Announced Primary Inspection

Name of Establishment:	**Bell Gray House**
Establishment ID No:	**1205**
Date of Inspection:	**30 July 2014**
Inspector's Name:	**Teresa Ryan**
Inspection No:	**17139**

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

Name of Home:	Bell Gray House
Address:	48 Dublin Street Newtownstewart BT78 4AG
Telephone Number:	(028) 8166 2075
E mail Address:	k.heywood@apexhousing.org
Registered Organisation/ Registered Provider:	Apex Housing Association / Mr Gerald Kelly
Registered Manager:	M/s Kirsty Heywood (Acting Manager)
Person in Charge of the Home at the time of Inspection:	M/s Kirsty Heywood
Categories of Care:	NH-I, NH-PH, NH-LD, RC-I
Number of Registered Places:	35: - 24 - Nursing I &PH 1- Nursing Learning Disability 10 –Residential - I
Number of Patients and Residents Accommodated on Day of Inspection:	21 - Nursing patients 6 - Residents
Scale of Charges (per week):	£581 – Nursing plus £20.00p per week top up payment. £461 - Residential
Date and type of previous inspection:	26 November 2013 Secondary Unannounced
Date and time of inspection:	30 July 2014 08.00 hours- 16.30 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 housing and care services manager
- discussion with the manager
- discussion with staff
- consultation with patients and residents individually and with others in groups
- 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/Residents	**13 individually and with others in groups**
Staff	**14**
Relatives	**-**
Visiting Professionals	**-**

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

Issued To	**Number issued**	**Number returned**
Patients / Residents	**5**	**4**
Relatives / Representatives	**5**	**2**
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

Bell Gray House is situated in its own landscaped grounds in a quiet residential setting, a short distance from the centre of Newtownstewart, Co Tyrone

The home is divided into two units; a nursing unit and a residential unit known as the Moyle unit.

The nursing unit comprises of 25 single bedrooms, two with en-suite facilities, two sitting rooms, dining room, kitchen, toilet/washing facilities and office accommodation.

The adjoining Moyle unit is two-storey accommodation with access to the first floor via a through floor lift and stairs. The unit comprises of nine single bedrooms, one double bedroom, two sitting rooms, designated smoking area, toilet/washing facilities, laundry and hairdressing facilities.

The grounds around the home were tastefully landscaped and well maintained.

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

M/s Kirsty Heywood is currently the acting manager of the home.
The home is registered to provide care under the following categories:

Nursing I - Old age not falling within any other category
Nursing PH - Physical disability other than sensory impairment
Nursing LD - Learning disability
Residential I - Old age not falling within any other category

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (announced) to Bell Gray House. The inspection was undertaken by Teresa Ryan on 30 July 2014 from 08.00 hours to 16.30 hours.

The inspector was welcomed into the home by M/s Kirsty Heywood, Acting Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to M/s Kirsty Heywood at the conclusion of the inspection. M/s Heywood is not registered with the RQIA and will therefore be referred to in the report as the manager. Verbal feedback was also provided over the telephone to M/s Muriel Sands, Housing and Care Services Manager, Apex Housing Association.

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 16 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, residents and staff. 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, residents, staff and relatives during the inspection.

The inspector also spent a number of extended periods observing staff, patient and resident interaction. Discussions and questionnaires are unlikely to capture the true experiences of those patients and residents 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 26 November 2013 four requirements and three recommendations were issued. These were reviewed during this inspection. The inspector evidenced that the four requirements and two recommendations were fully complied with. One recommendation was assessed by the inspector as moving towards compliance, therefore this recommendation is restated for the second time.

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

There was evidence of comprehensive and detailed assessment of patients and residents needs from the date of admission. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patients and residents needs was evidenced to inform the care planning process. Comprehensive reviews of both the assessments of needs, the risk assessments and the care plans were maintained on a regular basis plus as required. There was also evidence that the referring HSC Trust maintained appropriate reviews of the patient's and resident's satisfaction with the placement in the home and the quality of care delivered. A review of the staff training records confirmed that five registered nurses were trained in record keeping on the 25 November 2011. A requirement is made that all staff as appropriate be trained in this area.

