Announced Primary Inspection

Name of Establishment:	**The Tilery**
Establishment ID No:	**1217**
Date of Inspection:	**13 May 2014**
Inspector's Name:	**Teresa Ryan**
Inspection No:	**17127**

The Regulation And Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544

1.0 General Information

Name of Home:	The Tilery
Address:	130 Swanlinbar Road Florencecourt Enniskillen BT92 2DZ
Telephone Number:	028 6634 8811
E mail Address:	thetilery@btconnect.com
Registered Organisation/ Registered Provider:	Mrs Claire Stranney
Registered Manager:	Mrs Martina McGovern
Person in Charge of the home at the time of Inspection:	Mrs Martina McGovern
Categories of Care:	NH-I, RC-I Plus two day care places per day
Number of Registered Places:	36 (34 NH-I, two RC-I)
Number of Patients &Residents Accommodated on Day of Inspection:	32 Patients 2 Residents
Scale of Charges (per week):	£567 Nursing £450 Residential
Date and type of previous inspection:	28 October 2013 Unannounced Care Inspection
Date and time of inspection:	13 May 2014 08.00 hours – 16.40 hours
Name of 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 announced 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/Residents	**Eight individually and with others in groups**
Staff	**14**
Relatives	**Five**
Visiting Professionals	**-**

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

Issued To	**Number issued**	**Number returned**
Patients / Residents	**5**	**3**
Relatives / Representatives	**5**	**one**
Staff	**15**	**12**

6.0 Inspection Focus

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

The criteria from the following standards are included;

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

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

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

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

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

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

7.0 Profile of Service

The Tilery provides care for up to 34 patients and two residents. The home is situated in its own beautifully landscaped grounds off the main Enniskillen – Swanlinbar Road. The nursing home is owned and operated by Mr & Mrs Stranney. The current registered manager is Mrs Martina McGovern.

The home is divided into three corridors, East, South and Riverside wing and comprises of 26 single bedrooms – 15 with en-suite and five double rooms, one with en-suite. There are three sitting rooms, main kitchen, dining rooms, bathroom, shower, toilet and sluice facilities, a nurses' station, office and a laundry.

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

The home is registered in the following categories of care;

Nursing I – Old age not following within any other category
Residential I – Old age not falling within any other category.

The home is also registered to provide day care for two persons on a daily basis.

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (announced) to The Tilery. The inspection was undertaken by Teresa Ryan on Tuesday 13 May 2014 from 08.00 hours to 16.40 hours.

The inspector was welcomed into the home by Mrs Martina Mc Govern, Registered Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was provided to Mrs McGovern at the conclusion of the inspection.

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

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

Questionnaires were issued to patients, relatives 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 28 October 2013, three requirements and three recommendations were issued. These were reviewed during this inspection. The inspector evidenced that three requirements and two recommendations had been fully complied with. One recommendation was not addressed and is therefore restated. 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's needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patient's needs was evidenced to inform the care planning process.

The inspector reviewed four patients' care records. There were a number of shortfalls identified in these care records. These shortfalls are highlighted throughout the report. A requirement is made in regard to these shortfalls. A requirement is also made that records are kept up to date.

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.

- **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 also observed the serving of the lunch meal and can confirm that patients were offered a choice of meal and that the meal service was well delivered. Patients were observed to be assisted with dignity and respect throughout the meal. The inspector reviewed one identified patient's care records in regard to the management of enteral feeding systems. There were a number of shortfalls in this patient's care records. These are addressed under Section I in the main body of the report. As previously stated a requirement is made in regard to the shortfalls identified in the care records inspected. A requirement is made that staff as appropriate be trained in the preparation and presentation of pureed meals and the use of food and fluid thickening agents.

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

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

The inspector reviewed a sample of fluid intake records for one identified patient. The inspector also reviewed a sample of the records of the administration of fluid thickening agents to patients. There were a number of omissions in these records and the evidence provided indicated that patients were not offered fluids on a regular basis.

A number of these records failed to evidence;

- the total fluid intake for the patient over 24 hours
- an effective reconciliation of the total fluid intake against the fluid target established
- action to be taken if targets were not being achieved
- a record of reconciliation of fluid intake in the daily progress notes
- that patients were offered fluids on a regular basis over the 24 hour period.

.

