Unannounced Primary Care Inspection

Name of establishment:	**Lansdowne**
RQIA number:	**1263**
Date of inspection:	**10 October 2014**
Inspector's name:	**Norma Munn**
Inspection number:	**INO17006**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of establishment:	Lansdowne Nursing Home
Address:	41-43 Somerton Road Belfast BT15 3LG
Telephone number:	02890370911
Email address:	lansdowne.m@fshc.co.uk
Registered organisation **Responsible individual**	Four Seasons Health Care James McCall
Registered manager:	Karen Agnew (Registration Pending)
Person in charge of the home at the time of inspection:	Karen Agnew
Categories of care:	Nursing - I, PH, PH (E), TI DE to a maximum of 13 patients accommodated
Number of registered places:	86
Number of patients accommodated on day of inspection:	57
Scale of charges (per week):	£581 - £624
Date and type of previous inspection:	Secondary Unannounced Inspection 25 February 2014
Date and time of inspection:	Primary Unannounced Inspection 10 October 2014
Name of inspector:	Norma Munn

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 an unannounced primary care inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were met.

3.0 Purpose of the inspection

The purpose of this inspection was to consider whether the service provided to patients/residents 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 the preliminary assessment of achievement by the Provider 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 inspection visit by the inspector.

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

- review of any notifiable events submitted to RQIA, in accordance with Regulation 30 of the Nursing Homes Regulations (NI) 2005, since the previous inspection
- analysis of pre-inspection information submitted by the registered person/s
- discussion with manager, Ms Karen Agnew
- review of the returned quality improvement plan (QIP) from the previous care inspection conducted on 25 February 2014
- observation of care delivery and care practices
- discussion with staff on duty at the time of this inspection
- examination of records pertaining to the inspection focus
- consultation with patients individually and with others in groups
- tour of the premises
- evaluation and feedback.

5.0 Consultation process

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

Patients	**16 individually and other in groups**
Staff	**11**
Relatives	**2**
Visiting professionals	**1**

Questionnaires were provided by the inspector, during the inspection, to patients, their representatives and staff to seek their views regarding the quality of the service
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Issued to	**Number issued**	**Number returned**
Patients	**5**	**5**
Relatives / representatives	**0**	**0**
Staff	**5**	**4**

6.0 Inspection focus

The theme for the inspection year April 2014 – March 2015 is: 'Nursing Care'

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 regular reviewed. (Standard 5)

Under the 'Nursing Care' theme, inspection will focus on three areas of practice:

- management of wounds and pressure ulcers (Standard 11)
- management of nutritional needs of patients and weight loss (Standard 8 & 12)
- management of dehydration (Standard 12).

Only selected criteria from each of the four standards will be inspected across nine areas and incorporated into the Provider's Self-Assessment.

The inspector will also consider the management of patient's human rights during this inspection.

The inspection theme and focus for the 2014 – 2015 inspection year was outlined by RQIA at the annual Provider Roadshow in February 2014 and the self-assessment was made available on the RQIA website.

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

Lansdowne Care home is situated on the Somerton Road, just off the Antrim Road, in North Belfast.

The nursing home is owned and operated by Four Seasons Health Care
The current manager is Ms Karen Agnew, registration pending.

Accommodation for patients is provided over three floors of the home.
Access to all floors is via a passenger lift and stairs.

Communal lounge and dining areas are provided on each floor, the first and second floors having two dining areas each for patients to enjoy. The home also provides for catering and laundry services on the ground floor.

A number of communal sanitary facilities are available throughout the home. The home has extensive grounds. A secure garden/patio area is provided on the ground floor with direct access from the dementia care unit.

The home is registered to provide care for a maximum of 86 persons under the following categories of care:

Nursing care

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
PH(E)	physical disability other than sensory impairment over 65 years
DE	dementia care, to a maximum of 13 patients accommodated within the dementia unit on the ground floor.
TI	terminally ill

8.0 Executive summary

This unannounced inspection of Lansdowne Care Home was undertaken by Norma Munn on 10 October 2014 between the hours of 10.00 and 17.30. The inspection was facilitated by Ms Karen Agnew, manager, who was present during the inspection and was provided with verbal feedback at the conclusion of the inspection. Ms Agnew was recently appointed to the home as manager and her registration as registered manager with RQIA is still pending.

