Announced Primary Inspection

Name of Establishment:	**Slieve Na Mon Nursing Home**
Establishment ID No:	**1212**
Date of Inspection:	**24 April 2014**
Inspector's Name:	**Teresa Ryan**
Inspection No:	**17123**

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

Name of Home:	Slieve Na Mon Nursing Home
Address:	Tircur Road Omagh BT79 7TY
Telephone Number:	028 8225 1132
E mail Address:	manager@slievenamon.co.uk
Registered Organisation/ Registered Provider:	Dr Brendan McDonald
Registered Manager:	Mrs Joan McLaughlin
Person in Charge of the Home at the time of Inspection:	Mrs Joan McLaughlin
Categories of Care:	NH-I NH-DE NH-MP NH-MP(E) RC-MP (E) RC-DE
Number of Registered Places:	60
Number of Patients and Residents Accommodated on Day of Inspection:	51 Nursing 2 Residential
Scale of Charges (per week):	£567.00 - Nursing £450.00 - Residential
Date and type of previous inspection:	14 October 2013 Primary Announced
Date and time of inspection:	24 April 2014 08.00 hours- 17.20 hours
Name of Lead Inspector:	Teresa Ryan

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

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

4.0 Methods/Process

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

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

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

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

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

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

5.0 Consultation Process

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

Patients	**12 individually and to others in groups**
Staff	**23**
Relatives	**0ne**
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	**10**	**10**
Relatives / Representatives	**6**	**one**
Staff	**15**	**14**

6.0 Inspection Focus

The inspection sought to establish the level of compliance achieved regarding the selected DHSSPS Nursing Homes Minimum Standards. An assessment on the progress of the issues raised during and since the previous inspection was also undertaken.

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)

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

- 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

There will be an overarching view of the management of patient's human rights - 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 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

Slieve Na Mon Nursing Home provides care for up to 56 patients and four residents in the following categories of care:

Nursing Care

- NH-DE – a maximum of 36 patients
- NH-MP MP (E) – 19 patients in mental disorder excluding learning disability or dementia under 65 years and over
- NH-I – old age not falling within any other category (One identified patient)
- Day Care – 8 service users

Residential Care

- RC - RC (DE) – for three residents
- RC- MP (E) - for one resident

The home is divided into seven units, which share a main kitchen, laundry and staff accommodation/ offices. Each unit has its own sitting room, kitchenette, and toilet/ washing facilities. All bedrooms are single.

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) accurately reflected the categories of care and was appropriately displayed in a prominent position of the home.

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (announced) to Slieve Na Mon Nursing Home. The inspection was undertaken by Teresa Ryan on Wednesday 23 April 2014 from 08.00 hours to 17.20 hours.

The inspector was welcomed into the home by Mrs Joan McLoughlin, Registered Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Dr Brendan McDonald, Registered Provider and Mrs McLoughlin during the inspection feedback.

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

During the course of the inspection, the inspector met with patients, staff and one 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, the visiting relative 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 14 October 2013 one requirement and three recommendations were issued. These were reviewed during this inspection. The inspector evidenced that the requirement and recommendations were fully complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

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

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

There was evidence of comprehensive and detailed assessment of patient needs from date of admission. A variety of risk assessments were also used to supplement the general risk assessment tool. There were no infection control assessments undertaken for patients. The reviews undertaken of care plans and risk assessments did not fully reflect the care prescribed in care plans and the outcome of risk assessments.

There was no evidence available that the patients' care plans were reviewed following the review of the patients' assessment of needs. A requirement and two recommendations are made in regard to shortfalls in patients' care records. A requirement is made in regard to the health and welfare of an identified patient. A requirement is made in regard to the non -reporting of two incidents under Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.

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

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

The inspector evidenced that wound management in the home was well maintained. There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment. Care plans for the management of risks of pressure ulcers and wound care were maintained to a professional standard. As previously stated there were no infection control assessments in place.

