Announced Primary Inspection

Name of Establishment:	**Parkview House**
Establishment ID No:	**1197**
Date of Inspection:	**16 July 2014**
Inspector's Name:	**Teresa Ryan**
Inspection No:	**17136**

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

Name of Home:	Parkview House
Address:	Parkview Road, Castlederg, Co Tyrone, BT81 7XH
Telephone Number:	028 8167 9192
E mail Address:	da.mcallister@apexhousing.org
Registered Organisation/ Registered Provider:	Apex Housing Association Ltd
Registered Manager:	Mrs Davina McAllister
Person in Charge of the Home at the time of Inspection:	Mrs Davina McAllister
Categories of Care:	NH-I, NH-LD(E), NH-PH Maximum of two persons in category NH-LD(E) and one person in category NH-PH
Number of Registered Places:	15
Number of Patients accommodated on day of Inspection:	14
Scale of Charges (per week):	Nursing: £587:00
Date and type of previous inspection:	14 November 2013 Secondary Unannounced
Date and time of inspection:	16 July 2014 08.00 hours - 14.30 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:

- Review of any notifiable events submitted to RQIA since the previous inspection
- analysis of pre-inspection information
- discussion with the registered manager
- discussion with staff
- consultation with patients individually and with others in groups
- consultation with patients' relatives/representatives
- observation of care delivery and care practices
- examination of records
- tour of the premises
- evaluation and feedback.

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

5.0 Consultation Process

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

Patients	**Six patients individually and with others in groups**
Staff	**ten**
Relatives	**five**
Visiting Professionals	**-**

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

Issued To	**Number issued**	**Number returned**
Patients / Residents	**10**	**3**
Relatives / Representatives	**5**	**5**
Staff	**10**	**7**

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

Parkview House is situated within an Apex Housing complex on Parkview Road, a short distance from the centre of Castlederg.

The nursing home is owned and operated by Apex Housing Association Ltd. The current registered manager is Mrs Davina McAllister

The home is single storey accommodation and comprises of 15 single bedrooms (one with en-suite), two sitting-rooms, conservatory, two day rooms, a main kitchen, toilet/washing facilities, staff accommodation, offices and a designated smoking area for patients.

The home is registered to provide care for a maximum of 17 patients under the following categories of care.

- Nursing I - old age not falling within any other category
- LD, LD(E) - learning disability(two designated patients only)
- PH, PH(E) - physical disability under and over 65years

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, secure surroundings

Adequate car parking facilities are provided at the front and side of the home.

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (announced) to Parkview House. The inspection was undertaken by Teresa Ryan on 16 July 2014 from 08.00 hours to 14.30 hours.

The inspector was welcomed into the home by Mrs Davina McAlister, Registered Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Mrs McAlister 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. This self-assessment was received by the RQIA on the 21 May 2014. 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 five visiting relatives. The inspector observed care practices, examined a selection of records and carried out a general inspection of the nursing home environment as part of the inspection process.

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

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

As a result of the previous inspection conducted on 14 November 2013 one requirement and two recommendations were issued. These were reviewed during this inspection. The inspector evidenced that the requirement was assessed as moving towards compliance and is therefore restated. The two recommendations were fully complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

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

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

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

8.1 Inspection Findings

8.1.1 Management of Nursing Care – Standard 5

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

There was evidence of comprehensive and detailed assessment of patient's needs from date of admission. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patients' needs was evidenced to inform the care planning process. However, a requirement is made that one patient's assessment of needs be reviewed and updated.

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 is also restated for the third time in regard to 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. A review of the training records confirmed that staff require their knowledge and skills in record-keeping to be updated. A requirement is made in regard to this training.

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

8.1.2 Management of Wounds and Pressure Ulcers – Standard 11 (selected criteria)

On the day of inspection there were no patients in the home with wounds/pressure ulcers. 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 were maintained to a professional standard. A recommendation is made that a repositioning chart be maintained for one identified patient.

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.

