Announced Primary Inspection

Name of Establishment:	**Apple Mews**
Establishment ID No:	**12117**
Date of Inspection:	**29 April 2014**
Inspector's Name:	**Teresa Ryan**
Inspection No:	**17124**

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

Name of Home:	Apple Mews
Address:	95 Cathedral Road, Armagh, BT61 8AB
Telephone Number:	02837 517840
E mail Address:	RosemaryDilworth@priorygroup.com
Registered Organisation/ Registered Provider:	Priory (Watton) Limited Mrs Caroline Denny (registration pending)
Registered Manager:	Mrs Rosemary Dilworth
Person in Charge of the Home at the time of Inspection:	Mrs Rosemary Dilworth
Categories of Care:	Nursing LD, LD (E)
Number of Registered Places:	30: LD, LD (E)
Number of Patients Accommodated on Day of Inspection:	24
Scale of Charges (per week):	£1570 - 1700 per week
Date and type of previous inspection:	06 September 2013 Secondary Unannounced
Date and time of inspection:	29 April 2014 08.00 hours - 16.35 hours
Name of Lead Inspector:	Teresa Ryan

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year is required.

This is a report of a primary announced inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were met.

3.0 Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)

Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/Process

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the DHSSPS Nursing Homes Minimum Standards 2008.

The inspection process has three key parts; self-assessment (including completion of self- declaration), pre-inspection analysis and the inspection visit by the inspector.

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

- analysis of pre-inspection information
- discussion with the registered manager
- discussion with the deputy manager

- discussion with staff
- examination of records
- consultation with stakeholders
- tour of the premises
- evaluation and feedback.

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

5.0 Consultation Process

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

Patients	**8 patients individually and with others in groups**
Staff	**20**
Relatives	**One**
Visiting Professionals	**-**

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

Issued To	**Number issued**	**Number returned**
Patients / Residents	**5**	**3**
Relatives / Representatives	**5**	**None**
Staff	**15**	**15**

6.0 Inspection Focus

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

The criteria from the following standards are included;

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

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

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

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

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Guidance - Compliance statements	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Apple Mews has accommodation for 30 patients which is provided over five bungalows. The bungalows are situated in a quite area at 95 Cathedral Road in Armagh City. Each bungalow offers bright and spacious accommodation for six patients.

The single bedrooms are furnished with a profiling bed, a range of furniture providing storage for patients' personal belongings and an en-suite shower facility.

A number of these bedrooms have been fitted with overhead tracking hoists to assist in the moving and handling of patients.

There are lockable cupboards in each en-suite to store patients' personal toiletries.

A number of electrical sockets are available in each bedroom as well as a television aerial socket and internet access.

Call bells are available in each bedroom including the en-suites to enable patients to summon staff for assistance.

In addition there is an assisted bathroom with shower and toilet facilities and a separate toilet provided in each bungalow.

There is a staff room with en-suite facilities and a multi-purpose room in the upstairs part of bungalow one.

The multi-purpose room is generally used for patients to undertake activities/recreational events. This multi-purpose room is used from time to time for staff training purposes.

There is a fully fitted kitchen in each bungalow.

There is a spacious dining room off the kitchen in each bungalow. The dining rooms are well furnished with tables and chairs suitable to the individual needs of the patients. There is a small nurses' station off the kitchen in each bungalow where the patients' care records are stored securely.

A laundry with a washing machine, tumble drier and a belfast sink is provided in each bungalow.

A multi-sensory room with mobile multi-sensory equipment is available in each bungalow and this is commendable.

There is a well-furnished sitting room with chairs of varying heights in each bungalow. A television is provided in this room.

A fully equipped treatment room and a sluice with appropriate hand washing facilities, including alcohol hand gel, are provided in each bungalow. The main office is situated in bungalow five. All bungalows are wheelchair accessible.

Arrangements were in place to provide a designated smoke room for patients in bungalow four.

There are enclosed garden areas provided for each bungalow and these areas are suitable for wheelchair access. These garden areas were designed in accordance with the assessed needs of the patients being transferred from hospital to these bungalows.

Adequate car parking facilities are provided for the five bungalows.