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

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

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

The inspector observed the lunch meal in units five and six. Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely manner. However the desserts were served to a number of the patients at the same time as their main meal. Two of these patients were observed eating the dessert before the main course. A recommendation is made that this be addressed.

Staff were observed preparing and seating the patients for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients with their meal and patients were offered a choice of fluids. The tables were well presented with condiments appropriate for the meal served.

- **Management of Dehydration – Standard 12**

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. A recommendation is made that all sections in the template used to undertake registered nurses competency and capability assessments be individually signed by the nurse and the registered manager.

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

Patients / their representatives and staff questionnaires

Some comments received from patients and their representatives;
"Wonderful this is a great home"
"Staff treat me and my belongings with respect"
"The care and food is excellent, staff always pleasant, I don't know how they do it"
"I am very happy here, the food is excellent, you could not get better"
"Home is warm and comfortable but I miss my family"
"The staff contact the doctor right away if they have any concerns"
"My relative is always well presented, the food is good and my relative eats well".

Some comments received from staff;
"I had induction when I commenced work"
"The quality of care in the home is very good and staff treat the patients very well"

"I am confident that all staff are extremely conscientious in carrying out their duties in accordance with patients' care needs"
"Staff have very good relationships with the patients and the patients are treated with dignity and respect and seem to enjoy daily activities".

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

A requirement is made in regard to relevant staff training.
A requirement is made that patients' are appropriately supervised.
A requirement is made in regard to risk assessing the practice of holding patients' toiletries in unlocked cupboards/areas in patients' bedrooms/en-suites.
A recommendation is made that additional hours be provided for the provision of activities to patients.
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. Six requirements and six 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 provider, registered manager, registered nurses and staff for their assistance and co-operation throughout the inspection process.

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

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	16 (1)	The registered person shall ensure that a specific care plan on pain management is maintained in the identified patient's care record.	Discussion with the registered manager and review of this patient's care records revealed that a pain management care plan was in place.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	25.12	It is recommended that the registered person reviews a sample of patients/residents care records, and reviews staff training records during the Regulation 29 unannounced visits to the home.	Review of a sample of reports of unannounced visits undertaken in the home under Regulation 29 revealed that this recommendation was being addressed.	Compliant
2	5.1	It is recommended that written evidence is maintained in patients/residents care records to indicate that discussions had taken place between the nurse/patient/resident, and /or their representative in regard to planning and agreeing nursing interventions.	Review of a sample of patients' care records revealed that there was written evidence available that patients and their representatives had been involved in discussions in regard to agreeing and planning their care.	Compliant
3	5.3	It is recommended that a pain assessment is maintained in the identified patient's care record.	Discussion with the registered manager and review of this patient's care records revealed that a pain assessment was in place for this patient.	Compliant

9.1 Follow up on any issue arising since the previous inspection such as complaints or safeguarding investigations

Prior to the inspection RQIA received correspondence through an e-mail from a relative expressing concerns in relation the care of their relative in the home.

It is not the remit of RQIA to investigate complaints made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if there is considered to be a breach of regulation as stated in The Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection. The relative had raised their concerns with the registered manager of the home and the local healthcare Trust.

10.0 Inspection Findings

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.

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 : 5.1

- **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, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

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 care management team for the relevant Trust. 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), falls, pain, Bristol stool chart and continence were also completed on admission. However infection control assessments were not undertaken for these patients. A recommendation is made that this shortfall be addressed.

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

Review of three patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 1
11days or earlier of patient's admission to the home.

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

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

Section B

Standard 5: 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 Home 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 were outlined in the patient's guide. The roles and responsibilities of key workers should also be included in this guide.A recommendation is made that this be addressed.

Review of three care records and discussion with patients evidenced that patients and/or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Records also evidenced discussion with patients and/or their representatives following changes to the plans of care. As previously stated there were no infection control assessments undertaken for these three patients. There were pain assessments undertaken for these patients and pain management care plans were in place.