8.1.3 Management of Nutritional Needs, Weight Loss and Dehydration 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 GPs, 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 requirement is made in regard to relevant staff training.
A recommendation is made that the menu planner be reviewed to include choices for all meals and snacks for patients on therapeutic diets.

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 moving towards compliance.

8.2 Patients, their representatives and staff questionnaires

Some comments received from patients and their representatives;

“Wonderful, this is a great place”
“Staff treat me and my belongings with respect”
“I like my room and I am well cared for”
“I am very happy here, the food is very good and we get choices”
“I cannot recommend this home highly enough. Davina the manager is amazing and always has a listening ear and is very sympathetic. I live 80 miles from the home and I sleep well knowing that mum’s every need is covered”
“The home is a happy welcoming place”.

Some comments received from staff;

“The quality of care in the home is very good and staff treat the patients very well”

"Care in the home is first class"
"I feel that we provide a high quality of care to each of our patients"
"I think the home is a good quality nursing home and I would recommend this home to my family and friends"
"Care here is more than very good, we do not have anyone with pressure damage".

8.3 A number of additional areas were also examined;

- records required to be held in the nursing home
- guardianship
- Human Rights Act 1998 and European Convention on Human Rights CHR) 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

A requirement is made in regard to the reviewing and updating of a registered nurse's competency and capability assessment**.**
A recommendation is made that an activity therapist be appointed in the home.
A recommendation is also made that privacy blinds be provided on patients' bedroom windows.

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. Four requirements are made and one is restated. Four recommendations are also made. These requirements and recommendations are addressed throughout the report and in the quality improvement plan (QIP).

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

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

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	16(2)	It is required that the patients' care records are reviewed and updated in order to fully reflect the patients 'assessed needs	Review of four patients' care records revealed a number of shortfalls, however improvements were noted since the previous inspection. Restated	Moving towards compliance

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	20.4	It is recommended that the home's first aider be highlighted on staff rosters for all shifts over the 24 hour period.	Review of a sample of staff duty rosters revealed that this recommendation was being addressed.	Compliant
2	20.4	It is recommended that written records be held of staff competencies in cardiopulmonary resuscitation	Discussion with the registered manager and review of a sample of staff training records revealed that written records were held in this regard.	Compliant

10.0 Inspection Findings

10.1 Nursing Care - Standard 5

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. 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. Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, pain, infection control, Bristol stool chart and continence were also completed on admission Review of three patients' care records evidenced that a comprehensive holistic assessment of the patient's care needs was completed within 11 days of patient's admission to the home. 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 and five visiting relatives evidenced that patients as appropriate and their representatives were involved in discussions regarding the agreeing and planning of nursing interventions. Records also evedenced discussion with patients and or their representatives following changes to plans of care. This is in keeping with the DHSSPS Minimum Standards and the Human Rights Act 1998.

Review of three patients ' care records revealed that one patient's care plans were reviewed and re-written without reviewing and updating the patient's assessment of needs. There was no written evidence in two patients' care records that care plans were reviewed following the review of these patients' assessment of needs. A requirement is restated for the third time in regard to these shortfalls.

One patient's assessment of needs was dated 26 June 2013. Therefore this patient's assessment of need was not 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. A requirement is made in regard to this shortfall. The registered manager informed the inspector that she will ensure that all patients' care records are reviewed and updated within one month of the inspection.

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

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 require their knowledge and skills in record keeping to be updated. A requirement is made in regard to this training.

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

Prior to the inspection a patient's 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 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.

Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Moving towards compliance**

10.2 Management of Wounds and Pressure Ulcers- Standard 11

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;

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

The registered manager informed the inspector that there were currently no patients in the home who required wound management for wounds/pressure ulcers. The inspector reviewed two patients' care records who were assessed as being at risk of developing pressure ulcers/wounds

- Body mapping charts were completed for these patients on admission. These charts were reviewed and updated when any changes occurred to the patients' skin condition.
- Care plans were in place which specified the pressure relieving equipment in place on the patients' beds and also when sitting out of bed.
- The type of mattresses in use was based on the outcome of the pressure risk assessments. The specialist mattresses in use were being safely used and the registered manager informed the inspector that these mattresses were serviced on an annual or more often basis.