Mrs Rosemary Dilworth is the registered manager. Mrs Caroline Denny (registration pending) is the responsible person.

The home was re-registered on the 29 August 2013 to provide care for 30 patients in the learning disability under and over 65 years categories of care.

On the day of inspection there were 24 patients in bungalows one to four and bungalow five is currently vacant.

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8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (announced) to Apple Mews Care Centre. The inspection was undertaken by Teresa Ryan on Tuesday 29 April 2014 from 08.00 hours to 16.35 hours.

The inspector was welcomed into the home by Miss Dawn Rhodie, Deputy Manager. Mrs Rosemary Dilworth, Registered Manager was in charge of the home and was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Mrs Dilworth and Miss Rhodie at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. This self-assessment is appended to the report at Appendix One.

During the course of the inspection, the inspector met with patients, staff and one visiting relative. The inspector observed care practices, examined a selection of records and carried out a general inspection of the nursing home environment as part of the inspection process.

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

These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool is designed to help evaluate the type and quality of communication which takes place in the nursing home.

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

As a result of the previous inspection conducted on 06 September 2013, one requirement and four recommendations were issued. These were reviewed during this inspection. The inspector evidenced that the requirement and recommendations had been fully complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

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

with the patient, is accurately recorded and outcomes of care are regularly reviewed. (Selected criteria)

Standard 8: Nutritional needs of patients are met. (Selected criteria)
Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)
Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria)

Inspection Findings

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

The inspector can confirm that at the time of the inspection there was evidence to validate that patients receive safe and effective care in Apple Mews Care Centre. Review of three patients' care records revealed that one 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. This patient's care care plans had been reviewed and updated despite the assessment of need not being revised.

A variety of risk assessments were also used to supplement the general assessment tool. Comprehensive reviews of the risk assessments and the care plans were maintained on a regular basis plus as required. A recommendation is made in regard to a small number of entries in care records not being dated.

There was also evidence that the referring HSC Trust maintained appropriate reviews of the patient's satisfaction with the placement in the home and the quality of care delivered.

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

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

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

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

Robust systems were evidenced with risk assessments and appropriate referrals to GP's, speech and language therapists and/or dieticians being made as required.

Observation during the lunch meal confirmed that the cook prepared the meals in the kitchen of each bungalow. The cook was observed to be extremely busy and was noted to be working over the four bungalows during the lunch period. A requirement is made that an assistant cook be employed to assist and support the cook in the preparation of the patients' meals. The inspector observed the lunch meal in bungalow two.

One of the care staff served the meals from the kitchen to the patients in the dining room. 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. Table cloths were provided. However there were no other table settings including condiments provided. A recommendation is made that this be addressed.

During this period of observation the inspector observed communal use of a food/fluid thickening agent. A requirement is made that any medicine which is prescribed is administered as prescribed to the patient for whom it is prescribed, and to no other patient. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held in one of the bungalows for easy access by staff. This is commendable practice. A recommendation is made that this information be held in all bungalows. Review of the menu planner revealed poor choice for the patients' meals and snacks. (See details under Section H in the main body of the report.). This issue has been raised as a requirement. A recommendation is made that pictures be used to assist patients in the identification of food items. A requirement is made in regard to relevant staff training. A recommendation is made in regard to the provision of appropriate ventilation in the kitchen of each bungalow.

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

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

Review of a sample of fluid balance charts for patients revealed that these charts were accurately maintained and totalled for the 24 hour period. There was evidence that the patients were offered fluids on a regular basis.

The patients' recommended daily fluid intakes and the action to be taken if targets were not being achieved were addressed in the patients care plans. The patients' fluid intakes for the 24 hour period were recorded in the patients' daily evaluations of care and treatment provided to the patients.

During the inspection staff were observed offering patients fluids on a regular basis.

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

Patients / their representatives and staff questionnaires

Some comments received from patients and their representatives;

“I am able to get pain relief when I need it”
“Staff treat me and my belongings with respect”
“Staff can make me a cup of tea and a snack anytime”
“My relative is very content and I am kept very well informed”
“My relative is always warm, clean and comfortable when I visit”.