There was no evidence available that the patients' care plans were reviewed following the review of the patients' assessment of needs. Discussion with the registered manager and review of one identified patient's care records revealed that this patient sustained a head injury following a fall. This patient's GP was not requested to visit the home and examine the patient. There was no evidence available that head injury observations were undertaken for this patient. There was evidence available in the evaluations of care and treatment provided to the patient that staff were observing the site of the injury. This accident was not reported to the RQIA under Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. Two requirements are made in regard to these shortfalls.

The registered manager informed the inspector that there were a small number of patients in the home who required wound management intervention for wounds. Review of two of these patient's care records revealed the following;

Body mapping charts were completed for the patients on admission. These charts were reviewed and updated when any changes occurred to the patients' skin condition.

Care plans were in place which specified the pressure relieving equipment in place on the patients' beds and also when sitting out of bed. The type of mattresses in use was based on the outcome of the pressure risk assessments. The specialist mattresses in use were being safely used and records were available to reflect they were appropriately maintained.

Daily repositioning and skin inspection charts were in place for the patients with wounds and also for patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these charts revealed that patients' skin condition was inspected for evidence of change at each positional change. It was also revealed that patients were repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention.

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

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

Review of the patients' care plans who had wounds revealed that the dressing regimes were recorded in patients' care plans on wound management.

Wound observation charts outlined the dimensions of the wounds and were completed each time the dressings were changed. The registered manager undertook to ensure that entries would also be made in the daily evaluations of care and treatment provided to the patients each time the dressings were changed.

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 this patient was referred for a dietetic assessment. The dietician's recommendations

were addressed in the patient's care plan on eating and drinking.

Review of one patient's care records evidenced that the patient was referred to a speech and language therapist. (SALT). The patient's care plan was not reviewed to address this professional's recommendations.

Discussion with the registered manager, nursing sister, registered nurses, care staff and review of the staff training records revealed that 52 staff were trained in wound management and pressure area care and prevention during the previous 12 months. Forty three staff were also trained in the management of nutrition including the use of the malnutrition screening tool (MUST). The registered manager informed the inspector that arrangements were in place for further training in nutrition in May and June 2014.

Patients' moving and handling needs were assessed and addressed in their care plans. There was evidence that manual handling aids were used to minimise risk of friction. Staff consulted confirmed there was sufficient nursing equipment available to move and handle patients' appropriately. The registered manager, nursing sister and registered nurses informed the inspector that pressure ulcers were graded using an evidenced based classification system.

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

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

Section C

Standard 5: 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 Home 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 including wound care for each patient.

Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required.
The monthly reviews undertaken of care plans and the daily evaluations of care and treatment provided to patients did not fully reflect the care prescribed in patients' care plans. As previously stated a requirement is made in regard to shortfalls in care records.

Review of two patients' care records in relation to wound care indicated that these care records were reviewed each time the dressings were changed and also when the dressing regimes were changed or the condition of the wounds had deteriorated. Review of three patients' 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 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	**Substantially 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 Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)

Inspection Findings:

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

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

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

- DHSSPS 'Promoting Good Nutrition' A Strategy for good nutritional care in adults in all care settings in Northern Ireland 2011-16
- The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.

- The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care
- The European Pressure Ulcer Advisory Panel (EPUAP)
- RCN/NMC guidance for practitioners.

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

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

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

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

Section E

Standard 5: 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 Home 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 five staff had received training on 31 July 2013 on the importance of record keeping commensurate with their roles and responsibilities in the home. A requirement is made that all registered nurses in the home be provided with training in this area.

Review of three patients' care records revealed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient.

These statements reflected wound and nutritional management intervention for patients as required.

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

Entries were noted to be timed and signed with the signature accompanied by the designation of the signatory. A number of entries were not dated and a recommendation is made that this shortfall be addressed.