- A daily repositioning and skin inspection chart was in place for one of these patients. There was no repositioning chart in place for the other patient despite instructions in the patient's care plan on pressure area care and prevention that the patient should be repositioned on a two hourly basis. A recommendation is made that a repositioning chart be maintained for this patient.

The registered manager and registered nurse 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 the registered nurse evidenced that they were knowledgeable of the action to take to meet the patient's needs in the interim period while waiting for the relevant healthcare professional to assess the patient. Two tissue viability link nurses were employed in the home which is commendable.

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

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

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

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 nurse was 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

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

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**.**

Discussion with the registered manager, registered nurse, care staff and review of the staff training records revealed that staff were trained in wound management and pressure area care and prevention in February &June 2014.The registered manager informed the inspector that the

tissue viability link nurses for the home attend training in wound care provided by the WHSCT. These nurses cascade the knowledge and skills acquired from this training to the registered nurses and care staff in the home. This is commendable practice.

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

10.3 Management of Nutritional Needs, Weight Loss and Dehydration- Standard 8 &12

Inspection Findings:

The inspector confirmed the 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 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.

Review of a sample of fluid balance charts for a number of patients revealed there was evidence that the patients were not offered fluids from 21.00 hours to 08.00 the following morning. There was evidence that the patients were offered fluids on a regular basis throughout the day.

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.

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 three 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 choices available for patients on therapeutic diets for meals and snacks were not highlighted on this menu planner and a recommendation is made that this be addressed.

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 patients' meals confirmed that patients were offered choice prior to their meals.

Policies and procedures were in place for staff on making referrals to the dietician and other relevant professionals including the speech and language therapist (SALT). These included indicators of the action to be taken and by whom.

Staff spoken with were also knowledgeable regarding the indicators for onward referrals to the relevant professionals. eg. speech and language therapist and or dieticians.

Review of two patients' care records evidenced that these patients were referred for dietetic assessments in a timely manner. The patients' care plans on eating and drinking addressed the dietician's instructions. Review of one patient's care records revealed that this patient was referred to a speech and language therapist and this professional's recommendations were addressed in the patient's care plan on eating and drinking.

The inspector discussed the needs of the patients with the registered manager. It was determined that a number of patients had swallowing difficulties. There were two patients in the home who had enteral feeding systems in place.

Discussion with the registered manager, a number of staff and review of the staff training records revealed that staff knowledge and skills in the following areas require to be updated:

- nutritional awareness
- preparation and presentation of pureed meals
- fortification of foods
- dysphagia awareness
- Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes
- Enteral feeding systems including the use of specific pump equipment

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 nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Six staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held in the kitchen 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.

Inspector's overall assessment of the nursing home's compliance level against the standard assessed	Moving towards compliance

11.0 Additional Areas Examined

11.1 Records required to be held in the nursing home

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

11.2 Patients under Guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) Order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection. During the inspection there were no patients in the home who were subject to a guardianship order.

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

The inspector discussed the Human Rights Act and Human Rights Legislation with the 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 were discussed with staff during group staff supervision and that staff were 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 (DOLS) with the registered manager and registered nurse including the recording of best interest decisions on behalf of patients. A copy of DOLS was also available in the home**.** The registered manager informed the inspector that staff were trained in the Human Rights Act and Human Rights Legislation and this is commendable.

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. 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.

Positive interactions	All positive
Basic care interactions	-
Neutral interactions	-
Negative interactions	-

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

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

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

Observation of care practices 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 there were no complaints recorded in the previous 12 months.

11.6 Patient Finance Questionnaire

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

11.7 NMC declaration

Prior to the inspection the registered manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC.

11.8 Staffing/Staff Comments

Discussion with the 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. However there was no activity therapist employed. A recommendation is made that an activity therapist be employed to take the lead in the provision of age appropriate, meaningful and enjoyable activities to the patients. The ancillary staffing levels were found to be satisfactory.

