Secondary Unannounced Care Inspection

Name of Service and ID:	**The County (1214)**
Date of Inspection:	**09 December 2014**
Inspector's Name:	**Heather Moore**
Inspection ID:	**IN017144**

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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1.0 GENERAL INFORMATION

Name of Home:	The County
Address:	42 Tempo Road Enniskillen BT74 6HR
Telephone Number:	028 6632 3845
E mail Address:	the.county.m@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Season Healthcare Mr James McCall
Registered Manager:	Ms Wendy Shannon
Person in Charge of the Home at the Time of Inspection:	Ms Wendy Shannon
Categories of Care:	NH-DE, NH-I, NH-PH, RC-I
Number of Registered Places:	58
Number of Patients and Residents Accommodated on Day of Inspection:	46 Patients 3 Residents
Scale of Charges (per week):	£581.00 Nursing £481.00 Residential
Date and Type of Previous Inspection:	05 February 2014 Secondary Unannounced
Date and Time of Inspection:	09 December 2014 08.50 am - 1.50 pm
Name of Lead Inspector:	Heather Moore

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 are required.

This is a report of an inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being 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.

The Regulation and Quality Improvement Authority aims to use inspection to support providers in improving the quality of services, rather than only seeking compliance with regulations and standards. For this reason, annual inspection involves in-depth examination of a limited number of aspects of service provision, rather than a less detailed inspection of all aspects of the service.

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

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

- Discussion with the registered manager
- Discussion with staff
- Discussion with patients /residents individually and to others in groups
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- Review of a sample of care records
- Observation during a tour of the premises
- Evaluation and feedback.

5.0 Consultation Focus

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

Patients/Residents	**10**
Staff	**10**
Relatives	**1**
Visiting Professionals	**0**

Questionnaires were provided by the inspector, during the inspection, to patients / residents, their representatives and staff to seek their views regarding the quality of the service.

Issued to:	**Number Issued**	**Number Returned**
Patients /Residents	**6**	**6**
Relatives / representatives	**0**	**0**
Staff	**9**	**9**

6.0 Inspection Focus

The inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

STANDARD 19 - CONTINENCE MANAGEMENT

Patients receive individual continence management and support.

The inspector has 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		
Compliance statement	**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

The County is registered to provide care for up to 52 patients and six residents.

The home is registered in the following categories of care:
Nursing I - old age not falling within any other category
Nursing PH - physical disability other than sensory impairment
Nursing DE - dementia
Residential I - old and infirm not falling within any other category

The home is also registered for the provision of day care for five persons.

The home is situated in its own landscaped grounds off the Tempo Road on the outskirts of Enniskillen in Co Fermanagh.

The home comprises of 49 single and four double bedrooms with a number having en-suite facilities, main kitchen, two dining rooms, laundry, three bathrooms, showers and sluice facilities, five sitting rooms, designated smoking areas, visiting area, two general offices, two treatment rooms, and staff and store rooms.

The home is a split-level building with access to the lower ground floor via a through floor lift and stairs.

There is adequate car parking facilities at the front and side of the home.

8.0 Summary

This summary provides an overview of the services examined during an unannounced secondary care inspection to The County. The inspection was undertaken by Heather Moore on 09 December 2014 from 8.50am to 1.50 pm.

The inspector was welcomed into the home by Ms Wendy Shannon, Registered Manager who was also available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to the registered manager at the conclusion of the inspection.

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

As a result of the previous inspection conducted on 14 February 2014 two requirements and four recommendations were issued. These were reviewed during this inspection. The inspector evidenced that these requirements and recommendations had been complied with. Details can be viewed in the section immediately following this summary.

Discussion with the registered manager, a number of staff, patients and residents and review of three patients care records revealed that continence care was well managed in the home.

Staff were trained in continence care on induction and staff had also received additional training on continence awareness on 18 June 2014.

Currently a senior care assistant was appointed in the home to manage continence.

Examination of three care records confirmed a good standard of documentation.

A regular review of the management of patients and residents who were incontinent was undertaken and the findings were acted upon to enhance already good standards of care.

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

Two requirements are made. These requirements are detailed in the report and in the quality improvement plan (QIP).