Some comments received from staff;

“We helped to decorate the patients’ rooms in accordance with their personal preferences”
“I like the fact that we have more time to spend with the patients, it makes me happy to see a smile on their faces”
“I am more than impressed with the one to one time that we have with the patients, we are not under pressure to rush with any task”

A number of additional areas were also examined;

- records required to be held in the nursing home
- guardianship
- Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)
- Patient and staff quality of interactions (QUIS)
- Complaints
- patient finance pre-inspection questionnaire
- NMC declaration
- staffing and staff comments
- comments from representatives/relatives *and visiting professionals*
- environment
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A recommendation is made that an additional activity therapist be employed in the home.

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.

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. Five requirements and five recommendations are made. These requirements and recommendations are addressed throughout the report and in the Quality Improvement Plan (QIP).

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

The inspector would also like to thank the patients 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	12 (2) (b)	The registered person shall ensure that all aids and equipment used in or for the purpose of the nursing home is properly maintained and in good working order.	Review of a sample of the records of the daily checks of emergency equipment revealed that these records were in order.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	28.6	It is recommended that the staff training records are maintained in accordance with Standard 28 point 28.6. The qualification of the trainer /training agency should be recorded.	Review of a sample of staff training records revealed that this recommendation was being addressed.	Compliant
2	20.4	It is recommended that the home's first aider be highlighted on the staff rosters for all shifts over the 24 hour period.	Review of a sample of the staff duty rosters revealed that the home's first aider was highlighted for all shifts over the 24 hour period.	Compliant
3	13.5	It is recommended that additional mobile multi-sensory equipment be provided for sensory stimulation for patients.	Additional mobile multi-sensory equipment had been provided. The registered manager informed the inspector that arrangements were in place to provide multi-sensory equipment in bungalows three and four. This will be reviewed during the next inspection of the home.	Compliant
4	E 39	It is recommended that suitable ventilation is provided in the laundry areas in both bungalows.	Discussion with the registered manager and observation during a tour of the bungalows revealed that this recommendation had been addressed.	Compliant

Inspection Findings

Standard : 5.1
- **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment**

Standard 5.2
- **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission**

Standard 8.1
- **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent**

Standard 11.1
- **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3

Inspection Findings:

Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission and planned admissions to the home. 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.

There was evidence to demonstrate that patients' individual needs were established on the day of admission to the nursing home through pre-admission assessments and information received from the multi-disciplinary team for the relevant Trust. The senior staff in the home were involved in the multi-disciplinary team meetings prior to patients' admissions. The patients currently in the home were admitted from long stay hospitals. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks.

The inspector reviewed three patients' care records which evidenced that at the time of each patient's admission to the home, a registered nurse carried out initial risk assessments and developed agreed plans of care to meet the patient's immediate care needs.

Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), pain, infection control, falls, Bristol stool chart and continence were also completed on admission. Information received from the multi-disciplinary

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

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

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

The registered manager informed the inspector that there were currently no patients in the home who required wound management intervention for wounds/pressure ulcers.

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

Section 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.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

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

Standard 5.3

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

Standard 11.2

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

Standard 11.3

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

Standard 11.8

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

Standard 8.3

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

Nursing Homes Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16

Inspection Findings:

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

Review of three patient's care records revealed that one 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. This patient's care care plans had been reviewed and updated despite the assessment of needs not being revised. A requirement is made in regard to this shortfall.

Review of three care records and discussion with two patients and one visiting relative evidenced that patients as appropriate and their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Records also evidenced discussion with patients as appropriate and their representatives following changes to the plans of care.

The registered manager informed the inspector that there were no patients currently in the home who required wound management intervention for wounds/ pressure ulcers. The inspector reviewed three patients' care records who had been assessed and deemed to be at risk of developing pressure ulcers.

- Body mapping charts were completed for the patients on admission. These chars were reviewed and updated when any changes occurred to the patients' skin conditions.
- 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 mattress in use was based on the outcome of the pressure risk assessment. The specialist mattresses in use were being safely used and records were available to reflect they were appropriately maintained.
- Daily repositioning and skin inspection charts were in place for the patients. Review of a sample of these charts revealed that patients' skin condition was inspected for evidence of change at each positional change.