The inspector reviewed a record of the meals provided for patients. Records were maintained in sufficient detail which enabled the inspector to judge that the diet for each patient was satisfactory. For example, the record evidenced a choice at each mealtime.

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 this patient was referred for a dietetic assessment. The dietician's recommendations were addressed in the patient's care plan on eating and drinking.

Review of one patient's care records evidenced that the patient was referred to a speech and language therapist. The patient's care plan

was not reviewed to address this professional's recommendations.

Review of a sample of fluid balance charts for a number of patients revealed that these charts were accurately maintained and evidenced that patients were offered fluids at regular intervals. These charts were totalled for the 24 hour period. The patients' recommended daily fluid intakes and the action to be taken if targets were not being achieved were not addressed in the patients' care plans. It is acknowledged that the patients' recommended daily fluid intakes were recorded on the patients' fluid records. 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. Forty three staff were trained since the previous inspection in the management of nutrition including the use of the malnutrition screening tool (MUST). The registered manager informed the inspector that arrangements were in place for further training to be provided in May and June 2014. .As previously stated a requirement is made in regard to shortfalls in care records.

Discussion with the registered 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. 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	**Moving towards Compliance**

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 Home 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 Home 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 the patients with one exception had a care review undertaken through care management arrangements between 01 April 2013 and 31 March 2014. The registered manager informed the inspector that arrangements were currently being put in place for this care review to be undertaken.

The registered manager informed the inspector that patients' care reviews through care management arrangements were held post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff preferably the patient's named nurse attends each care review. A copy of the minutes of the most recent care review were 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 updated to reflect recommendations made at care management care reviews 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 three weekly menu planner in place. The registered manager informed the inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home. The inspector discussed with the registered manager and a number of staff the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients. Staff spoken with were knowledgeable regarding the individual dietary needs of patients to include their likes and dislikes. Discussion with staff and review of the record of the patient's meals confirmed that patients were offered choice prior to their meals.

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

As previously stated under Section B and E review of one patient's care records evidenced that his patient was referred for a dietetic assessment. The dietician's recommendations were addressed in the patient's care plan on eating and drinking.

Review of one patient's care records evidenced that the patient was referred to a speech and language therapist. The patient's care plan was not reviewed to address this professional's recommendations.

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

Review of the menu planner and records of patients' choices and discussion with a number of patients, nursing sister, registered nurses and care staff it was revealed that choices were available at each meal time. The registered manager confirmed choices were also available to patients who were on therapeutic diets. Review of the menu planner revealed that this should be reviewed to include additional vegetables as there was one vegetable recorded for the main meal a number of days per week. The choices available for patients on therapeutic diets for all meals and snacks should be included on this menu planner. Subsequent to the inspection a revised menu planner was forwarded to the RQIA Omagh office.

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

Section I

Standard 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 Homes Regulations (Northern Ireland)2005:Regulation/s13 (1) and 20**
Inspection Findings:
The inspector discussed the needs of the patients with the registered manager. It was determined that a number of patients had swallowing difficulties. Review of training records revealed that 18 staff had attended training in dysphagia awareness in November 2013 and further training was planned for May and June 2014. Sixty six staff had attended training in first aid during the previous 12 months. Training in the fortification of foods and the preparation and presentation of pureed meals was planned for May and June 2014. Seventeen staff were trained in the use of

food and fluid thickening agents prior to the inspection and further training was also planned for May and June 2014.

Review of one patient's care records evidenced that the patient was referred to a speech and language therapist. The patient's care plan was not reviewed to address this professional's recommendations.

Discussion with registered manager confirmed that meals were served at appropriate intervals throughout the day and in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.

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

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

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

On the day of the inspection, the inspector observed the lunch meal in units five and six. Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely manner. However the desserts were served to a number of the patients at the same time as their main meal. Two of these patients were observed eating the dessert before the main course. A recommendation is made that this be addressed.