A requirement is made that the registered person shall ensure that food and fluids are provided in adequate quantities and at appropriate intervals. A requirement is made in regard to the health and welfare of patients. A requirement is also made that records are kept up to date.

Patients were observed to be able to access fluids with ease throughout the inspection.

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

Patients, their representatives and staff questionnaires

Some comments received from patients and their representatives;

“Wonderful, this is a great home”
“The care and food is excellent, staff always pleasant and would do anything for you”
“I am very happy here, the food is very good, I always get choices”
“Excellent, could not be improved upon”
“This is the best home you could ask for everything is very good”.

Some comments received from staff;

“The quality of care in the home is very good and staff treat the patients very well”
“I feel under the new manager that the home will continue to provide a high standard of care, privacy and dignity to all the patients.”

"I am very happy here at the Tilery, it is a very pleasant working environment. Any concerns that I have are always addressed promptly. I find the staff and management very approachable".

A number of additional areas were also examined;

- records required to be held in the nursing home
- guardianship
- Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)
- Patient and Staff Quality of Interactions (QUIS)
- complaints
- patient finance pre-inspection questionnaire
- NMC declaration
- staffing and staff comments
- comments from representatives/relatives and visiting professionals
- environment

A recommendation is made that a deputy manager/senior nurse be appointed in the home.
A recommendation is made that additional hours be provided for the provision of activities to patients.
A recommendation is made that thumb turns be fitted on bedroom doors with exceptions noted in patients' and residents' care plans.
A recommendation is also made that suitable transparent privacy screening be provided at the nurses' station.

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

A recommended is restated that details in reports of visits undertaken under Regulation 29 be discussed with staff during staff meetings/forums.

Conclusion

The inspector can confirm that at the time of inspection the delivery of care to patients was evidenced to be of a good standard.

The home's general environment was well maintained and patients were observed to be treated with dignity and respect. However, areas for improvement are identified. Five requirements and four recommendations and one restated recommendation 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 relatives, 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, relatives and staff who completed questionnaires.

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	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 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. This requirement is made in regard to care, catering, domestic and laundry staffing levels.	Discussion with the registered manager and review of a sample of staff duty rosters revealed that the care staff, staffing levels were in accordance with the RQIA'S recommended minimum staffing guidelines. The catering staff, staffing levels were found to be satisfactory. Designated laundry staff had been employed and this is commendable. There was one domestic staff member rostered on the day of inspection and the registered manager informed the inspector that arrangements were in place to employ additional staff.	Compliant
2	13 (7)	The registered person shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff.	During the inspection staff were observed to undertake their duties in accordance with infection control policies and procedures.	Compliant

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
3	27 (2) (d)	The registered person shall, having regard to the number and needs of patients, ensure that all parts of the nursing home are kept clean and reasonably decorated.	On the day of inspection the home was found to be warm, clean and comfortable.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	20.2	It is recommended that emergency resuscitation equipment be held in the new extension of the home.	Observation during the inspection revealed that emergency resuscitation was held in the new extension of the home.	Compliant
2	25.12	It is recommended that details in reports of visits undertaken under Regulation 29 be discussed with staff during staff meetings/forums and ways forward agreed on how action plans contained within these reports will be addressed	Review of a sample of the minutes of staff meeting revealed that this recommendation had not yet been addressed. Restated	Not compliant
3	1.2	It is recommended that action plans be drawn up following patients, residents, relatives and staff meetings. Records should be held of the action taken on comments and suggestions made for improvement.	Review of a sample of the minutes of meetings revealed that this recommendation was being addressed.	Compliant

10.0 Inspection Findings

Section A

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.**

Inspection Findings:

Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

The inspector reviewed four patients' care records which evidenced that patients' individual needs were established on the day of admission to the nursing home through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks.

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

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 four patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 11 days 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	**Compliant**

Section B

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.**

Inspection Findings:

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

Review of four patients' care records and discussion with patients and five visiting relatives evidenced that patients as appropriate and their representatives were involved in discussions regarding the agreeing and planning of nursing interventions. Records also evedenced discussion with patients and or their representatives following changes to the plans of care.

Review of four patients' care records revealed that a number of care plans for one patient were not reviewed following the re-assessment of the patient's needs. Review of four patients' care records also revealed that a number of care plans and supplementary risk assessments were not reviewed on a monthly of more often basis. The reviews of supplementary risk assessments and care plans did not fully reflect the outcome of assessments and the care prescribed in care plans. The patients' spiritual needs were not addressed in the care plans inspected.

