Announced Primary Inspection

Name of Establishment:	**Harold McCauley House**
Establishment ID No:	**1196**
Date of Inspection:	**15 April 2014**
Inspector's Name:	**Teresa Ryan**
Inspection No:	**17122**

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:	Harold McCauley House
Address:	7 Camowen Terrace Omagh BT79 0AX
Telephone Number:	028 8225 2550
E mail Address:	amcfarland@pcibsw.org
Registered Organisation/ Registered Provider:	Mrs Linda May Wray Presbyterian Board of Social Witness
Registered Manager:	Mrs Caroline Crawford
Person in Charge of the Home at the time of Inspection:	Mrs Caroline Crawford
Categories of Care:	NH-I, NH-DE, NH-LD
Number of Registered Places:	32
Number of Patients Accommodated on Day of Inspection:	31
Scale of Charges (per week):	£567.00
Date and type of previous inspection:	13 May 2013: Primary Announced
Date and time of inspection:	15 April 2014 08.00 hours-15.40 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 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	**10 patients individually and with others in groups**
Staff	**18**
Relatives	**-**
Visiting Professionals	**One**

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**	**5**
Staff	**10**	**9**

6.0 Inspection Focus

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

The criteria from the following standards are included;

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

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

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

The 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

Harold McCauley House purpose built voluntary nursing home provides care for up to 32 patients. The home is situated in its own landscaped grounds off the main Omagh – Cookstown Road in Omagh, Co, Tyrone. The home is registered in the following categories of care:

Nursing Care

- NH-I – Old age not falling within any other category
- NH-DE – Dementia (7 patients)
- NH-LD – Learning Disability (One identified patient)

Harold McCauley House is owned and administrated by the Presbyterian Residential Trust and Mrs Caroline Crawford is the registered manager.

Accommodation consists of 30 single and one double bedrooms (all en -suite), a main sitting room on each floor, a small sitting room upstairs, a main kitchen, two small kitchenettes, laundry, dining room, bathroom, shower and toilet facilities, staff and office accommodation.

The grounds around the home are beautifully landscaped and well maintained. The grounds provide secluded areas to enable patients to walk and/or relax in tranquil surroundings. A furnished summer house is located at the rear of the home.

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (announced) to Harold McCauley House Voluntary Nursing Home. The inspection was undertaken by Teresa Ryan on Tuesday 15 April 2014 from 08.00 hours to 15.40 hours.

The inspector was welcomed into the home by Caroline Crawford, Registered Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Mrs Crawford at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. **(See Appendix One)**.

During the course of the inspection, the inspector met with patients, staff and one professional visitor. 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 and staff during the inspection. Subsequent to the inspection a number of relatives/representatives completed questionnaires. 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.

As a result of the previous inspection conducted on 13 May 2013 no requirements and four recommendations were issued. These were reviewed during this inspection. The inspector evidenced that three recommendations had been fully complied with and one was substantially complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

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

Standard 8: Nutritional needs of patients are met. (Selected criteria)

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

Inspection Findings

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

The inspector can confirm that at the time of the inspection there was evidence to validate that patients receive safe and effective care in Harold McCauley House, Voluntary Nursing Home.

There was evidence of comprehensive and detailed assessment of patient needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patient need 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. A requirement, two recommendations and a restated recommendation are made in regard to a number of shortfalls in the care records inspected.

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 (selected criteria)**

The inspector evidenced that wound management in the home was well maintained. There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment. Care plans for the management of risks of pressure ulcers and wound care were maintained to a professional standard.

- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12 (selected criteria)**

The inspector reviewed the management of nutrition and weight loss within the home.

Robust systems were evidenced with risk assessments and appropriate referrals to GP's, speech and language therapists and/or dieticians being made as required. The inspector also observed the serving of the lunch meal and can confirm that the patients were offered a choice of meal and that the meal service was well delivered. Patients were observed to be assisted with dignity and respect throughout the meal. A recommendation is made that the menu planner be reviewed to include choices for snacks for patients on therapeutic diets.

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

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 were not completed over the night duty period. This omission to record fluid intake means that the total fluid intake cannot be accurately reconciled. This issue has been raised as a requirement in the quality improvement plan.

Patients were observed to be able to access fluids with ease throughout the inspection.

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

Patients, their representatives and staff questionnaires

Some comments received from patients and their representatives;

"Wonderful, this is a great home"
"Staff treat me and my belongings with respect"
"The care and food is excellent, staff always pleasant, there is nothing missing, I don't know how they have the patience.
"Much appreciated spiritual care, conscientious staff and lots of good food"
"This home has an ethos beyond financial return, it is not perfect but always trying to be better".