The registered manager, deputy 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 deputy manager and four registered nurses evidenced that they were knowledgeable of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient. A tissues viability link

nurse was employed in the home which is commendable.

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

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

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

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

Policies and procedures were in place for staff on making referrals to the dietician. These include indicators of the action to be taken and by Whom.

All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment. Review of one patient's care records evidenced that the patient was referred for a dietetic assessment in a timely manner. The dietician's recommendations were addressed in the patient's care plan on eating and drinking.

Discussion with the registered manager, deputy manager and registered nurses, care staff and review of the staff training records revealed that 49 staff were trained in wound management and pressure area care and prevention during the previous 12 months. Forty five staff were also trained in the management of nutrition.

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.

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

Section 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.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

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

Standard 5.4

- **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.**

Nursing Homes Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16

Inspection Findings:

Review of three patients' care records revealed that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care for each patient.

Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required.
As previously stated the registered manager informed the inspector that there were currently no patients in the home who required wound management intervention for wounds/pressure ulcers.

Review of three care records revealed that nutritional care plans for patients were reviewed monthly or more often as deemed appropriate. The evaluation process included the effectiveness of any prescribed treatments, for example prescribed analgesia.

Discussion with the registered manager and deputy manager and review of governance documents evidenced that a number of care records were audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

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

Section D

Standard 5: 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.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

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

Standard 5.5

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

Standard 11.4

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

Standard 8.4

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

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

Inspection Findings:

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

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

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

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

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

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs of patients and the principles of providing good nutritional care. Sixteen staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held in one of the bungalows for easy access by staff. This is commendable practice. A recommendation is made that this information be held in all bungalows. In making this recommendation it is acknowledged that the patients' assessed needs in regard to eating and drinking were addressed in their care plans.

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

Section 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. **The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:** • **Management of Wounds and Pressure Ulcers –Standard 11** • **Management of Nutritional Needs and Weight Loss – Standard 8 and 12** • **Management of Dehydration – Standard 12**
Standard 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Standard 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Standard 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Homes Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**
Inspection Findings:

A policy and procedure relating to record 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 40 staff had received training on 05 November 2013 on the importance of record keeping commensurate with their roles and responsibilities in the home.

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

Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patients' status or to indicate communication with other professionals/representatives concerning the patients.

Entries were noted to be timed and signed with the signature accompanied by the designation of the signatory. Review of three patients' care records revealed that a small number of entries were not dated and a recommendation is made that this shortfall be addressed.
The inspector reviewed the records of the meals provided for patients. Records were maintained in sufficient detail to enable the inspector to judge whether the diet for each patient was satisfactory.

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

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

As previously stated under Section B, review of one patient's care records evidenced that the patient was referred for a dietetic assessment in a timely manner. The dietician's recommendations were addressed in this patient's care plan on eating and drinking. Review of a sample of fluid balance charts for patients revealed that these charts were accurately maintained and totalled for the 24 hour period. There was evidence that the patients were offered fluids on a regular basis.

The patients' recommended daily fluid intakes and the action to be taken if targets were not being achieved were addressed in the patients' care plans. The patients' fluid intakes for the 24 hour period were recorded in the patients' daily evaluations of care and treatment provided to the patients.

Staff spoken with were knowledgeable regarding patients' nutritional needs. Thirty five staff were trained in the management of nutrition during the previous 12 months.

Discussion with the registered manager, deputy manager and review of governance documents evidenced that the quality of record management was in-keeping with DHSSPS Minimum Standards and NMC guidelines and the management of nutritional needs were audited on a monthly or more often basis as required. There was also evidence to confirm that action was taken to address any deficits or areas for improvement.

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

Section F

Standard 5: 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. **The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:** • **Management of Wounds and Pressure Ulcers –Standard 11** • **Management of Nutritional Needs and Weight Loss – Standard 8 and 12** • **Management of Dehydration – Standard 12**
Standard 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Homes Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**
Inspection Findings:
Please refer to criterion examined in Section E. In addition the review of three patients' care records evidenced that consultation with the patient and/or their representative had taken place in relation to the planning of the patient's care. This is in-keeping with the DHSSPS Minimum Standards and the Human Rights Act 1998.