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.

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

On the day of inspection there were a small number of 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. One patient's repositioning chart was not accurately maintained and a requirement is made that records are kept up to date.

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.

On the day of the inspection, the inspector observed the lunch meal. Observation confirmed that the meal was served in two sittings. The patients who required assistance with their meals had their meal at the second sitting. A number of issues arose during the serving of this meal. These issues are addressed under 10.3 Management of Nutritional Needs, Weight Loss and Dehydration. A requirement and two recommendations are made and one recommendation is restated that these issues be addressed. A requirement is also made in regard to relevant staff 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.

8.2 Patients, residents, their representatives and staff questionnaires

Some comments received from patients, residents and their representatives;

"I am very happy here this home is very good"
"Staff treat me and my belongings with respect"
"I like the food and I get choices"
"I am very happy here, the food is very good and we get choices"
"Staff treat my relative with dignity and respect"
"I know who to speak to about my relative's care".

Some comments received from staff;

"Everyone that works in Bell Gray does their very best. The patients are all happy and seem to like the home. I love to come into my work and sometimes come in on my days off"
"The quality of care in the home is very good and staff treat the patients very well"
"All the staff are hardworking and work well as a team"
"I feel that we do not have enough time to talk to the patients and residents"
"Bell Gray is a lovely home, the patients are so nice and I give them the best care that I can".

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 recommendation is made that an activity therapist be appointed in the home.

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

Conclusion

Three requirements and three recommendations are made. One recommendation is also restated. These requirements and recommendations are addressed throughout the report and in the Quality Improvement Plan (QIP).

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

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

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	16 (1)	The registered person shall ensure that a written nursing plan is prepared by a nurse in consultation with the patient or the patient's representative as to how the patient's needs in respect of his health and welfare are to be met.	Review of a sample of patients' care records revealed that care plans were in place for patients who had Do Not Attempt Resuscitation directives maintained in their care records.	Compliant
2	20 (1)(c)	Ancillary staff require to be trained in moving and handling and in first aid.	Discussion with the manager and review of the staff training records revealed that ancillary staff were trained in first aid on 20 March 2014 and these staff were trained in moving and handling on 30 May2014.	Compliant
3	13 (7)	The registered person shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff.	Observation of care practices during the inspection revealed that infection control policies and procedures were being adhered to.	Compliant
4	12 (2) (b)	The registered person shall ensure that all aids and equipment used in or for the purposes of the nursing home is properly maintained and in good working order.	Discussion with the manager and review of the records of checks of emergency equipment held in the home revealed that daily checks were being maintained.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	30.1	It is recommended that care staff, staffing levels for day duty be reviewed in order to ensure the number of staff rostered on duty are adequate to fully address the patients' and residents' assessed needs. In reviewing these staffing levels, working practices in the home should also be reviewed.	Discussion with the manager and review of the care staff, staffing levels revealed that the number of care staff rostered on duty on the day of inspection was in line with the RQIA's recommended minimum staffing guidelines.	Compliant
2	12.5	It is recommended that the serving of meals be reviewed to improve the dining experience for the patients and residents. It is also recommended that the mealtimes be reviewed to ensure appropriate intervals between meals.	Discussion with the manager and observation of the lunch meal on the day of inspection revealed that the meal was served in two sittings. However a number of issues emerged during the observation of this meal that require to be addressed. Restated	Moving towards compliance
3	E54	It is recommended that a designated office be provided for use by the manager of the home.	Discussion with the manager revealed that arrangements were in place to provide a designated office for use by the manager.	Compliant

10.0 Inspection Findings

10.1 Nursing Care - Standard 5

Inspection Findings:

Policies and procedures relating to patients' and residents' 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 and The Residential Care Homes Regulations (Northern Ireland) 2005, DHSSPS Residential Care Homes Minimum Standards (2011)

The inspector reviewed three patients' and one resident's care records which evidenced that patients' and the resident's 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/resident 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' and one resident's care records evidenced that comprehensive holistic assessments of the patients' and resident's care needs were completed within11 days of patients and residents 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 patients/residents guide.