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"
"Everybody works well as a team".

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

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

Conclusion

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

The home's general environment was well maintained and patients were observed to be treated with dignity and respect. However areas for improvement are identified. Two requirements and three recommendations and one restated recommendation 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 professional, registered manager, registered nurses and staff for their assistance and co-operation throughout the inspection process.

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

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
		Not applicable		

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	25.12	It is recommended that a policy and procedure is developed on Regulation 29 unannounced visits.	Discussion with the registered manager revealed that this policy had been drawn up. A copy of this policy was made available to the inspector.	Compliant
2	25.12	It is recommended that the RQIA's template for Regulation 29 unannounced visits be used to record these visits.	In discussion with the registered manager it was revealed that the senior management team were currently reviewing the template used for reports of unannounced visits to the home under Regulation 29 to correspond with RQIA's revised template.	Compliant
3	28.1	It is recommended that registered nurses competency and capability assessments are reviewed and updated to include wound management.	Review of five registered nurses competency and capability assessments revealed that wound management was included and addressed.	Compliant

4	5.3	It is recommended that patients care plans are reviewed and updated to specify the pressure relieving equipment on the patient's bed and also when sitting out of bed.	Review of three patients' care records revealed that the pressure relieving equipment in use on the patients' beds and when sitting out of bed was addressed in two of the three care records inspected. Restated.	Substantially 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 three 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, Bristol stool chart and continence were also completed on admission. However pain and infection control assessments were not undertaken for these patients. A recommendation is made that this shortfall be addressed.

Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure ulcer/wound and if required, the specific care plans regarding the management of the pressure ulcer/wound.

Review of three 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 registered manager she demonstrated a good awareness of the patient who required wound management intervention for a wound and the number and progress of patients who were assessed as being at risk of weight loss and dehydration.

Provider's overall assessment of the nursing home's compliance level against the standard 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.**

Inspection Findings:

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 three patients' care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Records also evidenced discussion with patients and/or their representatives following changes to the plans of care.

Patients' care records revealed that the pressure relieving equipment in place on the patients' beds and when sitting out of bed was not addressed in two of the patients' care plans on pressure area care and prevention. A recommendation is restated in regard to this shortfall. The inspector was unable to confirm that pain assessments were appropriately used for these patients despite the presence of pain and an active pain relief prescription. It is acknowledged that care plans on pain management were in place for these patients.

The registered manager informed the inspector that there was one patient in the home who required wound management for a wound. Review of this patient's care records revealed the following;

- A body mapping chart was completed for the patient on admission. This chart was reviewed and updated when any changes occurred to the patient's skin condition.

- A care plan was in place which specified the pressure relieving equipment in place on the patient's bed and also when sitting out of bed.

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

- A daily repositioning and skin inspection chart was in place for the patient with the wound and also for patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these 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. As previously stated a pain assessment was not undertaken for the patient, however a pain management care plan was in place for the patient.

Discussion with the registered manager and two registered nurses and three patients' care records confirmed that where a patient was assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention plan and treatment programme.

The registered manager and registered nurses 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 two registered nurses evidenced that they were 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 patient's weight was recorded on admission and on at least a monthly basis or more often if required.

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

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

Review of wound care in a patient's care plan evidenced that the dressing regime was recorded appropriately.

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 care records for one patient evidenced that the patient was referred for a dietetic assessment in a timely manner. This patient was also referred to the speech and language therapist. The patient's care plan however was not reviewed to address the dietician's recommendations. The patient's care plan addressed, with one exception, the speech and language therapist's recommendations. This professional recommended a special cup for the patient and this was not addressed in the patient's care plan.

Discussion with the registered manager, registered nurses, care staff and review of the staff training records revealed that 27 staff were trained in wound management and pressure area care and prevention on 22 and 29 January 2014. Twenty staff were also trained in the management of nutrition. The registered manager informed the inspector that arrangements were in place for further training in nutrition on 21 May 2014.

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 registered manager and registered nurses informed the inspector that pressure ulcers were graded using an evidenced based classification system.

A requirement is made in regard to shortfalls in patients' care records inspected.

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	**Moving towards compliance**

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

Inspection Findings:

Review of three 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 including wound care for each patient.

Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required.

Review of one patient's care records in relation to wound care indicated that these care records were reviewed each time the dressing was changed and also when the dressing regime was changed or the condition of the wound had deteriorated. Review of care records also evidenced that nutritional care plans for patients were reviewed monthly or more often as deemed appropriate.

The evaluation process included the effectiveness of any prescribed treatments, for example, prescribed analgesia.