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

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	20 (1) (a)	The registered person shall, having regard to the size of the nursing home, the statement of purpose and the number and needs of the patients, ensure that at all times suitably qualified, competent and experienced persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients and residents.	Observation on the day of inspection and examination of three weeks duty rosters confirmed that registered nurses and care staffing levels were satisfactory and in line with the RQIA's minimum staffing guidelines. Discussions with the registered manager confirmed that since the previous inspection one registered nurse's hours had been increased to 20.00 hours. An additional care assistant had also been rostered from 14.00 hours to 20.00 hours.	Compliant
2	12 (2) (b)	The registered person shall ensure that all aids and equipment used in or for the purpose of the nursing home is properly maintained and in good working order.	Discussions with the registered manager confirmed that a review of the emergency equipment had been undertaken two nebulisers are now available in the home and the oxygen cylinders have been included in the regular review of emergency equipment.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	20.4	It is recommended that the home's first aiders be recorded on the staff duty rosters for all shifts over each 24 hour period.	Examination of the staff duty roster confirmed that the home's first aiders were recorded appropriately.	Compliant
2	5.3	It is recommended that care plans on "Do Not Attempt Resuscitation" be further developed to address spiritual care, dignified and respectful care after death and communication and support for the patient's family.	Inspection of three patients care records confirmed that care plans on "Do Not Attempt Resuscitation" had been further developed to include the patients' holistic needs.	Compliant
3	20.4	It is recommended that records are held to evidence staff competencies in cardiopulmonary resuscitation.	Discussion with the registered manager and examination of records confirmed that a written record on the staff member's competency on basic resuscitation skills was available on the day of inspection.	Compliant
4	25.12	It is recommended that a summary of staff comments be recorded in reports of visits undertaken in the home under regulation 29.	Inspection of a sample of Regulation 29 reports confirmed that a summary of staff comments were recorded.	Compliant

9.1 Follow up on any issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

There were no issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support.	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of three patients'/residents' care records revealed that bladder and bowel continence assessments were undertaken for these patients and residents. The bladder and bowel assessments and the care plans on continence care were reviewed and updated on a monthly or more often basis as deemed appropriate monthly. The promotion of continence, skin care, fluid requirements and patients' and the resident's dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients and residents were referred to their GPs as appropriate. Review of care records revealed that there was written evidence held of patient/resident and their relatives' involvement in developing and agreeing care plans. Discussion with staff and observation during the inspection revealed that there were adequate stocks of continence products available in the home.	Compliant
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place; • continence management / incontinence management • stoma care • catheter care. The inspector can also confirm that the following guideline documents were in place;	Compliant

• Nice Guidelines on Faecal incontinence • Nice Guidelines on urinary incontinence. Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not applicable.	Not Applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the registered manager and review of the staff training records revealed that staff were trained in continence care on induction. Staff had also received training on continence care on 11 and 16 September 2014. Registered nurses had also received training in male catheterisation on 10 March 2013. Discussion with the registered manager revealed that currently in the home there were patients that required assistance with stoma appliances. A senior care assistant in the home is nominated as the named person to manage continence care. The registered manager informed the inspector that all patients and residents were reassessed for the delivery of new continent products, which had proven positive for the patients comfort.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

During the inspection the staff were noted to treat the patients and residents with dignity and respect. Good relationships were evident between patients, residents and staff.

Patients and residents were well presented with their clothing suitable for the season.

Staff were observed to respond to patients' and residents' requests promptly.

The demeanour of patients and residents indicated that they were relaxed in their surroundings.

11.2 Patients' and Residents' and Relative's Comments

During the inspection the inspector spoke to 10 patients and residents individually and to others in groups. Six patients and residents also completed questionnaires. These patients and residents expressed high levels of satisfaction with the standard of care, facilities and services provided in the home. A number of patients and residents were unable to express their views verbally. These patients and residents indicated by positive gestures that they were happy living in the home.

Examples of patients' and residents' comments were as follows:

- "I am very happy here."
- "The food is very good."
- "We have a Christmas party soon."

The inspector spoke to one relative during the inspection process, this relative also completed a questionnaire.

Example of the relative's comments was as follows:

- "The care here is excellent, I have no problems."

11.3 Staffing/Staff Comments

On the day of inspection the number of registered nurses and care staff rostered on duty were in line with the RQIA's recommended minimum staffing guidelines for the number of patients and residents currently in the home.

The inspector spoke to a number of staff during the inspection. Nine staff completed questionnaires. No issues or concerns were brought to the attention of the inspector.