Staff were provided with a variety of relevant training including mandatory training since the previous inspection. Review of six competency and capability assessments for registered nurses revealed that five of these had been reviewed and updated. A requirement is made that that this shortfall be addressed.

During the inspection the inspector spoke to10 staff. The inspector was able to speak to a number of these staff individually and in private. Seven 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"
"Care in the home is first class"
"I feel that we provide a high quality of care to each of our patients"
"I think the home is a good quality nursing home and I would recommend this home to my family and friends"
"Care here is more than very good, we do not have anyone with pressure damage"
"I feel the home provides a good standard of nursing care"
"There is good team work and staff turnover is low"
"Patients are treated with dignity and respect".

11.9 Patients' Comments

During the inspection the inspector spoke to six patients individually and to a number in groups. Three patients completed questionnaires. The following are examples of patients' comments during the inspection and in questionnaires;

"Wonderful, this is a great place"
"Staff treat me and my belongings with respect"
"I like my room and I am well cared for"
"I am very happy here, the food is very good and we get choices"
"The only problem I have is that I get too much to eat"
"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"
"I have access to drinks throughout the day".

11.10 Relatives' Comments

On the day of inspection the inspector spoke to five visiting relatives. Five relatives completed questionnaires. The following are examples of relatives' comments during inspection and in questionnaires;

"I cannot recommend this home highly enough. Davina the manager is amazing and always has a listening ear and is very sympathetic. I live 80 miles from the home and I sleep well knowing that mum's every need is covered"
"Windows and doors left open a lot and patients feel cold"
"The home is a happy welcoming place"
"I feel confident to express my views on how my relative is being cared for"
"Generally feel happy with the level of care and support, staff are friendly and helpful".

11.11 Environment

During the inspection the inspector undertook a tour of the premises and viewed all of the patients' bedrooms, sitting areas, dining room, laundry, bath/shower and toilet facilities. The home was found to be warm, clean, and comfortable. A recommendation is made that privacy blinds be provided as appropriate on patients' bedroom windows. These blinds should be washable and disinfectable. In addressing this recommendation consultation should be made with the patients and their representatives.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Davina McAlister 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

Appendix One

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**
Following a referral from the Care Manager, a pre-admission assessment is carried out for each patient. On admission to the home, a Nurse carries out an holistic assessment using validated assessment tools and a Care Plan is developed to meet assessed needs and risks within 11 days.	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**
All patients have a named primary Nurse who will discuss and draw up a nursing care plan in liaison with family/significant others and the multi-disciplinary team, promoting independence for each patient. Referral arrangements are in place for patients identified as being at risk.	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**
We have daily ongoing assessment and care plans which are updated monthly or, when care needs change.	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**
Nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standards. A validated tool is used to assess and manage plan of care. Guidelines are available and accessible for staff to implement care on an ongoing basis.	Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing records are maintained and recorded within NMC guidelines based on outcomes for patients. A detailed record is held of all meals provided. Referral arrangements are in place for patients identified as being at risk and specific care plans *are* implemented.	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**
Patient's care and outcomes are monitored and recorded on an ongoing basis and are reviewed in collaboration with the patient, relevant multi-disciplinary team and family.	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**
Patients and/or families participate in their multi-disciplinary care review meetings arranged by the local HSC Trust. Agreed outcomes and objectives are recorded and a copy of the care review form is maintained in the care plan and distributed to all relevant parties.	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**
A detailed record is held of all meals provided. Referral arrangements are in place for patients identified as being at risk and specific care plans implemented. Following nutritional guidelines, a nutritious and varied diet is provided, taking into account patient choice, likes or dislikes and any specific dietary requirements.	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**
Nurses and Caring staff are knowledgeable in feeding techniques for patients and adhere to recommendations set out by Speech and Language therapists. Meals, drinks and snacks are provided at conventional times or as requested by patients. Fresh drinking water is available at all times. Individual Care Plans and risk assessments are developed and tailored according to eating and drinking needs, outlining any assistance and aids required.	Compliant

The Tissue Viability and Link Nurse shares their knowledge and expertise to fellow colleagues in relation to wound care assessment and management of dressings.	