Staff were observed preparing and seating the patients for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients with their meal and patients were offered a choice of fluids. The tables were well presented with condiments appropriate for the meal served.

Discussion with the registered manager, nursing sister, registered nurses, care staff and review of the staff training records revealed that 52 staff were trained in wound management and pressure area care and prevention during the previous 12 months.

A tissue viability link nurse was employed in the home.

Discussion with the registered nurses clearly evidenced their knowledge in the assessment, management and treatment of wounds. Review of the template used to undertake competency and capability assessments for registered nurses revealed that pressure ulcer/wound care was addressed. Review of a sample of these competency and capability assessments revealed that each section was not individually signed by the nurse and registered manager. Group signatures were used. A recommendation is made that this be 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 check list of records required to be held in the home under Regulation 19(2) Schedule 4 of The Nursing Homes Regulations (Northern Ireland) 2005 was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required records were maintained in the home and were available for inspection. The inspector reviewed the following records:

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

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

11.2 Patients under guardianship

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

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

The inspector discussed the Human Rights Act and Human Rights Legislation with the registered manager and one of the registered nurses. The inspector can confirm that copies of these documents were available in the home. The registered manager and registered nurse displayed an awareness of the details outlined in these documents. The registered manager informed the inspector that these documents will be discussed with staff during staff meetings and that staff will be made aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patients care and accompanying records. The inspector also discussed the Deprivation of Liberty Safeguards with the registered manager and registered nurse including the recording of best interest decisions on behalf of patients. A copy of DOLS was also available in the home.

11.4 Quality of interaction schedule (QUIS)

The inspector undertook a number of periods of observation in the home which lasted for approximately 30 minutes each. The inspector observed the lunch meal being served in units five and six. The inspector also observed care practices in the in a number of sitting

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

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

On the day of the inspection, the inspector observed the lunch meal. Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely manner. However the desserts were served to a number of the patients at the same time as their main meal. Two of these patients were observed eating the dessert before the main course. A recommendation is made that this be addressed.

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

Observation of care practices in the sitting rooms 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 generally positive in regard to the care of patients in the home.

11.5 Complaints

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being pro-actively managed. The inspector reviewed the complaints records during the inspection. This review revealed that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought. The registered manager informed the inspector that lessons learnt from investigations were acted upon. There was one complaint currently under investigation by the WHSCT.

Prior to the inspection RQIA received correspondence through an e-mail from a relative expressing concerns in relation the care of their relative in the home.
It is not the remit of RQIA to investigate complaints made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if there is considered to be a breach of regulation as stated in The Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

The relative had raised their concerns with the registered manager of the home and the local healthcare Trust.

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 pro-forma 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 pro-forma 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 registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients currently in the home. However at the beginning of the inspection the inspector undertook a tour of the premises accompanied by the registered manager. During this tour the inspector observed that there was no staff supervision of patients who were up and dressed in the sitting areas. The staff on duty were assisting and supporting the patients in their bedrooms in preparation for the day. A requirement is made in regard to the supervision of patients. The ancillary staffing levels were found to be satisfactory.

There were two activity therapy staff employed, one full time and one part time. There was also a bus driver employed two days per week to take the patients on outings. However this staff member was on special leave at the time of inspection.

Taking into account the number of patients currently in the home, the layout of the premises (seven units) a recommendation is made that additional hours be provided for the provision of activities to patients. Staff were provided with a variety of relevant training including dementia awareness, management of enteral feeding systems and mandatory training since the previous inspection. However in addition to the training required throughout the report a requirement is made that staff as appropriate be trained in the following areas;

Care of patients with mental health needs;
Parkinson's disease awareness;
The provision of activities to patients with dementia related conditions and mental health needs.