Review of three patients' and one resident's care records and discussion with patients and residents evidenced that patients and residents as appropriate and their representatives were involved in discussions regarding the agreeing and planning of nursing and care interventions.

Records also evedenced discussion with patients, residents 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.

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 five registered nurses were trained in record keeping on the 25 November 2011. A requirement is made that all staff as appropriate be trained in this area.

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. Residential staff on day and night duty also recorded statements to reflect the care and treatment provided to each resident.

Prior to the inspection a patient's / resident's care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that all the patients and residents 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/residents and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended, an updated assessment of the patients and residents 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	**Substantially compliant**

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 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.

The manager informed the inspector that there were currently two patients in the home who required wound management for wounds/pressure ulcers. The inspector reviewed these two patients' care records.

- 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 manager informed the inspector that these mattresses were serviced on an annual or more often basis.
- The dressing regimes were recorded in the patients' care plans on wound management.
- Wound observation charts outlined the dimensions of the wound/ pressure ulcer and were completed each time the dressings were changed.
- A daily repositioning and skin inspection chart was in place for one of these patients. Review of a sample of these chats indicated that the patient was not repositioned in bed on a two hourly basis in accordance with the instructions in the care plan. However discussion with the manager and a number of staff, and review of the records of the daily evaluations of care and treatment provided to the patient, confirmed that the patient was repositioned in bed in accordance with the instructions in the care plan. A requirement is made that records are kept up to date.

The 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 the registered nurses 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. A tissue viability link nurse was 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 of food and fluid intake for patients assessed as being at risk of weight loss and or dehydration.

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 nurses 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. The manager and registered nurses 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 manager, registered nurses, care staff and review of the staff training records revealed that staff were trained in wound management and pressure area care and prevention in June and July 2014. The manager informed the inspector that the tissue viability link nurse for the home attended training in wound care provided by the WHSCT. This nurse cascades 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 and residents. Records were maintained in sufficient detail to enable the inspector to judge that the diet for each patient and resident was satisfactory.

The inspector reviewed the care records of three patients and one resident 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/resident/representative their dietary needs
- where necessary a referral had been made to the relevant specialist healthcare professional
- a record was made of any discussion and action taken by the registered nurse
- care plans had been devised to manage the patients' / resident's nutritional needs and were reviewed on a monthly or more often basis.

Review of a sample of fluid balance charts for patients revealed that these patients were offered fluids on a regular basis and these charts were totalled for the 24 hour period. The patients' total fluid intakes for the 24 hour period were recorded in the daily evaluations of care and treatment provided to the patients.

Staff spoken with were evidenced to be knowledgeable regarding patients' and residents' 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 four weekly menu planner in place. The manager informed the inspector that the menu planner had been reviewed and updated in consultation with patients, residents, their representatives and staff in the home. The current menu planner was implemented on 18 June 2014. The choices available for patients on therapeutic diets for meals and snacks were not highlighted on this menu planner. On the day of inspection there were a number of choices available for the dessert with the main meal of the day, however these choices were not recorded on the menu planner. A recommendation is made that the menu planner be reviewed and updated to address these shortfalls.

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

Staff spoken with were knowledgeable regarding the individual dietary needs of patients and residents to include their likes and dislikes. Discussion with staff and review of the record of the patients' and residents meals confirmed that patients and residents 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 three patients' care records evidenced that one of these patients was referred for dietetic assessments in a timely manner. This patient's care plan on eating and drinking addressed the dietician's instructions. Review of three patients' care records revealed that two of these patients were referred to a speech and language therapist and this professional's recommendations were addressed in the patients' care plans on eating and drinking.