The registered manager informed the inspector that there were currently two patients in the home who required wound management for wounds. Review of these patients' 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 charts were in place for the patients with the wounds and also for patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these charts revealed there was no evidence available that the patients' skin condition was inspected for evidence of change at each positional change. The registered manager reviewed and updated the repositioning chart on the day of inspection to address patients' skin condition. It was 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 and two registered nurses and review of four 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 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 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 patients. A tissue 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' weight was recorded on admission and on at least a monthly basis or more often if required.

The patients' nutritional status was reviewed on a monthly basis or more often basis.

Daily food and fluid records were maintained for patients assessed as being at risk of malnutrition and dehydration.

Review of wound care in two patients' care plans evidenced that the dressing regimes were recorded appropriately.

Policies and procedures were in place for staff on making referrals to the dietician. These included 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 care records for two patients evidenced that the patients were referred for a dietetic assessment in a timely manner. The patients' care plans on eating and drinking were reviewed to address the dietician's recommendations.

Discussion with the registered manager, registered nurses, care staff and review of the staff training records revealed that 17 staff were trained in wound management and pressure area care and prevention during the previous 12 months. The registered manager informed the inspector that further training in pressure area care and prevention was planned for 24 June 2014. Fourteen staff were also trained in the management of nutrition on 12 February 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 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 identified in the 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 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Homes Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**
Inspection Findings:
Review of four patients' care records evidenced 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. Review of four patients' care records revealed that a number of care plans and supplementary risk assessments were not reviewed on a monthly or more often basis. As previously stated a requirement is made in regard to shortfalls identified in the care records inspected. 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 wound had deteriorated. The evaluation process included the effectiveness of any prescribed treatments, for example, prescribed analgesia. Discussion with the registered manager, two registered nurses and review of governance documents evidenced that a number of care records were audited on a monthly basis.

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 5.5

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

Standard 11.4

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

Standard 8.4

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

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

Inspection Findings:

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

Discussion with the registered manager, 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. Registered nursing staff were found to be knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care.

Ten staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held in the kitchen for easy access by staff**.** This is commendable practice.

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 5.6

- **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.

Inspection Findings:

A policy and procedure relating to nursing records management was available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

Registered nurses spoken with were aware of their accountability and responsibility regarding record keeping.

A review of the training records confirmed that staff had received training on the importance of record keeping commensurate with their roles and responsibilities in the home on 16 April 2014.

Review of four 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 dated, timed and signed with the signature accompanied by the designation of the signatory.

The inspector reviewed a record of the meals provided for patients. Records were maintained in sufficient detail to enable the inspector to judge that the diet for each patient was satisfactory.

The inspector reviewed the care records of four patients identified as 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 for patients assessed as being at risk of malnutrition and dehydration
- 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 generally reviewed on a monthly or more often basis.

The inspector reviewed a sample of fluid intake records for one identified patient. The inspector also reviewed a sample of the records of the administration of fluid thickening agents to patients. There were a number of omissions in these records and the evidence provided indicated that patients were not offered fluids on a regular basis.

A number of these records failed to evidence;

- the total fluid intake for the patient over 24 hours
- an effective reconciliation of the total fluid intake against the fluid target established
- action to be taken if targets were not being achieved
- a record of reconciliation of fluid intake in the daily progress notes
- that patients were offered fluids on a regular basis over the 24 hour period

.

A requirement is made that the registered person shall ensure that food and fluids are provided in adequate quantities and at appropriate intervals. A requirement is made in regard to the health and welfare of patients. A requirement is also made that records are kept up to date. Staff spoken with were evidenced to be knowledgeable regarding patients' nutritional needs.

Fourteen staff were trained in the management of nutrition on 12 February 2014. Two registered nurses were trained in diabetes care on 23 January 2014. A diabetic link nurse was employed in the home and this is commendable.

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 5.7 • **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.**
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 5.8

- **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.**

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 in the home with one exception had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014. The registered manager informed the inspector that arrangements were currently being put in place for a multi-disciplinary care review to be undertaken for a specific patient.

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

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

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 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.

Standard 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.

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 current menu planner was reviewed on 07 March 2014.