During the inspection the inspector spoke to 23 staff. The inspector was able to speak to a number of these staff individually and in private. On the day of inspection 14 staff completed questionnaires. The following are examples of staff comments during the inspection and in questionnaires;

"I had induction when I commenced work"
"The quality of care in the home is very good and staff treat the patients very well"
"I am confident that all staff are extremely conscientious in carrying out their duties in accordance with patients' care needs"
"Staff have very good relationships with the patients and the patients are treated with dignity and respect and seem to enjoy daily activities"
"I think the home is a good quality nursing home and I would recommend this home to my family and friends "
"I feel this is a good nursing home and the patients are treated as individuals and cared for in a good way"
"I feel the home provides a good standard of nursing care"
"Very good nursing home, I would recommend this home to other people. The patients are very happy and content"
"Patients are well cared for and nursing and care staff are very competent"
"Staff here are very friendly and caring. Team work is paramount, I can talk to the manager very easily"
"Excellent team work"
"Patients are encouraged to be independent".

11.9 Patients' Comments

During the inspection the inspector spoke to12 patients individually and to a number in groups. On the day of inspection10 patients were assisted in the completion of questionnaires. The following are examples of patients' comments during the inspection and in questionnaires;

"Wonderful this is a great home"
"Staff treat me and my belongings with respect"
"The care and food is excellent, staff always pleasant, I don't know how they do it"
"I am very happy here, the food is excellent, you could not get better"
"Home is warm and comfortable but I miss my family"
Staff always respect my privacy and they always knock my door before entering"
"I am very happy staying here"
Everything is fine, the staff are outstanding".
"I would like to go out to day care"
"I do not like other people coming into my room whenever they like".

11.10 Relatives' Comments

On the day of inspection one relative completed a questionnaire. This relative also took the opportunity to speak to the inspector. The following are examples of the relative's comments;

"The staff contact the doctor right away if they have any concerns"
"My relative is always well presented, the food is good and my relative eats well"
"There are plenty of staff and they are always available when I visit".

11.11 Incidents

Review of a sample of incident records revealed that there was one incident recorded relating to two patients that should have been reported to the RQIA under Regulation 30 of

the Nursing Homes Regulations (Northern Ireland) 2005. A requirement is made in regard to this shortfall.

11.12 Environment

During the inspection the inspector undertook tour of the premises and viewed the majority of the patients' bedrooms, sitting areas, dining rooms, laundry, bath/shower and toilet facilities. The home was found to be warm, clean, and comfortable. During a tour of the home it was revealed that toiletries were held in unlocked cupboards / areas in patients' bedrooms/en-suites. Taking into account the categories of care of the patients in the home, a requirement is made that this practice be risk assessed.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Dr Brendan McDonald, Registered Provider and Mrs Joan McLoughlin, Registered Manager during the inspection feedback.

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**
A full admission process is carried out for each new patient admitted to the nursing home. 12 activities of daily living, risk assessemnt, moving and handling assessment and body mapping form are all completed on the day of admission and all careplans were risks are involved are completed within 12-24hrs of admission. All careplans and furhter assessemnts of MUST, Braden, continence assessment we aim to complete within one week of the asmission date. A preadmission assesssment is carried out prior to pt coming to home and identified needs are recorded at this time.	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**
Careplans for each patient are individualised and represent the level of support a pt may need with meeting their every day needs. A Primary Nurse is allocated for each pt on admission and this is highlighted on the pts notes and in their bedroom. Relatives are encouraged to discuss the identified risks and careplans that have been devised and to sign that they are in agreemnt with this plan of care.	Compliant

Any pt who is admitted with a pressure ulcer or develops a pressure ulcer while in the nursing home has an assessment of the area carried out and referred to our own woundcare link nurse for appropiate form of treatment. A careplan and woundcare chart are devised and implemented. A trained nurse will refer out to tissue viability for a visit should assessment show that wound is not improving or is deteriorating. Any pt who develops an ulcer to lower limb/foot area is referred to podiatry as urgent. Only inidine dressings applied to these areas until fully assessed by podiatry and instructions given. Any pt who scores 2 in the MUST assessment is automatically referred to the dietitic services for urgent assessment. Any pt scoring only 1 in the MUST assessment staff might also refer out yo be assessed if they have genuine concerns about the pts dietary needs yet MUST is scoring only 1.	