Discussion with one registered nurse 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)

Inspection Findings:

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

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

The inspector 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 registered manager and registered nurses confirmed that they had a good awareness of these guidelines. Review of patients' care records evidenced that registered nurses implemented and applied this knowledge.

Discussion with the registered manager, registered nurses and review of governance documents evidenced that the quality of pressure ulcer/wound management was audited each time dressings were changed and discussed at each hand over report. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process. 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.

Sixteen 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 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.

Inspection Findings:

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.

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

Review of three 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 wound 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 timed and signed with the signature accompanied by the designation of the signatory. Review of three patients' care records revealed that a number of entries were not dated and a recommendation is made that this shortfall be addressed.

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

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

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

As previously stated under Section B review of one patient's care records evidenced a deficit in recording directions from the speech and language therapist.

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 21.30 hours to 08.30 the following morning. There was evidence that the patient was offered fluids on a regular basis throughout the day.

The fluid intake records for this identified patient failed to evidence;

- the total fluid intake for the patient over 24 hours
- an effective reconciliation of the total fluid intake against the fluid target established
- action to be taken if targets were not being achieved
- a record of reconciliation of fluid intake in the daily progress notes

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

Twenty staff had attended training in the management of nutrition. The registered manager informed the inspector that arrangements were in place for further training in nutrition on 21 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	**Moving towards Compliance**

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.**
Inspection Findings:
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.**

Inspection Findings:

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 had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014.

The registered manager informed the inspector that patients' care reviews were held post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff, preferably the patient's named nurse, attends each care review. A copy of the minutes of the most recent care review was held in the patient's care record file.

The inspector viewed the minutes of three care management care reviews which evidenced that, where appropriate, patients and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended, an updated assessment of the patient's 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.

Inspection Findings:

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

There was a four weekly menu planner in place. The registered manager informed the inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home. The current menu planner was implemented on 01 April 2014.

The inspector discussed with the registered 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 or dieticians.

As previously stated under Sections B and E, review of one patient's care records evidenced that the patient was referred for a dietetic assessment in a timely manner. This patient was also referred to the speech and language therapist. The patient's care plan was not reviewed to address the dietician's recommendations. The patient's care plan addressed with one exception the speech and language therapist's recommendations. This professional recommended a special cup for the patient and this was not addressed in the patient's care plan.

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, registered nurses and care staff it was revealed that choices were available at each meal time. The registered manager confirmed choices were also available to patients who were on therapeutic diets. A recommendation is made that the menu planner be reviewed to include choices for snacks for patients on therapeutic diets.

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.**

Inspection Findings:

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

Review of training records revealed that 29 staff had attended training in dysphagia awareness during the previous three years and further training was planned for 21 May 2014. Twenty four staff had attended training in first aid during the previous 12 months.

Review of one patient's care record evidenced that the care plan failed to fully reflect the instructions of a recent speech and language swallow assessment.

Discussion with registered 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 registered 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 and refreshed regularly. 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. Sixteen 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 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 nurses was employed in the home.

Discussion with the registered nurses clearly evidenced their knowledge in the assessment, management and treatment of wounds. Review of the template used to undertake competency and capability assessments for the registered nurses revealed that pressure ulcer/wound care was addressed.

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**

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. The inspector reviewed the following records:

- The home's statement of purpose
- the patient's guide
- sample of reports of unannounced visits to the home under regulation 29
- sample of staff duty rosters
- record of complaints
- sample of incident/accident records
- record of food provided for patients
- statement of the procedure to be followed in the event of fire
- sample of the minutes of patients'/relatives' and staff' meetings
- staff training record.

These records were found to be maintained in accordance with the regulation and good practice guidance.

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 registered manager and one of the registered nurses. The inspector can confirm that copies of these documents were available in the home. The registered manager and registered nurse displayed an awareness of the details outlined in these documents. The registered 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 registered manager and registered nurses 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 upstairs sitting room. The inspector also observed care practices in the main sitting room following the lunch meal. The observation tool used to record this observation was the Quality of Interaction Schedule (QUIS). This tool uses a simple coding system to record interactions between staff, patients and visitors.

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 what their meals consisted of and provided appropriate assistance and support to the patients

Observation of care practices in the sitting room 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 registered 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. This was also evidenced by the inspector on the day of inspection.

11.8 Staffing/Staff Comments

Discussion with the registered manager and a number of staff and review of a sample of staff duty rosters evidenced that the registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients currently in the home. The registered manager informed the inspector that arrangements were in place for the appointment of a deputy manager in the home which is commendable. The ancillary staffing levels were found to be satisfactory. The registered manager informed the inspector that discussions were currently taking place in regard to providing additional hours for the provision of activities to patients.

