from the patient and or relative in respect of their care plan	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 registered nurses are encouraged to continually update their knowledge through on-going learning either self directed or via a range of courses/seminars facilitated by the local Clinical Education Centre at Altnagelvin Area Hospital. Specific training on the management of pressure ulcers has been arranged through Mrs C Thompson, Nurse Consultant. Staff liaise closely with the Trust's TVN as required. Nutritional Guidelines are available for all staff to refer to	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
Contemporaneous nursing records are maintained by both day and night staff for all patients. A specific profoma check list has been put in place for all patients who require assistance/supervision at meal times and is signed off by each member of staff . Individual fluid balance charts are recorded for all patients who potentially have problems	Compliant

maintaining an adequate intake of fluids.	
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**
All patients records are updated on a daily basis with their overall care plan being updated on a monthly basis or more frequently as their needs change. A yearly care review is completed involving the patient, relatives, staff from the home and respective care managers from the relevent Health Care Trust	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**
These reviews are completed on a yearly basis following admission to the home. The relevant key worker/name nurse from the home completes an assessment/update of the patient's progress from the most review and the final record of the meeting/review is completed by the respective care manager which is then filed within the patient's file	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**
Patients are provided with a varied nutritional choice of diet on a daily basis. Individual preferences in respect of food choices are always accommodated. Referrals are made to Dietician's (SALT) as and when required particularly where staff detect actual or potential problems both in respect of swallowing or weight loss/gain	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**
All nurses and care staff have been advised of patients within the home who have actual or potential problems with swallowing. These problems are recorded within respective patient care plans. Advice is always sought from SALT as required. A supply of hot and cold drinks is available to patients over the 24 hour period. All registered nurses have recieved training in the management of wound care. They are aware of the referral process to the Trust's Tissue Viability Nurse (TVN). Care staff have also been advised re the importance of taking proactive measures to avoid patient's developing pressure wounds.	Compliant

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

Quality Improvement Plan

Unannounced Secondary Inspection

Woodmount

11 February 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Jill Woods, Registered Provider and Mr Thomas Monteith, 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	Requirement	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	16 (2)	The registered person shall ensure that patients care plans are reviewed monthly or more often if deemed appropriate. **Ref: 5.3 Section 9**	Two	All Nurses advised of the importance of reviewing care plans monthly. Monthly audits will take place to monitor same	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	5.3	It is recommended that patients repositioning charts are recorded and completed appropriately. **Ref: 5.3 Section 9**	One	All staff advised of the importance of recording patients repositioning charts accurately to reflect changes in position. Daily random checks will be made by the Registered Manager to ensure compliance	One Week
2	5.3	It is recommended that the Malnutrition Universal Screening Tool (MUST) is recorded monthly or more often if deemed appropriate. **Ref: 5.3 Section 9**	One	All Nurses advised of the importance of completing/recording MUST screening tool every month or more frequently. Regular checks of relevant case notes will be made by the Registered manager to monitor compliance	One Week

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

Name of Registered Manager Completing Qip	Thomas Monteith
Name of Responsible Person / Identified Responsible Person Approving Qip	Jlll Woods

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Heather Moore	05 March 2015
Further information requested from provider			