Examples of staff comments were as follows:

- "I feel that the staff make the nursing home feel like a home, the residents are all well looked after."
- "The general atmosphere is friendly and positive."

- “I am extremely happy working in The County. Staff are all very supportive. We have an excellent manager.”
- “I have been working here for two months and I had an induction. The staff are all very helpful.”
- “All of the residents are treated with the best of care and respect by all members of the team.”
- “I am very happy in my work the residents are all well looked after.”
- “The staff work well as a team, residents are all treated with respect.”
- “Residents receive excellent care.”

11.4 Environment

The inspector undertook a tour of the premises and viewed the majority of the patients’ and residents’ bedrooms, sitting areas, dining rooms, and laundry, kitchen, bathroom, and shower and toilet facilities.

The home was found to be clean warm and comfortable with a friendly and relaxed ambience. However the following environmental issues require to be addressed:

- Replace the identified patients bedroom floor coverings
- Repaint the identified patients bedrooms.

A requirement is made in this regard.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Wendy Shannon, Registered Manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

Heather Moore
The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 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**
Prior to admission to the home, the Home Manager or designated representaitve carries out a pre-admission assessment. This is based on information gleaned from the the resident/representative, where possible, nursing and medical records and information provided by the Care Management Team. Initial assessments include Braden Tool and MUST, if known, are also carried out at this stage. Following the assessment, a decision is made of the Home's ability to meet the needs of the resident. In the case of an emergency where pre- admission assessment is not possible, this is completed by telephone with the comprehensive assessment from the Care Management Team following by either fax or the Care Manager hand delivering it to the Home. The admission does not take place until the manager is in receipt of this information and she is satisfied the home can meet the residents needs. Following admission to the Home, the named nurse completes a comprehensive Admission Assessment using	Compliant

validated assessment tools within 11 days of admission e.g,Moving & Handling Profile, Falls Assessment,Continence Assessment, Oral Assessment, body map and Braden Score and bed rail assessment as per FSHC Policies and Procedures. The assessment is person centred. Pressure ulcer risk assessment is carried out that includes a nutritional assessment, using the MUST screening tool and pain and continence assessments The comprehensive assessment identifies risks and how to manage those risks in a safe and effective manner The plan of care is formualted, using a person centred approach in conjuntion with the resident representative, where possible, to meet the residents needs. The clinical judgement of the nurse is also considered in the formulation of the care plan to ensure the wishes and expectations of the resident/representative are met and consent sought. This is evidenced in the care plan via the consent forms e.g. photographs, bedrails. A record of personal effects is also documented. A Needs Assessment which includes 16 areas of need includes the necessaary information to formulate the plan of care The residents representative is included in the formulation of the care plan and this is evidenced on each individual care plan with a signature of the representative.	
Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8**	

• **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Each resident in the Home has a named nurse who has responsibility for formulating a comprensive and holistic plan of care, as cited in Section A, within the required timescale as indicated in the Care Home Minimum Standards. Care Plans document and demonstrate the promotion of maximum independance and rehabilition the resident is capable of doing independantly, taking into account advice from relevant health care professionals. The nursing team in the Home are fully aware of the referral arrangements to the Tissue Viability Team in the Trust. Referral forms are held on file and the contact name and number of the TVN is available. For those residents who are at risk or have diabetic foot ulceration, this is managed by the Trust Diabetic Podiatrist with regular follow up reviews. Where a resident is at risk of developing presure sores, a care plan is formulated. The care plan includes skin care,frequency of positioning, types of device implemented e.g. pressure releiving mattress. All care plans are formulated and interventions and treatment agreed with the resident and representative. Again, advice is sought from the multi -disciplinary team where appropriate. The Registered Nurse takes the decision to make a referral to the dietician based on the score of the MUST tool and using their clinical judgement. Referral forms are held in the Home and completed by staff . Telephone advice is also available whilst awaiting a visit. to the resident. A care plan is formulated to reflect advice, interventions and recommendations, again in agreement with the resident and representative. The care plan is evaluated monthly or more frequently if necessary. The Regional Manager is informed of wounds, pressure ulcers on unannounced monthly monitoring visit (Reg29) and is also reportred monthly to the SMT at regional office monthly. (Clinical dashboard). Wounds and pressure ulcers are also audited on a monthly basis by the Home Manager or designated person. A Tissue Viablity Resource File is held in the Home which contains evidence based guidelines for wound care and prevention of pressure ulcers e.g. NICE Guidelines ' Pressure Ulcers:prevention and management of pressure ulcers April 2014	Compliant