The inspector discussed the needs of the patients and residents with the manager. It was determined that a number of patients had swallowing difficulties. There were no patients in the home who had enteral feeding systems in place.

Discussion with the manager, a number of staff and review of the staff training records revealed that a number of staff were trained in dysphagia and nutrition awareness in 2010, 2011 and 2012. Twelve staff were trained in dysphagia awareness in February 2013. However, a number of staff including the catering staff require their knowledge and skills updated in the following areas;

- nutrition awareness
- preparation and presentation of pureed meals
- fortification of foods
- dysphagia awareness
- Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes

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

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

Staff spoken with were knowledgeable regarding nutritional guidelines, the individual dietary needs and preference of patients/residents and the principles of providing good nutritional care. Nine staff consulted could identify patients and residents who required support with eating and drinking. Information in regard to each patient's/ resident'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 the meal was served in two sittings. The patients who required assistance with their meals had their meal at the second sitting.

Staff were observed preparing and seating the patients and residents for their meal in a caring, sensitive manner. Staff were also noted assisting patients and residents with their meal and patients and residents were offered a choice of fluids. The portion size served to a number of patients and residents should be reviewed as a number of patients and residents did not eat their full meal. The main course for the second sitting was served on cold plates. This issue was brought to the attention of the chef who immediately addressed this. The tables were well presented with condiments appropriate for the meal served. During the first sitting the inspector observed staff rushing the patients and residents to finish their meal and to leave the dining room in order to prepare for the second sitting. Staff were observed to assist patients and residents from the dining tables before other patients and residents were finished their meal. During the first sitting it emerged that the house keeping staff were required to clean the dining room following the lunch meal and these staff were off duty at 13.30 hours. The manager informed the inspector that the breakfast is served at 09.00 hours, morning snack at 11.00 hours, lunch meal at 12.30 pm onwards, afternoon snack at 14.30 hours, evening meal at 17.00 hour and the supper at 20.00 hours.

A recommendation is restated that the serving of meals be reviewed to improve the dining experience for the patients and residents. A recommendation is also restated that the mealtimes are reviewed to ensure appropriate intervals between meals. During the lunch meal a

registered nurse administered medicines to the patients and residents in the dining room. This registered nurse was not available in the dining room throughout the patients' and residents' meal and a recommendation is made that this shortfall be addressed. A requirement is made that the registered person shall make suitable arrangements to ensure that the nursing home is conducted in a manner which respects the privacy and dignity of patient and residents. A recommendation is made that the hours worked by housekeeping staff be reviewed to facilitate the smooth running of the home.

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 manager. The inspector can confirm that copies of these documents were available in the home. The manager displayed an awareness of the details outlined in these documents. The manager informed the inspector that these documents will be discussed with staff during staff meetings and that staff will be made aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patients' and residents' care and accompanying records. The inspector also discussed the Deprivation of Liberty Safeguards (DOLS) with the manager including the recording of best interest decisions on behalf of patients and residents. 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. The inspector also observed care practices in two of the sitting rooms 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	5
Basic care interactions	-
Neutral interactions	-
Negative interactions	5

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

On the day of the inspection, the inspector observed the lunch meal. Observation confirmed that the meal was served in two sittings. The patients who required assistance

with their meals had their meal at the second sitting. A number of issues arose during the serving of this meal. These issues are addressed under 10.3 Management of Nutritional Needs, Weight Loss and Dehydration. A requirement and two recommendations are made and one recommendation is restated that these issues be addressed. These issues were discussed with the manager during the inspection feedback and also with M/s Muriel Sands Housing and Care Services Manager over the telephone.

Observation of care practices in the sitting rooms revealed staff initiated conversation with patients and residents and listened to their views and was respectful in their interactions with them.

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 complainant's satisfaction with investigations undertaken was sought.