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

Staff spoken with were knowledgeable regarding the individual dietary needs of patients to include their likes and dislikes. Discussion with staff and review of the record of the patients' meals' confirmed that patients were offered choice prior to their meals.

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

As previously stated under Sections B, review of two patients' care records evidenced that the patients were referred for a dietetic assessment in a timely manner.

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, registered nurses and care staff, it was revealed that choices were available at each meal time. Choices were also available to patients who were on therapeutic diets.

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 I

Standard 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.**

Standard 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.**

Standard 12.10

- **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:**
  - **risks when patients are eating and drinking are managed**
  - **required assistance is provided**
  - **necessary aids and equipment are available for use.**

Standard 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.**

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 24 staff had attended training in dysphagia awareness during the previous 12 months. Training in first aid was provided to staff on a number of occasions during the previous 12 months and the registered manager informed the inspector that further training was planned for 28 May 2014. A number of staff were trained in oral health on 18 February 2014. Staff had not been trained in the use of food/fluid thickening agents and the preparation and presentation of pureed meals. A requirement is made in regard to this training.

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. Ten staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held in the kitchen for easy access by staff**.** This is commendable practice.

On the day of the inspection, the inspector observed the lunch meal. Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely manner.

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

The inspector reviewed one identified patient's care records in regard to the management of enteral feeding systems. This review evidenced that the patient's care plan on enteral feeding did not fully address the dietician's instructions in regard to the feed, flushes and care of the enteral feeding tube. There were daily records in place in relation to the care of the enteral feeding tube and there were a number of shortfalls in these records. Review of a sample of the patient's fluid/feed records revealed that a number of these records were not totalled for the duration of the feed and flushes. Oral hygiene was addressed in the patient's care plan, however the daily records of the evaluations of care and treatment provided to the patient failed to evidence that oral hygiene was provided to the patient as and when required. There were a number of shortfalls in these evaluation records. It is acknowledged that in discussion with staff they confirmed that this patient's oral hygiene was addressed on a regular basis. As previously stated requirements are made in regard to shortfalls in care records, the management of records, the health and welfare of patients and the provision of fluids to patients.

Five registered nurses were trained in the management of enteral feeding systems on 31 March 2014 and the registered manager informed the inspector that further training was planned for 29 May 2014.

As previously stated 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 seven competency and capability assessments for registered nurses revealed that pressure ulcer/wound care was addressed. These competency and capability assessments had been reviewed and updated within the previous 12 months.

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

11.0 Additional Areas Examined

11.1 Records required to be held in the nursing home

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

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 was one patient in the home who was subject to a guardianship order. The registered manager informed the inspector that arrangements were currently being put in place for a multi-disciplinary care review to be undertaken for this patient. During the inspection the inspector spoke to this patient. This patient indicated that they were happy with the standard of care facilities and services provided in the home. This patient did not complete a questionnaire.

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

The inspector discussed the Human Rights Act and Human Rights Legislation with the registered manager and registered nurses. The inspector can confirm that copies of these documents were available in the home. The registered manager and registered nurses 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 nurses including the recording of best interest decisions on behalf of patients. A copy of DOLS was also available in the home**.**

Twenty three staff were trained in the Human Rights Act on 12 May 2014 and this is commendable.

11.4 Quality of Interaction Schedule (QUIS)

The inspector undertook a number of periods of observation in the home which lasted for approximately 30 minutes each. The inspector observed the lunch meal being served in the dining room. The inspector also observed care practices in the main sitting room following the lunch meal. The observation tool used to record this observation was the Quality of Interaction Schedule (QUIS). This tool uses a simple coding system to record interactions between staff, patients and visitors.

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

The inspector evidenced that the quality of interactions between staff and patients were positive.

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

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

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

Observation of care practices in the sitting room revealed staff initiated conversation with patients, and listened to their views and was respectful in their interactions with them. Overall the periods of observation were positive in regard to the care of patients in the home.

11.5 Complaints

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being pro-actively managed. The inspector reviewed the complaints records during the inspection. This review revealed that one complaint was currently under review by personnel from the WHSC. The registered manager informed the inspector that lessons learnt from investigations were acted upon.

11.6 Patient Finance Questionnaire

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

11.7 NMC declaration

Prior to the inspection the registered manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC). The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC.