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

Section G

Standard 5: 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.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

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

Standard 5.8

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

Standard 5.9

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

Nursing Homes Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)

Inspection Findings:

Prior to the inspection a patients' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that 18 patients in the home had a care review undertaken through care management arrangements between 01 April 2013 and 31 March 2014. The registered manager provided written evidence to the inspector that arrangements were in place for care reviews for six patients on the day following the inspection. These six patients were recently admitted to the home.

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

The inspector viewed the minutes of three care management care reviews which evidenced that, where appropriate, patients and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended, an assessment of the patient's needs and a record of issues discussed. Care plans were evidenced to be updated post care review to reflect recommendations made where applicable.

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

Section H

Standard 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 Homes Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**
Inspection Findings:
A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance. There was a ten weekly menu planner in place. Review of this menu planner revealed the following; • there was one choice for the main meal of the day • pancake juice or tea was recorded for all mid-morning snacks • soup and a dessert was recorded for all the evening meals • tea coffee or juice was recorded for all the afternoon snacks • weetabix or ready break, tea or juice was recorded for all supper snacks • The alternatives available to the patients were not recorded on the menu planner.

Discussion with the registered manager, deputy manager and a number of staff revealed that if patients did not like what was on the menu an alternative choice was provided. Review of a sample of patients' food record charts revealed that on a small number of occasions alternative choices had been recorded. There were no records to evidence that patients were offered choice in advance of their meals. It is acknowledged that due to the category of care of the patients in the home there were a number of patients unable to communicate verbally. However the majority of the patients could indicate their likes and dislikes through non-verbal cues. A requirement is made that the registered person shall provide choice for the patients and that the menu is varied at suitable intervals.

In reviewing and updating the menu planner the patients as appropriate, their representatives and staff views should be taken into account. Choices for patients on therapeutic diets for all meals and snacks should also be included on this menu planner. Taking into account the category of care of the patients in the home consideration should be given to the use of pictures to identify food. A recommendation is made that this be addressed.

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

As previously stated under Section D relevant guidance documents were in place.

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

Section 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:**
  - **risks when patients are eating and drinking are managed**
  - **required assistance is provided**
  - **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 Homes Regulations (Northern Ireland)2005:Regulation/s13 (1) and 20

Inspection Findings:

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

Review of training records revealed that 27 staff had attended training in dysphagia awareness during the previous 12 months. Thirteen staff were also trained in the preparation and presentation of pureed meals. Discussion with a number of staff revealed that these staff were not trained in dysphagia awareness, the fortification of foods, the preparation and presentation of pureed meals and the use of food/fluid

thickening agents. A requirement is made in regard to this training. Ninety five per cent of staff had attended training in first aid during the previous 12 months.

Review of three patients' care records who had been assessed by a speech and language therapist. These patients' care plans addressed the speech and language therapist's recommendations.

Discussion with registered manager and deputy 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, deputy manager and a number of staff confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements were offered midmorning, afternoon and at supper times. However a variety of snacks were not included on the menu planner.

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

Staff spoken with were knowledgeable regarding the nutritional guidelines, the individual dietary needs of patients and the principles of providing good nutritional care. Sixteen staff consulted could identify patients who required support with eating and drinking.

Observation confirmed that the cook prepared the meals in the kitchen of each bungalow. The cook was observed to be extremely busy and was noted to be working over the four bungalows during the lunch period. A care assistant served the meals to the patients in each bungalow. On the day of the inspection, the inspector observed the lunch meal in bungalow two. One of the care staff served the meals from the kitchen to the patients in the dining room. This care staff member also pureed the meals for the patients on therapeutic diets. 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. Table cloths were provided. However there were no other table settings including condiments provided. A recommendation is made that this be addressed.

During this period of observation the inspector observed communal use of a food/fluid thickening agent. A requirement is made that any medicine which is prescribed is administered as prescribed to the patient for whom it is prescribed, and to no other patient.