The theme for the 2014 – 15 inspection year is 'Nursing Care' (Standard 5) and the inspection focused on three areas of practice related to:

- management of wounds and pressure ulcers (Standard 11)
- management of nutritional needs of patients and weight loss (Standard 8 & 12)
- management of dehydration (Standard 12).

The inspector also considered the management of patient's human rights during this inspection. The requirement and recommendations made as a result of the previous inspection were also examined.

Prior to the inspection, the manager completed a self-assessment using the standard criteria outlined in the theme inspected. This self-assessment was received on 3 April 2014. The comments provided by the manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

Review of pre-inspection information submitted by the manager indicated that notifiable events were provided to RQIA in accordance with legislation. Analysis of other documentation including the returned QIP from the previous care inspection on 25 February 2014 confirmed that sufficient information had been provided.

During the course of the inspection, the inspector met with patients, staff and relatives, who commented positively on the care and services provided by the nursing home. One concern was brought to the attention of the inspector by a visiting professional in relation to the management of pressure area care and this was referred to the manager during the inspection. Refer to section 10.

A review of the staff duty rosters week commencing 22 September 2014 and 29 September 2014 evidenced that the number of staff on duty was in line with RQIA'S recommended minimum staffing guidelines. However, discussion with staff revealed that care staff are currently carrying out activities with the patients in the ground floor dementia unit. A personal activity leader is assigned to work in the first and second floor of the home but not in the dementia unit. This issue was discussed with the team leader and manager. It was agreed that the manager would review the provision of activities in the dementia unit to ensure the needs of the patients are met. A recommendation has been made.

Patients were observed to be well presented with clothing suitable for the season and several patients had matching accessories of their choosing. The demeanour of patients indicated that they were relaxed in their surroundings. Delivery of care to patients was evidenced to be of a very satisfactory standard and patients were observed to be treated by staff with dignity, respect and compassion. The inspector observed interactions between staff and patients throughout the home which were seen to be respectful and considerate of the patients' abilities and well-being. Staff were observed to respond to patients' requests promptly and it was evident that staff had developed good relationships with the patients in the home. This is to be commended.

The environment was generally well maintained. The home was found to be clean, fresh smelling, warm and comfortable. Bedrooms presented as homely and comfortable, some patients had added some personal items of furnishings which contributed to a homely ambience. The inspector observed items belonging to patients stored in a bathroom in the dementia unit. A Requirement has been made in this regard.

The dementia unit environment was discussed with the manager and it was agreed that attention needs to be given to this unit to afford a more enabling and interesting environment for patients who have dementia. The manager informed the inspector that this had been discussed with senior management and it is proposed the unit will go forward to dementia care accreditation. A dementia audit is to be carried out and the outcome of the audit to be used to develop the environment in order to meet the needs of patients who have dementia. However, due to the lack of progress a recommendation has been made

There were systems and processes in place to ensure the effective management of the standards inspected. However, areas for improvement were identified in relation to pressure area care and the management of weight loss. Review of five patient's care records evidenced that validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart, Pain and continence were completed on admission. However, the MUST assessment was not undertaken for one patient following a readmission from hospital. A requirement has been made..

A review of one patient's care plan evidenced that instructions from the tissue viability nurse on pressure area care and prevention detailed in the care plan had not been carried out as a result a requirement has been made.

One patient was observed to be seated in a wheelchair with a lap belt in place. Discussion with the patient and staff confirmed that the lapbelt was in place to prevent the patient from falling out of the chair. The patient's care records did not contain a rationale for the use of restraint and there was no evidence that the patient, their representative and relevant professionals had been consulted. This issue was discussed with the deputy manager and manager and it was agreed that the manager review the use of restraint within the home as a matter of urgency. Detail is contained in section 12.1 of the report and requirements have been made in relation to these matters.

Issues of concern were also raised with the manager to be addressed in relation to health and safety as a matter of urgency. Refer to section 11.9. A requirement has been made in this regard.

As a result of the issues raised above in relation to restraint and health and safety an urgent findings letter was issued to the manager to address. Following the inspection a response was received from the home providing assurances that these issues have been addressed.

The inspector reviewed and validated the home's progress regarding the one requirement and four recommendations made at the last inspection on 25 February 2014 and confirmed compliance outcomes as follows: All requirements and recommendations had been fully complied with.

Verbal feedback of the inspection outcomes was given to Karen Agnew, manager, at the conclusion of the inspection process.