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

Appendix 2

Explanation of coding categories as referenced in the Quality of Interaction Schedule (QUIS)

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic Care: (BC) –** basic physical care e.g. bathing or use if toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc. (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away • Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others	**Examples include:** Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (NS) –** communication which is disregarding of the residents' dignity and respect.
Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions • Not showing interest in what the patient or visitor is saying	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness') • Seeking choice but then ignoring or over ruling it • Being angry with or scolding older patients • Being rude and unfriendly • Bedside hand over not including the patient

References

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.

Quality Improvement Plan

Primary Announced Inspection

Parkview House

16 July 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 Davina McAlister, 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	15 (2)(b)	The registered person shall ensure that the assessment of the patient's needs is revised at any time where it is necessary to do so having regard to any change of circumstances and in any case not less than annually. Ref. Section 10 Nursing care standard	One	Assessment of the patients needs will now be planned before the annual date it is due or reviewed earlier as and when necessary	Two weeks
2	16 (2)	It is required that the patients' care records are reviewed and updated in order to fully reflect the patients 'assessed needs . Ref. Section 10, point 10.1 Nursing care standard	Three	All care plans that will be still current when the patients needs assessment as been revised will now have the same review date with a statement to include that the care plan is in accordance with the assessment of daily living	One month
3	12 (4)(a)	The registered person shall ensure that food and fluids are provided in adequate quantities and at appropriate intervals. Ref. Section 10, point 10.3 Management of nutritional needs, weight loss and dehydration standard	One	Food and fluids are provided at appropriate intervals and snacks are also available at any other time outside the planned times. All staff have been reminded to record all food and fluids offered and taken over the 24 hour period	One week
4	20 (1) (c) (i)	Staff as appropriate are required to be trained in the following areas; Record keeping Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes	One	Training as been planned for; 3rd September - record keeping 5th & 10th September - for Nutritional Guidelines and Menu Checklist for Residntial &	Two months

		Enteral feeding systems including the use of specific pump equipment Preparation and presentation of pureed meals Fortification of foods Nutritional awareness Dysphagia awareness Ref. Section 10, point 10.1 Nursing care standard and Section 10, point 10.3 Management of nutritional needs, weight loss and dehydration standard.		Nursing Homes, Preparation and Presentation of pureed meals, fortification of foods, nutritional awareness 9th September Dysphagia awareness training which was already previously planned We are currently planning a date for an update on enteral feeding training	
5	20 (3)	The registered person shall ensure that at all times a nurse is working at the nursing home and that the registered manager carries out a competency and a capability assessment with any nurse who is given the responsibility of being in charge of the home for any period of time in his absence. (This requirement is made in regard to the reviewing and updating of a registered nurses competency and capability assessment). All sections in these assessments should be individually signed by the registered nurse and the registered manager. Ref. Section 11 point, 11.8 (additional areas examined)	One	The outstanding annual review of the competency capability assessment form will be reviewed on the nurse's return from long term sick leave	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	11.3	It is recommended that a repositioning chart be maintained for an identified patient. Ref. Section 10, point 10.2 Management of wounds and pressure ulcers standard	One	The repositioning charts have been reviewed for all patients	One week
2	12.3	It is recommended that the menu planner be reviewed and updated to highlight choices available for all meals and snacks for patients on therapeutic diets. Ref. Section 10, point 10.3 Management of nutritional needs, weight loss and dehydration standard.	One	A specialised menu planner is currently being planned for all therapeutic meals and snacks	Two weeks
3	30.1	It is recommended that an activity therapist be employed in the home. Ref. Section 11, point 11.8 (additional areas examined	One	Apex Housing is reviewing this recommendation	Two months
4	1.1	In order to enhance patients' privacy it is recommended that privacy blinds be provided on patients' bedroom windows. Ref. Section11, point 11.11 (additional areas examined)	One	This recommendation will be reviewed with patients choice	Two months

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	Davina McAllister
Name of Responsible Person / Identified Responsible Person Approving Qip	Muriel Sands

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	T Ryan	19/08/14
Further information requested from provider			