Nine per cent of staff were trained in food safety.

During the inspection it emerged that the cook prepares the patients' meals before her days off and these meals are held in the fridges in the bungalows overnight. A requirement is made that an assistant cook be employed to assist the cook in the preparation of patients' meals. This assistant cook should be rostered on the cook's days off.

The temperature in the kitchens in the bungalows was very warm and presented as an uncomfortable working environment. A recommendation is made that appropriate ventilation be provided in these areas.

Discussion with the registered manager, deputy manager and registered nurses, care staff and review of the staff training records revealed that 49 staff were trained in wound management and pressure area care and prevention during the previous 12 months. As previously stated there were currently no patients in the home who required wound management intervention for wounds/pressure ulcers.

Review of the template used to undertake competency and capability assessments for the registered nurses revealed that pressure ulcer/wound care was addressed.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**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. The inspector reviewed the following records;

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

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

11.2 Patients Under Guardianship

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

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

The inspector discussed the Human Rights Act and Human Rights Legislation with the registered manager and one of the registered nurses. The inspector can confirm that copies of these documents were available in the home. The registered manager and deputy manager displayed an awareness of the details outlined in these documents. The registered manager informed the inspector that these documents will be discussed with staff during staff meetings and that staff will be made aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patients care and accompanying records. The inspector also discussed the Deprivation of Liberty Safeguards with the registered manager and deputy manager including the recording of best interest decisions on behalf of patients. A copy of DOLS was also available in the home. Forty staff were trained in the Human Rights Act on the 05November 2013 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 bungalow one. The inspector also observed care practices in bungalows three and four following the lunch meal. The observation tool used was the Quality of Interaction Schedule (QUIS). This tool uses a simple coding system to record interactions between staff, patients and visitors.

Positive interactions	positive
Basic care interactions	
Neutral interactions	
Negative interactions	

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

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

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

Observation of care practices in bungalows three and four 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 no complaints were received in the home since registration.

11.6 Patient Finance Questionnaire

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

11.7 NMC declaration

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

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC. This was also evidenced by the inspector on the day of inspection.

11.8 Staffing/ Staff Training/Staff Comments

Discussion with the registered manager and a number of staff and review of a sample of staff duty rosters revealed the number of registered nurses and care staff rostered on duty in each bungalow was adequate to meet the complex needs of the patients.

There was one activity therapist employed on a full time. There are four of the five bungalows currently occupied therefore a recommendation is made that an additional activity therapist be appointed to assist the activity therapist in the provision of age appropriate, failure free, meaningful activities to the patients. In making this recommendation it is acknowledged that care staff provide some activities for the patients. The care staff also undertake laundry and cooking duties.
A full time housekeeper was employed and the registered manager informed the inspector that arrangements were in place to employ an additional housekeeper on a part time basis.

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

During the inspection the inspector spoke to 20 staff. The inspector was able to speak to a number of these staff individually and in private. On the day of inspection 15 staff completed questionnaires. The following are examples of staff comments during the inspection and in questionnaires;

“We helped to decorate the patients’ rooms in accordance with their personal preferences”
“I like the fact that we have more time to spend with the patients, it makes me happy to see a smile on their faces”
“I am more than impressed with the one to one time that we have with the patients, we are not under pressure to rush with any task”
“The patients are taken out for walks and bus trips”
“Patient centred care is top priority in Apple Mews”
“Holistic care is the staff main priority and supporting independence as much as possible”
“Each patient is offered choice and care is personalised in April cottage. Each patient is included in activities. All staff appear to be very proud of working in April cottage”
“My heart lies with being able to provide a healthy nutritious diet for the patients’ individual needs”
“Since I started work in Apple Mews I got a pride award in London, I think all the staff helped not just me. I think this is a brilliant place for all patients”.

11.9 Patients’ Comments

During the inspection the inspector spoke to eight patients individually and to a number in groups. On the day of inspection three patients were assisted by staff to complete

questionnaires. The following are examples of patients' comments during the inspection and in questionnaires;

"I am able to get pain relief when I need it"
"Staff treat me and my belongings with respect"
"Staff can make me a cup of tea and a snack anytime"
"Staff are aware of the help I need with eating and drinking"
"I do not like the soup"
"I always feel cared about and respected"
"I feel safe in this home"
"Everything is fine, the staff are very nice".