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**
All pts the are admitted to the Home have a pre admission assessment carried out by the home manager (except in emergency situations). During this assessemtn the full needs of the pt can be fully identified and guidance given on how best to meet these needs. Pts have all careplans devised within one week of admission. Care needs are based on the pre admission assessment/social workers report/medical report/medications prescribed and family/pt input. All careplans are evaluated atleast monthly and any new problems identified will have a careplan devised at that thime. Careplans are evaluated and assessed if still required as ongoing or no longer applicable.	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**
We use up to date information provided through our specialist teams/crest guidelines/nmc guidelines/nipec and this is available to all staff and is used to support all care actioned for our pts. We presently use the Braden scale on all our pts and this is carried out on a monthly basis. Action is taken immediately when a pt is amber/red lighting in order to prevent deterioration to skin. Any pt who has a pressure ulcer has a careplan devised specific to that pressure ulcer with specific information on the dressings to be used and the frequency of the dressing change. We presently have guidelines in use from the Health , Social Services and Public Safety Agency with regards to promoting good nutrition to pts in care settings.	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**
Nurses are fully naware of their accountability with regards to record keeping and the importance of ensuring that all pts notes have full and accurate entries made and that they are signed and dated. Pts notes are evaluated atleast twice in every 24hrs but more frequently as needs determine. Residents are offered a choice of meals each day and this is recorded and forwarded to the catering staff for their attention. Choices are fully adhered to. There are a number of residents who are on fluid balance/food record charts and full documentation of their daily intake is recorded. Those pts who do not have these charts still have their meal choices recorded each day and how well they ate their meals. All food/fluid charts are given to the nurse in charge prior to ending of each shift for checking and signing off. Care staff are made aware of the importance of reporting early in the shift when a pts appetite/fluid intake is reduced. When staff are concerned about a pts reduced fluid/food intake referrals are made out to GP and dietitic services.	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 pt has their care evaluated atleast twice a day and more frequent if their needs require this. Entries are timed and dated. Careplans that have been implemented in guiding staff in delivering care to each pt are evaluated atleast on a monthly basis. Familys are made aware of careplans/risk assessments that are in place and sign off on these when they have been explained to them.	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**
Where appropiate the pts are involved in the review of their planned care through MD/care review meetings. Relatives are invited and encouraged to attend these meetings to act as advocate for their relative.	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**
The menus are reviewed every 3-4 months by the head chef to look at offering a variety of meals for the pts and utilising any suggestions that come forward from pt meetings or pt feedback forms. Any pts that are on special diets the kitchen is made fully aware of this and any specific information coming in from other professional eg speech and language therapist/dietitian is also made available to the kitchen. All pts on admission has a record of food likes/dislikes completed and this is updated as necessary. There is always a choice of two meals at dinner and supper time.	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**
There has been training provided by speech and language therapist with regards to giving guidance on assisting pts with their foods and the safety aspect of this. More training is to be arranged to ensure that all staff feel confident in this area. Any information provided by SALT are adhered to and a copy is kept in pts notes and this is relayed on to the care staff at reports and at each meal time. All meals are served to meet the pts needs and should a pt require a meal outside of the arranged meal times this is accommodated. Drinks and snacks are served and available throughout the day.	Substantially compliant

We aim to have the full compliment of staff working on the floor and available for serving of meals at all main meal times. Full assistance is given to those pts who are assessed as requiring support with meals, snacks and drinks. We have one nurse as the woundcare link nurse and she updates staff on how to assessa wound the the most appropiate dressings to aid with healing. Most of the trained staff have recently attended treaining in woundcare management.	

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.