Staff were provided with a variety of relevant training including mandatory training since the previous inspection.

During the inspection the inspector spoke to18 staff. The inspector was able to speak to a number of these staff individually and in private. On the day of inspection nine 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"
"Everybody works well as a team"
"Staff have very good relationships with the patients and the patients are treated with dignity and respect and seem to enjoy daily activities"
"I think the home is a good quality nursing home and I would recommend this home to my family and friends
"All staff listen to the patients carefully and any wounds or pressure ulcers are reported"
"I feel the home provides a good standard of nursing care"
"I have worked for 21 years in the home and feel we provide a very high standard of care to all our patients"
"Harold McCauley House provides the highest standard of care".

11.9 Patients' Comments

During the inspection the inspector spoke to 10 patients individually and to a number in groups. On the day of inspection five patients completed questionnaires. The following are examples of patients' comments during the inspection and in questionnaires.

"Wonderful this is a great home"
"Staff treat me and my belongings with respect"
"The care and food is excellent, staff always pleasant, there is nothing missing, I don't know how they have the patience"
"I am very happy here, the food is excellent, you could not beat it"
Staff can make me a snack and a cup of tea at any time"
"I find this home a very happy comfortable place and the staff are very good"
Staff always respect my privacy and they always knock my door before entering"
"I feel safe in this home"
Everything is fine, the staff are outstanding".

11.10 Relatives' Comments

Subsequent to the inspection five relatives completed questionnaires. The following are examples of relatives' comments during inspection and in questionnaires;

"Much appreciated spiritual care, conscientious staff and lots of good food"
"This home has an ethos beyond financial return, it is not perfect but always trying to be better"
"I am delighted with every aspect of care in the home. I have complete confidence in the staff, my mum is happy which means I have peace of mind"
"I am happy to leave my relative in the care of this home, and amazed by the patience that staff have for the patients"
"Home is excellent".

11.11 Professionals' Comments

One professional visited the home during the inspection. This professional expressed high levels of satisfaction with the quality of care, facilities and services provided in the home.

11.12 Environment

During the inspection the inspector undertook tour of the premises and viewed the majority of the patients' bedrooms, sitting areas, dining room, laundry, bath/shower and toilet facilities. The home was found to be warm, clean, and comfortable. The patients' bedrooms were very well personalised and this is commendable .On the afternoon of the inspection the inspector observed 22 patients seated in the main sitting room in the downstairs part of the home. A number of the patients' wheelchairs were also stored in this room. This room presented as being overcrowded and consideration should be given to encouraging patients to use the sitting room in the upstairs part of the home. Subsequent to the inspection Mr Raymond Sayers, Estates Inspector, RQIA visited the home on the day following this inspection. Following this visit Mr Sayers stated that although the available space in this sitting room complied with The Nursing Homes Minimum Standards, the storage of wheelchairs in this room should be discontinued.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Caroline Crawford, 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:

Teresa Ryan
The Regulation and Quality Improvement Authority
Hilltop
Tyrone and Fermanagh Hospital
Omagh
Co Tyrone
BT70 0NS

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**
5.1 Each resident is visited prior to admission to carry out an initial assessment which includes medical and current medical history, current medication, a nursing assessment, emergency contact details and social interests. Further information is requested from the Social Worker and other Health Care Professionals including any relevant risk assessments. 5.2 A comprhensive, holistic assessment of the residents care needs is completed within 11 days of admission. This includes specific validated assessment tools such as Moving and Handling, Braden Scale, Malnutrition Universal Screening Tool(Must). Assessments for other requirements e.g. bedrails, fall risk, pain and continence assessments may be included. On admission each resident has a skin assessment chart completed to indicate any pressure sores or potential risk or any other skin condition.	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**
5.3 A named nurse is assigned to each resident to discuss, plan and agree nursing interventions to meet identified need with the resident &/or their representative. Advice and recommendations from other Health Professionals is incorporated into the residents care plan. Referrals are made to the appropriate Health Professional to obtain advice and support when required.	Compliant

Residents who are deemed "at risk" of developing pressure ulcers, through the Braden Presurer ulcer risk assessment have care plans developed to meet their need and comfort. Referral arrangements are in place to specific health care professionals for advice and support including Tissue Viability , Podiatrist, Dietitican, Speech and Language.	