BNF Wound Guidance NHS Wound Classification Chart NI Wound Care Formulary Crest Guidelines on General Principles of Caring for Patients with Wounds/ Pressure Sores EPUAP Pressure Ulcer Classififcation System The resource file also contains researc articles and information wound dressing products	
Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The resident is assessed on a daily basis and any changes noted in the daily progress sheet. This occurs twice over the 24 hour period. Once by day staff and once by the night staff. The care plan is then updated as necessary in agreement with the resident or representative. Any changes or issues identified are reported to the Home Manager via the 24 hour shift report The Needs Assessmentt, risk assessments and care plans are evaluated on a monthly basis or more often if there is a change in the residents condition. The plan of care dictates the frequency of reviews and reassessment	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All nursing interventions, activities and procedures are implemented based on best evidence and guidelines e.g. NICE, GAIN, RCN, PHA, HSSPS and RQIA. The EPUAP grading system is a validated tool used by the Home to screen residents who have skin damage in the form of a wound or pressure ulcer. If a wound is present on admission or develops following admission, an initial wound assessment is completed with an agreed plan of care. This includes the grade of the pressure ulcer, dressing regimen, wound cleansing, frquency of positioning, pressure reliving devices used e.g. mattress and type and time interval for review. An ongoing wound assessment is then complted going forward. The care plan is evaluated monthly or more often if required i.e. if dressing regimen is alteredor any change in integrity of the wound. There are evidence based up to date nutritional guidelines held in the Home. These include: 'Promoting Good Nutrtition'-A Strategy for Good Nutritional Carefor Adultsi n all Care Settings in Northern Ireland RCN-Water for Health and Nutrition Now' , PHA-Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes', NICE Guidelines-Nutrition Support in Adults'. The Caroline Walker Trust- 'Eating Well for Older People'	Compliant

NPSA Dysphagia Diet Food Texture Descriptors Food Standards Agency-' Controlling the Risk of Cross Contamination from E.coli These guidelines and various documents are available for staff to refer to. Staff also must adhere to FSHC policies in relation to nutrition care,diabetic guidelines, sub cutaneous fliuds and care of PEG feeding	
Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing records are kept of all interventions, activities and procedures that are carried out in relation to each resdent. The records are contemporaneous and in accordance with NMC Guidelines-Record Keeping- Guidance for nurses and midwives.	Compliant