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Primary Announced Inspection

Slieve Na Mon Nursing Home

24 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 Dr Brendan McDonald, Registered Provider and Mrs Joan McLaughlin, Registered Manager during the inspection feedback.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers/managers should note that failure to comply with regulations may lead to further enforcement and/or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider/manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

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

Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on the HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and the Nursing Homes Regulations (NI) 2005

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	16(2)	The registered person shall ensure that patients' care records are reviewed and updated in accordance with their assessed /changing needs. Ref. Sections B and E	One	A new assessment of needs form was devised and has been implemented by the primary nurses in updating their allocated patients assesssment of needs. This will updated on a regular basis as the patients needs change. Assessment of needs and careplans now correspond. We are also working towards computerising all individual careplans. This is a slow process but will be a very valuable exercise.	One Month
2	13 (a)	The registered person shall ensure that the nursing home is conducted so-as –to promote and make proper provision for the nursing, health and welfare of patients. Ref. Section B	One	Staff have been made fully aware of the requirement to give a detailed evaluation based on the patients careplans and this was implemented with immediate effect.	One week
3	30 (1) (d)	The registered person shall give notice to the Regulation and Improvement Authority without delay of the occurrence of –any event in the nursing home which adversely affects the wellbeing or safety of any patient. Ref. Section B and Section 11, point 11.11	One	All trained staff have been updated in the importance of reporting incidents to RQIA in a timely manner.	One week

4	20 (1) (c)(i)	Staff as appropriate should be trained in the following areas. Care of patients with mental health needs Parkinson's disease awareness The provision of activities to patients with dementia related conditions and mental health needs. Ref. Section 11, point 11.8	One	Training for all staff on Mental Health Needs has been booked for 3rd July 2014 and 24th July 2014. We are awaiting training through the Trust for training staff on Parkinsons disease which will be delivered inhouse. I have contacted our representrative from Sterling University who is based in Belfast-she will inform me when training will be available in provision of activities.	One Month
5	13 (b)	The registered person shall ensure that the nursing home is conducted so as- to make proper provision for the nursing and where appropriate, treatment and supervision of patients. Ref. Section 11, point 11.8	One	The nursing home presently meets rqia guidelines on staffing levels. We have taken into consideration the period when patients are rising/retiring and looked at providing additional cover at these times. This has now been addressed and implemented.	One week
6	14 (2) (c)	The registered person shall make arrangements for unnecessary risks to the health or safety of patients are identified and so far as possible eliminated. Ref, Section 11, point 11. 11	One	All patients now have risk assessments completed regarding toileteries been stored in a closed door vanity unit in their bedroom or on open shelves in their ensuites. We are also looking at magnetic locks for vanity units but ? the patients right to have access to their own	Two weeks

				possessions.	

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.3	It is recommended that infection control assessments be undertaken for patients on admission to the home. Ref. Section A	One	This has been completed.	One week
2	5.3	It is recommended that the roles and responsibilities of key workers be outlined in	One	This has been completed.	One month

		the patient's guide. Ref. Section A			
3	6.2	It is recommended that all entries in care records be dated, timed and signed with the signature accompanied by the name and designation of the signatory. Ref. Section E	One	All trained staff have been made aware of this and always put the date now as well as the time of each entry.	One week
4	13.5	It is recommended that additional hours be provided for the provision of activities to patients. Ref. Section 11, point 11.8	One	A full activity is emploted within the home. There are a further two part-time activity assistants in post. One of the Part-timers hour are going to be slightly increased.	One month
5	12.5	It is recommended that main courses and desserts are not served at the same time to patients. Ref. Section I	One	This has been implemetned and is now ongoing.	One week

6.	30.4	It is recommended that the template used to undertake competency and capability assessments for registered nurses be individually signed by the registered manager and registered nurse. Ref. Section I	One	This has been implemented and now ongoing.	One week

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

Name of Registered Manager Completing Qip	S. Mc Laughl
Name of Responsible Person / Identified Responsible Person Approving Qip	

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	yes		11/6/2014
Further information requested from provider			