11.10 Relatives' Comments

One relative visited the home on the day of inspection. The following are examples of this relative's comments:

"My relative is very content and I am kept very well informed"
"My relative is always warm, clean and comfortable when I visit"
"The staff are always welcoming and friendly and I have no suggestions for improvement".

11.11 Environment

During the inspection the inspector undertook a tour of the bungalows. The bungalows were found to be warm, clean, and comfortable. The furniture and fittings were of a high standard. The patients' bedrooms were very well personalised and this is commendable. As previously stated a recommendation is made that suitable ventilation be provided in the kitchen of each bungalow**.**

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Rosemary Dilworth, Registered Manager and Miss Dawn Rhodie, Deputy Manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Preadmission assessments are completed on all residents prior to admission. A MDT meeting is held with staff from Apple Mews, hospital ward staff, consultant psychatrist, advocate, SALT, care manager, resettlement manager and families, to discuss and plan discharge for each resident to Apple Mews. At pre admission the residents care need are identified and draft careplans are compiled in consultation with ward staff, they are then agreed and signed of by family and the MDT team. Minutes of these meetings are available in the clients files. The Must Tool is used in pre admission assessments along with any relevant SALT or dietitican information, to nutritionally screen each resident prior to admission then reviewed monthly or more often if required. Braden is used to assess each residents risk of developing pressure sores and reviewed monthly or more often if required.	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**
Each resident has a named nurse who is responsible for the development and review of each residents care plan, along side the input from the ward staff from where the residents are coming from. The named nurses are responsible for reviewing and	Substantially compliant

updating at least monthly. Involvement from the MDT and family and resident are also used in the review of care plans. Referrals to the TVN Rosemary Anderson, are made directly to her from the trained staff at Apple Mews, this is followed up either by a visit or telephone call from her to continue to offer support and guidance. She provides expert advice on choice of dressings and frequency of dressing change. She also devises a plan of care which the nurses must follow. Trained staff at Apple Mews then will develop a careplan and wound care charts in line with the TVN plan of care and review and evaluate. Referrals are made directly to podiatory for the residents who require any input in relation to lower limb or foot ulceration. Referrals to the dietician are made through the GP from the trained staffs request based on their clinical assessment and judgement.residents are seen by the dietician and plans of care are drawn up for trained staff to incorporate into their careplans and disseminate and review.	

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**
The trained staff within Apple Mews Review the care delivered at least monthly intervals using the assessment tools and clinical records.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All assessment tools and clinical assessments are based on evidence based tools, braden pressure assessment tool is used for all residents and updated monthly at least. Nutritional guidelines are available in each bungalow and form the basis for the development of menus. Resident choice and dietician advise are also incoporated into menu choice.	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**
Progress notes are kept and updated at least twice daily on all residents, they are completed by trained staff. trained staff also complete careplans, risk assessments and evaluate them at least monthly. After each meal a record is kept of what has been eaten/offfered/refused for each resident. All residents fluids are recorded and a daily target for 24hrs is recorded and the actual daly intake is recorded in the progress notes. Each residents care plan specifies the target fluid intake for 24hrs and where the target is not achievable, advise is sought from the MDT and utilized.	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**
Each individual residents progress notes are updated at least twice within a 24hr period. Any changes, outcomes and care interventions are recorded by the nurse in charge. The care plans, risk assessments are evaluated monthly by the primary nurse and they are reviewed at patient care reviews along with the care manager, family and members of the MDT.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care reviews are attended by the primary nurse, caremanager, family, patient advocate, consultant psychiatrist, and where possible the resident. Care reviews are minuted and any changes agreed at the meeting, acopy of the care review minutes is kept in te residents file and a copy sent to the patients NOK. Where the resident is unable to be involved in the care reviews, they are spoken to separately and any views expressed is recorded andincluded in the outcomes of the meeting.	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**
Menus have been devised by a qualified cook in consultation with dietitianand health promotion agency, incorporating residents like/dislikes and specialised diets. Staff are aware and are pro active in provising alternatives, if a resident doesnt eat the prepared meal, thisis recorded in the food/fluid intake record. Nutritional guidelines are available in each Bungalow.	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 carers have an ongoing training plan to ensure their knowledge and skills are maintained for assisting residents with swallowing difficulties. The SALT team reguarly review the residents and complete a plan of care which the trained staff then incorporate intothe care plans and dissemeinate tothe care staff. Trained staff also make professional judgement calls and ask for SALTto review clients they have concerns about and care plans are up dated accordingly. Meals are provided at conventional times for the residents and additional snacks and hot cold drinks are always availble, where	Compliant