11.8 Staffing/Staff Comments

Discussion with the registered manager and a number of staff, and review of a sample of staff duty rosters evidenced that the registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients/residents currently in the home. However, taking into account the roles and responsibilities of the registered manager, a recommendation is made that a deputy manager/senior nurse be appointed to assist and support the registered manager in the overall operation and management of the home. Administrative, catering and laundry staffing levels were found to be satisfactory. There was one domestic staff member rostered in the home on the day of inspection. The registered manager informed the inspector that arrangements were in place to employ additional staff. An activity therapist was employed for 12 5 hours per week over five days. Taking into account the number of patients/residents currently in the home, a recommendation is made that additional hours be provided for activity provision in the home.

In addition to the training outlined throughout the report, staff were provided with a variety of relevant training including safeguarding vulnerable adults, the use of the McKinley syringe driver and mandatory training since the previous inspection. The registered manager is commended on the quality and frequency of the training that is provided in the home.

During the inspection the inspector spoke to14 staff. The inspector was able to speak to a number of these staff individually and in private. On the day of inspection12 staff completed questionnaires. The following are examples of staff comments during the inspection and in questionnaires;

"The quality of care in the home is very good and staff treat the patients very well"
"I feel under the new manager that the home will continue to provide a high standard of care, privacy and dignity to all the patients."
"Staff have very good relationships with the patients and the patients are treated with dignity and respect and seem to enjoy the activities"
"I think that the nursing home is kept well, the patients seem happy and content"
"The working environment in general and staff morale has much improved since the appointment of our new manager M. McGovern. In spite of a much increased workload all the staff are working together under her expert guidance to provide the best possible care to all our patients"
"I am very happy here at the Tilery, it is a very pleasant working environment. Any concerns that I have are always addressed promptly. I find the staff and management very approachable"
"Most of the carers are very good and do a good job and the nurses are very good"
"Would like more time to converse with patients"
"The number of care staff on duty to cover the patients' evening meal should be increased".

11.9 Patients' Comments

During the inspection the inspector spoke to eight patients individually and to a number in groups. On the day of inspection three patients were assisted by their representatives 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 and would do anything for you"
"I am very happy here, the food is very good, I always get choices"
Staff can make me a snack and a cup of tea at any time"
"This home is the next best thing to my own home"
Staff always respect my privacy and they always knock my door before entering"
"I feel safe in this home"
"A year has made a great change to all including the standard of care. Thank you to the staff".

11.10 Relatives' Comments

During the inspection five relatives visited the home and took the opportunity to speak to the inspector. The following are examples of relatives' comments during the inspection and in questionnaires;

"Excellent could not be improved upon"
"This is the best home you could ask for, everything is very good"
"I am very happy with how my relative is cared for, it could not be better"
"Everything is very well improved here, the care is very good and the food is of a high standard"
"Home is excellent".

11.11 Environment

During the inspection the inspector undertook a tour of the premises and viewed the majority of the patients' bedrooms, sitting areas and dining room, laundry, bath/shower and toilet facilities. The home was found to be warm, clean, and comfortable. The patients' bedrooms were very well personalised and this is commendable

During a tour of the premises it was observed that there were no locks provided on the patients'/residents' bedroom doors in the main part of the home. In order to enhance privacy especially when personal care is being provided by staff to patients and residents, a recommendation is made that thumb turns be fitted on bedroom doors with exceptions noted in patients' and residents' care plans. The nurses' station is situated in the foyer of the home. In order to enhance privacy during e.g. discussions, phone calls, report writing and hand over reports. a recommendation is made that suitable transparent privacy screening be provided at this station.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Martina McGovern, Registered Manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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