11.6 Patient /Resident Finance Questionnaire

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

11.7 NMC declaration

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

The evidence provided in the returned proforma indicated that all nurses, including the manager, were 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 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 and residents currently in the home. These staffing levels were being maintained through the use of agency staff. The manager informed the inspector that arrangements were in place to recruit three registered nurses. 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, failure free, meaningful and enjoyable activities to the patients and residents.

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 these were reviewed and updated in the previous 12 months. Ancillary staffing levels were found to be satisfactory. However as previously stated under point 10.3, a recommendation is made that the hours worked by housekeeping staff be reviewed to facilitate the smooth running of the home.

During the inspection the inspector spoke to14 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;

"Everyone that works in Bell Gray does their very best. The patients are all happy and seem to like the home. I love to come into my work and sometimes come in on my days off"
"The quality of care in the home is very good and staff treat the patients very well"
"All the staff are hardworking and work well as a team"
"I feel that we do not have enough time to talk to the patients and residents"
"Bell Gray is a lovely home, the patients are so nice and I give them the best care that I can"
"Bell Gray delivers great care and is a nice clean home"
"Staff have been helpful during my placement and is providing the highest standard of care for each individual patient"
"Staff work together as a team ensuring holistic care is provided to all patients and residents"
"Patients and residents are treated with dignity and respect".

11.9 Patients'& Residents' Comments

During the inspection the inspector spoke to 13 patients individually and to a number in groups. Two patients/residents completed questionnaires. Two representatives completed questionnaires on behalf of patients/residents. The following are examples of patients' and residents' comments during the inspection and in questionnaires;

"I am very happy here this home is very good"
"Staff treat me and my belongings with respect"
"I like the food and I get choices"
"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 am well cared for and the staff would do anything for you"
"Everything is very nice here but I would like to be at home"
"I like being in the home and I can go to bed for a rest at any time"
"Staff definitely very good to me"
"I have access to drinks throughout the day".

11.10 Relatives' Comments

On the day of inspection two relatives completed questionnaires. The following are examples of relatives' comments in questionnaires;

"Staff treat my relative with dignity and respect"
I know who to speak to about my relative's care"
"Staff make me feel welcome in the home"

“Mum is very happy, she tells her family this is her home now. Staff know all her needs because of the length of time she has been in the home” .

11.11 Environment

During the inspection the inspector undertook a 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 improvements in the environment standards since the previous inspection are acknowledged. These improvements included the redecoration of the dining room.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with M/s Kirsty Heywood, Acting Manager and M/s Muriel Sands, Housing and Care Services Manager, Apex Housing Association 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**
A pre-assessment is completed by a Registered Nurse and the CM5 is also used to provide information. The patient's needs are assessed using the Roper/Logan/Tierney model. The MUST Tool is used to measure nutritional needs The Braden Scale is used to measure risk of pressure ulcer before admission and regularly reassessed.	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 are allocated a Primary Nurse. The multi-displinary team are involved where needed to promote independance A pressure ulcer care plan is in place for patients indentified at risk by the Braden Scale The Tissue Viability Nurse is contacted by phone when needed. Dietician referrals are made through the G.P. and SLT are contacted by telephone.	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**
Care Plans are updated when changes occur and also on a monthly basis	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**
Knowledge is regularly updated by attending Link Nurse study days and information cascaded to staff Specialist nurses are referred to. The NI Wound Care Formulary, WHSCT guidelines and Crest guidelines also referred to. NPUAP Tool used to grade pressure ulcers. HSC Nutritional Guidelines and menu checklist 2014 referred to.	Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care Plans clearly show interventions that are carried out for each patient to reach the required outcome. Menu plans are available. A record of the daily intake of patients who are at risk of malnutrition is kept. If MUST is below 20 patient is referred to dietician through the G.P.	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 is evaluated daily Reviews are carried out by prior arrangement with Care Managers, patients, their representatives and staff	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 attend and participate in their reviews where they are able to do so. A copy of reviews are available and care plans will reflect any changes. Relatives and patients are continually updated on progress	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Patients likes and dislikes are taken into account. Meals are prepared using HSC Nutritional Guidelines by kitchen staff. Guidance provided by other professionals is reflected in the menu choices. Alternative meals are offered if required.	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All staff are informed of SLT instructions. Teaching is ongoing in feeding techniques for patients with compromised swallow Information from Dysphagia study days are cascaded to all staff. All care staff are present when meals are served A policy of protected meal times is in place. All staff including kitchen staff are informed of patients who are on special diets or who have swallowing difficulties with a copy of SLT recommendations available. All nurses are competent in assessing wounds and carrying out dressings as per-protocol. The wound care link nurse cascades up to date information to the other care staff.	Compliant