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**
Care records reflect updates at least monthly or as a resident's condition changes. Where other multi-disciplinary staff are involved their advice is reflected in care plans to provide the best possible individual care. Daily progress notes are maintained for individual residents. Residents and/or their representatives are updated on their ongoing care and actively encouraged to sign individual care plans provided they are in agreement with the content.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All nursing intervention, activities and procedures are supported using research and evidence based guidelines. Staff use the Braden Pressure Ulcer Risk Assessment alongside the Must Nutritional Risk Assessment and the National Institute for Health and Clinical Excellence (Nice) for management of pressure ulcers. Residents and or their representatives are updated on their ongoing care and activity encouraged to sign individual care plans,provided they are in agreement with the content.	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**
5.6 Contemporaneous nursing records according to NMC guidelines are kept of all nursing interventions, activities and procedures for each resident. These are dated and signed with the signature accompanied by the designation of the signatory. Records are kept of all residents meals and drinks provided including the amount comsumed. A four week menu planner is displayed for residents and their representatives. Relevant referrals for individual residents are made to the appropraite Health Professionals e.g.Speech & Language, Dietitican, Diabetic nurse for advice and support which is reflected in the residents care plan.	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care plans are implemented for each residents needs using the Roper Logan and Tierneys 12 activities of Daily Living Model, alongside various risk assessments to reflect individualised person centred care. These are subject to ongoing review and evaluation. There are daily progress notes for all individual residents with a minimal entry by day and night staff. Residents &/or their representatives are updated on their on going care and activity encouraged to sign individual care plans provided they are in agreement with the content.	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**
5.8 Residents are visited by their social workers for update on their progress and afforded the opportunity for them or their representatives to participate in their scheduled review. Care reviews may also be arranged in response to changing needs or with any expression of dissatifaction with care provision, or at the request of the resident or representative. A member of Nursing Staff attends each review and all minutes of meetings are recorded and changes are made to nursing care plans with the residents and or representatives agreement.	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**
12.1 Each resident dietary requirements are discussedwith staff including kitchen staff and meals are prepared to meet each individual recorded dietary need and preferance, where approprate guidance from relevant health care professionals e.g. Dietitican, Speech and Language is incorporated into each residents meal plan. Each meal time residents are provided with a choice of meal suitable to their dietary requirements &/or individual preference.	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**
8.6 Nurses have attended training on conservative management of non-complex dysphagia. Advice from the speech and language health professional is requested for residents who have altered swallowing. Asessments are incorporated into residents care plans to include risks, assistance and aids required. Meal times are displayed on the notice board. a variety of hot and cold drinks and fresh water plus snacks are available at all times. 11.7 Wound Assessments/Pressure ulcers are managed according to the National Institute for Health & Clinical Excellence NICE Guidelines. Nurses have access to appropriate Health Professional e.g. Tissue Viability via referal for assessment and advice on wound mangement.	Compliant

A link nurse from Harold McCauley attends updates on wound management. Nurses have access to the Northern Ireland Wound Care formulary on wound care products and dressings and have completed competency and capability assessments on pressure area care. All pressure ulcers which are a grade 2 or above are reported to the RQIA in accordance with Regulation 3 within the Nursing Home Regulations.	

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

Quality Improvement Plan

Primary Announced Inspection

Harold McCauley House

15 April 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Caroline Crawford, Registered 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	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	16 (2)	It is required that patients' care records are reviewed and updated in order to ensure that care plans fully reflect the patients' assessed needs. Ref. Section B	One	Residents care records have been reviewed and updated to ensure care plans fully reflect the residents' assessed need.	One month
2	12 4 (a)	The registered person shall ensure that food and fluids are provided in adequate quantities and at appropriate intervals. Ref. Section E (This requirement is made in relation to the provision of fluids to an identified patient during night time hours.)	One	Identified residents fluid chart completed and totalled to include night time hours.	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	5.2	It is recommended that infection control and pain assessments are undertaken for patients on admission to the home. Ref. Section A and B	One	Infection control and pain assessments have been completed.	One week
2	6.2	It is recommended that all entries in care records be dated, timed and signed with the signature accompanied by the name and designation of the signatory. Ref. Section E	One	Entries in care records are dated timed and signed with the signature accompanied by the name and designation of the signatory.	One week
3	12 .3	It is recommended that the menu planner be reviewed to include choices for snacks for patients on therapeutic diets. Ref. Section H	One	Menu planner revised to include choices for snacks for residents on therapeutic diets.	Two weeks
4	5.3	It is recommended that the pressure relieving equipment in use on patients' beds and when sitting out of bed be addressed in patients' care plans on pressure area care and prevention. Ref. Section B	Two	Pressure relieving equipment in use on residents' beds and when sitting out addressed in residents' care plan on pressure care and prevention.	One month

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	Caroline Crawford
Name of Responsible Person / Identified Responsible Person Approving Qip	Linda Wray

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	T Ryan	21/05/14
Further information requested from provider			