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**
On admission the nurse carries out the initaial assessment using the Roper Logan & Tierney activities of daily living assessment tool. Using the M.U.S.T. tool the patients nutritional screening is carried out on admission or within 24 hours. These assessments enable the nurse to complete the pressure ulcer risk assessment and identify additional resources/equipment required to reduce risks. An agreed plan of care is drawn up to meet the needs of the patient. All careplans are completed within 11 days of admission.	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**
The patient is allocated a named nurse who is responsible for drawing up the agreed plan of care. Where risks are identified and support is required from other professionals, the relevant referral is made and their recommendations or plan of care is adhered to by staff.	Compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Reassessment of the care provided is undertaken daily and recorded in patients file. Audits of patients records are carried out at regular intervals and improvements required identified.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing intervention, activities and procedures carried out are supported by evidence and guidelines. A validated pressure ulcer grading tool is used to screen patients who develope pressure damage and treatment plan is then implemented. Up to date nutritional guidelines are available for staff to use on a daily basis.	Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Contemproaneous records inline with NMC guidelines are maintained for all patients and daily care provided is recorded. Records of meals provided are maintained and are available for inspection when requested. Where careplan requires a record is kept of all food/fluids consumed . If necessary a referral is made to the relevant professional, record of referral and response is kept.	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care provided and the outcome is monitored and recorded daily. Careplans are reviewed monthly and updated as required. The patient or representative is involved and informed of changes to 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**
Formal reviews are held by the patients Social Worker. The patient and / or representative are encouraged to attend and contribute to the meeting. Minutes of the review are recorded and where necessary changes are made to the nursing care plans. Patient or representative are informed of progress made.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Patients are provided with nutritious, varied diets to meet their nutritious needs. Any guidance given by dietician or speech and language therapist are recorded in the patients careplan. The menu offers the patient a choice of meals. If the menu for the day is not what the patient wants an alternative meal will be provided.	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:** ○ **risks when patients are eating and drinking are managed** ○ **required assistance is provided** ○ **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nurses have up to date knowledge and skills in feeding techniques for patients with swallowing difficulties and adhere to instruction provided. Risks to patients when eating and drinking are identified and managed. Assistance, supervision and suitable aids are provided. When a patient requires woundcare nurses have the expertise and skills to carry out a wound assessment, apply the appropriate dressing and manage the wound throughout the healing process.	Compliant

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

Appendix Two

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Primary Announced Inspection

The Tilery

13 May 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Martina McGovern, 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	20 (1)(c)(i)	Staff as appropriate are required to be trained in the following areas; Preparation and presentation of pureed meals Food & fluid thickening agents. Ref. Section I.	One	Training arranged in the preparation and presentation of pureed meals and the use of fluid thickening agents. Arranged for 07/08/14	One month
2	13 (1)(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 E & I	One	The registered person will ensure that there is proper provision for the Health and Welfare of the patient.	One week
3	16 (2)	The registered person shall ensure that the patients ' care records are reviewed and updated in order to ensure that care plans fully reflect the patients 'assessed needs. The care plans should be kept under review. Ref. Sections B, C,& I.	One	Nurses will ensure Care records are updated in accordance with changes in the assessed needs of the patient and careplans are reviewed monthly.	Two weeks
4	19 (3)(a)	The registered person shall ensure that records are kept up to date. Ref. Sections E & I	One	The regtistered person will continue to audit and ensure all records are kept up to date.	One week
5	12 (4)(a)	The registered person shall ensure that food and fluids are provided in adequate quantities and at appropriate intervals. Ref. Sections E & I	One	Reiterated to all staff to ensure food and fluid is provided at frequent and appropriate intervals, recorded on relevant charts of those at risk of	One week

				dehydration and action to be taken when targets are not achieved.	

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	30.1	It is recommended that a deputy manager/ senior nurse be appointed to assist and support the registered manager in the overall operation and management of the home. Ref. Section 11, point 11.8 (additional areas examined)	One	The position of deputy manager / lead nurse is currently being reviewed. Position has been advertised internally and applicants shall be interviewed August 14th.	One month
2	13.5	It is recommended that additional hours be provided for the provision of activities to patients. Ref. Section 11, point 11.8 (additional areas examined)	One	Additional activity hours increased by 2.5 hours per week.	Two weeks
3	1.1	It is recommended that turn knobs be fitted on bedroom doors with exceptions noted in patients' care plans. Ref. Section 11, point 11.11 (additional areas examined)	One	maintenance person sourcing suitable 'turn knobs'.	One month
4	E54	It is recommended that suitable transparent privacy screening be provided at the nurses' station. Ref. Section 11 point 11.11 (additional areas examined).	One	Transparent privacy screen will be erected within two weeks.	One month

5	30.9	It is recommended that details in reports of visits undertaken under Regulation 29 be discussed with staff during staff meetings/forums. Ref. Section 9, Follow up on Previous Issues.	Three	Regulation 29 Report has been discussed in detail at staff meeting.	One month

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

Name of Registered Manager Completing Qip	Martina McGovern
Name of Responsible Person / Identified Responsible Person Approving Qip	Claire Sharvey

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes		6/8/14
Further information requested from provider			