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

Appendix Two

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

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

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

References

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

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

Quality Improvement Plan

Primary Announced Inspection

Bell Gray House

30 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 M/s Kirsty Heywood, Acting Manager and M/s Muriel Sands, Housing and Care Services Manager, Apex Housing Association as part of the inspection process.

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	19 (3)(a)	The registered person shall ensure that records are kept up to date. Ref.10.2 Management of wounds and pressure ulcers.	One	Repositioning charts will be completed for all relevant residents as per instructions in the care plan.	One week
2	20 (1)(c)(i)	Staff as appropriate are required to be trained in the following areas; • nutrition awareness • preparation and presentation of pureed meals • fortification of foods • dysphagia awareness • Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes • Record keeping Ref. 10.1 Nursing care standard and 10.3 Management of nutritional needs, weight loss and dehydration.	One	Training will be sourced by the acting manager within agreed timescales for all relevant staff in, 1.Nutrition awareness 2Preparation and presentation 3fortification of foods 4Dyphagia awareness Nutritional guidelines and menu checklist for Residential and Nursing homes 6 Record Keeping	Two months
3	13 (8)(a)	The registered person shall make suitable arrangements to ensure that the nursing home is conducted in a manner which respects the privacy and dignity of patients/residents. Ref. 10.3 Management of nutritional needs, weight loss and dehydration.	One	Mealtimes will be reviewed to improve the Dining experience for all residents and to ensure that there are appropriate intervals between meals	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	30.1	It is recommended that an activity therapist be employed in the home. Ref. Section 11, point 11.8 Additional areas examined	One	A submission has been made to the Henry Dickinson foundation for funding for an Activity Therapist for 3 years in the first instance	Two months
2	12.10	It is recommended that a registered nurse supervises the patients' and residents' meals. Ref. 10.3 Management of nutritional needs, weight loss and dehydration.	One	The Acting manager/manager will ensure that a registered nurse will supervise the patients and residents during their meals.	One week
3	30.5	It is recommended that the times that housekeeping staff are rostered be reviewed to facilitate the smooth running of the home. Ref 10.3 Management of nutritional needs, weight loss and dehydration and 11.8 Additional areas examined.	One	A review of the roster for Housekeeping staff will be undertaken by the Acting Manager to facilitate the smooth running of the home	Two weeks
4	12.5	It is recommended that the serving of meals be reviewed to improve the dining experience for the patients and residents. It is also recommended that the mealtimes be reviewed to ensure appropriate intervals between meals. Ref. 10.3 Management of nutritional needs, weight loss and dehydration.	Two	The times of meals being served will be reviewed by the Manager in conjunction with the Catering manager.Consideration will be given to ensuring appropriate intervals between meals	Two weeks

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

Name of Registered Manager Completing Qip	Kirsty Heywood. Acting Nurse manager
Name of Responsible Person / Identified Responsible Person Approving Qip	Muriel Sands (Housing Officer)

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable			
Further information requested from provider Initial return not completed accurately. This was requested to be resubmitted and has not been received	x	Frances Gault	31/12/14