residents are unable to verbalize a request staff use there non verbals cue to determine their request. Staff are well updated and informed of any risks or changes to the eating and drinking needs of the residents, this is desseminated through handover, staff meetings and resident updates as changes may occur. Trained staff have training in wound care management and are supported by the TVN for additional guidance and support.	

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

Appendix Two

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

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

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

References

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

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

Quality Improvement Plan

Announced Primary Inspection

Apple Mews

29 April 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Rosemary Dilworth, Registered Manager and Miss Dawn Rhodie, Deputy Manager 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	15 (2) (b)	The registered person shall ensure that the patient's assessment of needs is-revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually. Ref. Section B	One	This was completed by the 01.05.14 and has been discussed at staff meetings on the 15.05.14 and 19.05.14. Home Manager will review this as part of careplan audit.	One week
2	12 (4) (d) (e)	The registered person shall-provide choice for the patients; and that the menu is varied at suitable intervals. Ref. Section H	One	Menu has been reviewed to reflect two choices at lunch and evening. Four week cycle menu has been implementated from the 19.05.14	Two weeks
3	20 (1) (c) (i)	It is require that staff as appropriate be trained in the following areas; Dysphagia awareness Fortification of foods Preparation and presentation of pureed meals Use of food/fluid thickening agents Ref. Section I	One	Training was arranged for the 22.05.14 and further dates have been set for 25th and 26th June.	One month
4	20 (1) (a)	It is required that an assistant cook be employed. Ref. Section I	One	Advert has been placed and currently in the recruitment process. Expected completion date is 30.06.14.	One month

5	13 (4) (b)	The registered person shall make suitable arrangements for any medicine which is prescribed is administered as prescribed to the patient for whom it is prescribed, and to no other patient Section I	One	Supervision has been completed with nursing staff and discussed at staff meetings 15.05.14 and 19.05.14. It has been incorporated into the managers checklist.	One week

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	12	It is recommended that the following be addressed; The use of pictures to enable patients to identify food The provision of table settings including condiments. Ref. Section H and I	One	Menu's have been fully reviewed and the use of pictures have been incorporated to enable residents to identify food choices. Tables have been reviewed to include condiments on the tables.	One month
2	12	It is recommended that information in regard to each patient's nutritional needs including aids and equipment recommended to be used be held in each bungalow for easy access by staff. Ref. Section D	One	Individual placemats have been completed for each resident and this is held in their individual care file.	One month
3	E 10	It is recommended that appropriate ventilation be provided in the kitchen of each bungalow. Ref. Section I and Section11, point 11.11	One	Quotes have been requested and are currently awaiting this. Expected date of completion 01.07.14.	One Month
4	6.2	It is recommended that all entries in care records be dated, timed and signed with the signature accompanied by the designation of the signatory. Ref. Section E	One	Supervision and discussion at staff meetings has occured 15.05.14 and 19.05.14. Currently reviewed as part of the resident of the day scheme.	One week

5	13.5	It is recommended that an additional activity therapist be employed. Ref. Section 11, point 11.8	One	Advert has been placed internally and externally and currently awaiting to commence HR proceedures.	One month

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

Name of Registered Manager Completing QIP	Rosemary Dilworth
Name of Responsible Person / Identified Responsible Person Approving QIP	Caroline Denny

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	T Ryan	20/06/2014
Further information requested from provider			