Records of the meals provided for each resident for each meal are recorded on a daily menu choice form. The Catering Manager also holds diet notification forms on every resident which includes information on specialist dietary advice/requirements e.g. diabetic diet and also texture of food served for those residents who have been assessed by SALT as having swallowing difficutlies. Food and fluid records are completed for residents who have been assessed as being at risk of malnutrition, dehydration or eating/drinking excessively. This information is recorded in the appropriate FSHC record booklets. The food charts are recorded over a 24 hour period and in addition, the fluid intake is totallled at the end of the 24hour period. Any deficits identified have appropriate action taken, with referrals bieng made to the releavnt MDT team member. Any change to the plan of care is also discussed with the resident and the representative. Where actions are required, nursing staff will make the necessary referral to to relarvant member of the MDT	
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**
The outcome of care delivered is monitored and recorded on a daily basis in the daily progress notes with at last a minimum of one entry during the day and one further entry made by the night staff. The outcome of care is reviewed as indicated on the care plan or more often if there is a change in the residents condition or should any further recommendations be made by the MDT. Residents and representatives are also involved in the evaluation process and this is evidenced in the communication notes within the careplan	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care Management Reviews are held approxamately 6 weeks following admission to the Home. Thety are scheduled annually thereafter. Reviews can also be scheduled if there is a change inn the residents needs, if concerns are raised or at the request of the resident or representative. The Trust are responsible for scheduling the reviews but care managers can also be prompted by the nursing team if they are deemed to be overdue. The resident, where appropraite is invited to attend the review along with the reperesentative. The nurse will also attend the review. Copies of the review are held in the residents file and a copy is maintained by the Care Manager. Any recommendations made as a r esult of the review are actioned by the Home and care plans formulaied to reflect any changes. The residents and representative are included in the process and of progress towards agreed goals. Care Management Reviews are checked quarterly by the Manager/designated person to ensure reviews are held within the required timescale	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 Home follows FSHC policies and procedures in relation to nutrition, based on best evidence as cited in Section D. Registered nurses assess each residents dietary needs on admission and this is reviewed on an ongoing basis. The care plan reflects the type of diet, any special dietary requirements, personal preferences in regard to likes and dislikes, specialist equipment required, if the resident is independent or requires a certain level of assistance and recommendations made by the dietician or speech and language therapist. The care plan is evaluated on a monthly or more often if necessary. The Home has a 3 week menu which is reviewed 6 monthly on the basis of information gleaned from the resident food surveys and taking into account seasonal availability of foods. The cook attends residents meetings to ensure residents are satisfied with menu and quality of food served at mealtimes. The PHA document ' Nutrition and Menu Checklist for Residential and Nursing Homes' is referred to to ensure the menu is nutritious and varied. Copies of instructions and recommendations from the dietician and speech and language therapist are available in the kitchen along with the diet notification form which informs the cook snd kitchen staff of special dietary requirements. Residents are offered a choice of two meals and desserts each mealtime, if the resident does not want anything from the daily menu available, an alternative meal of their choice is provided. The menu offers the same choice, as far aspossible to those on therapeutic diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments , sauces and fresh fluids are availble at each meal. Menus are on display in the dining room and the 3 week menu is in a display folder in both foyers of the Home	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**
Registered nurses are attending training on dysphagia on 22/7/14. Trained staff received training on PEG tube feeding on 5/6/14. Furthermore, all staff, ncluding care staff, are invited to attend training on the use of thickened fuids on 30/6/14. All nursing, care and kitchen staff in the Home have completed the E-learning module 'Nutrition & Malnutrition in Older People' The speech and language therapist and dietician also review those residents who have swallowing difficulties on a regular basis and more often if condition deteriorates. All nursing, care and kitchen staff are aware of the resdients who have swallowing difficulties as lists are located in both nurse stations and the kitchen. The NPSA document	Compliant

'Dysphagia Diet Food Descriptors' is also available for guidanc along with NICE guidelines 'Nutrition Support in Adults'. The kitchen also have a copy of SALT recommendations on file with the dietary notification forms. Meals are served at conventional times but if a resident requests any alteration to have their meal outside of the conventional time, this is upheld. Hot and cold drinks and a variety of snacks are available at all times day and night and on request. Snacks are also available on request and for those on modified or fortified diets. Cold drinks are availble at all times in the lounge and for those residents who prefer to stay in their bedroom during the day. This is replenished on a regular basis. Any matters concerning a residents eating and drinking are detailed in the care plan e.g. likes and dislikes,type and consistency of food and fluids, specialist equipment required. and if assistance is required.. A diet notification form is completed for each residen and kept in the care plant with a copy given to the kitchen. Meals are not served unless a member of staff is preeent in the dining room. Resisents who require supervision, full or partial are given assistance and fed at a pace suitable to them taking into consideration possibilitty of choking. Nursing and care staff have completed the e-learning module on pressure area care. The home has a Wound Care link nurse who attends the meetings provided by the WHSCT and this provided support to other nurses in the Home. Nursing staff attended Tissue Viablity update provided by the WHSCT TVN on 27/5/14. All nurses in the Home involved in wound care have also a wound assessment competency.	

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

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Secondary Inspection

The County

09 December 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 Ms Wendy Shannon, Registered Manager either during or after the inspection visit.

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	27 2 (d)	The registered person shall ensure that the identified patients' bedroom floor coverings are replaced. **Ref Section11 (Additional Areas Examined) point 11.6**	One	Replacement flooring approved and purcahse order received 6/1/15	Three Months
2	27 2 (b)	The registered person shall ensure that the identified patients' bedrooms are repainted. **Ref: Section 11 (Additional Areas Examined) point 11.6**	One	Actioned. Redecorating programme commenced on 6/1/15	Three Months

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	Recommendation	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
		No recommendations were made as a result of this inspection.			

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	Wendy Shannon
Name of Responsible Person / Identified Responsible Person Approving Qip	JR Watson Jim McCall DIRECTOR OF OPERATIONS 6.1.15

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

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Heather Moore	06 January 2015
Further information requested from provider			