Conclusion

As a result of this inspection, six requirements and two recommendations were made. Details can be found in section 10.0 11.0 and 12.0 in the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, the visiting professional, 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 the requirements and recommendations issued as a result of the previous unannounced care inspection conducted on 25 February 2014

4.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	20 (3)	The registered person shall ensure that at all times a nurse is working at the nursing home and that the registered manager carries out a competency and capability assessment with any nurse who is given the responsibility of being in charge of the home for any period of time in his absence. The registered manager must ensure all areas of the competency and capability assessment are completed, both parties have signed the completed document and a final statement of competency validated by the registered manager is present.	Discussion with the manager confirmed that the competency and capability assessments of nurses in charge of the home in the absence of the manager have been fully completed and signed by both parties	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken – As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	28.8	It is recommended the effect of training on practice and procedures is evaluated as part of quality improvement.	Discussion with the manager confirmed that the effect of training is evaluated	Compliant
2	32.1	It is recommended a suitable storage facility is provided for care staff to store care documentation which was being kept in the lounge areas of the home.	Observation and discussion with staff confirmed that care documentation is now stored in suitable storage facilities in the lounges	Compliant
3	1.1	It is recommended the values that underpin the standards inform the philosophy of care and staff consistently demonstrate the integration of these values within their practice. This recommendation related to best practice in dementia care.	Observation of the lunch time meal in the dementia unit confirmed that delivery of care to patients was of a very satisfactory standard and patients were observed to be treated by staff with dignity, respect and compassion. Interactions with patients were respectful and considerate of the patients' abilities and well-being. Staff were observed to respond to patients' requests promptly and it was evident that staff had developed good relationships with the patients in the home.	Compliant

4	28.4	It is recommended staff in the dementia unit undertake training and/or refresher training in relation to being 'person centred'. This training should be reflected in the development of care plans i.e. written in a person centred manner.	Discussion with staff and a review of training records evidenced that staff had attended training in person centred care. Review of two patients care records evidenced that care plan were being written in a more person centred way.	Compliant

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

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if there is considered to be a breach of regulation as stated in the Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

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10.0 Inspection findings

Section A – On admission a registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Standard criterion 5.1, 5.2, 8.1 and 11.1 examined.
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 five 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. Review of five patient's care records evidenced that validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart, Pain and continence were also completed on admission. However, the Malnutrition Universal Screening Tool (MUST) assessment was not undertaken for one patient following a readmission from hospital. A requirement was made that this shortfall is addressed. Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure ulcer/wound and if required, the specific care plans regarding the management of the pressure ulcer/wound. Review of five patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 11 days of the patient's admission to the home. Discussion with nursing staff demonstrated a good awareness of patients who required wound management intervention for a wound 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 criterion assessed	**Substantially compliant**

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

Section B –A registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Care records evidence involvement of the patient and /or their representative and that care planning and delivery reflect the recommendation from relevant health professionals. Referrals to healthcare professionals are made as required and in a timely manner. Standard criterion 5.3, 11.2, 11.3, 11.8 and 8.3 examined.

The inspector observed that a named nurse system was operational in the home.

Review of five patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Records also evidenced discussion with patients and/or their representatives following changes to the plans of care.

Review of two patients' care records who required wound management for wounds revealed that pressure relieving equipment was in place on the patients' beds and when sitting out of bed. Discussion with staff evidenced that pain assessments were appropriately used for these patients.

- A body mapping chart was completed for each patient on admission. This chart was reviewed and updated when any changes occurred to the patients' skin condition.
- A care plan was in place which specified the pressure relieving equipment in place on the patient's bed and also when sitting out of bed.
- The type of mattress in use was based on the outcome of the pressure risk assessment. The specialist mattresses in use were being safely used and records were available to reflect they were appropriately maintained.
- A daily repositioning and skin inspection chart was in place for each patient with the wound and also for patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these charts revealed that patients' skin condition was inspected for evidence of change at each positional change. However, discussion with a visiting podiatrist revealed that one patient had not been repositioned in bed in accordance with the advice and guidance from the tissue viability nurse. A review of the patient's care plan evidenced that instructions detailed in their care plan on pressure area care and prevention had not been carried out. A requirement was made that this shortfall is addressed.

Discussion with the registered nurses and a review of two 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.

Discussion with registered nurses evidenced that they were knowledgeable of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

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

Review of two care records verified that patients' weight was recorded on admission and on at least a monthly basis or more often if required. Discussion with registered nurses showed they were knowledgeable on the patients who have been identified to have their weight recorded on a weekly basis, and explained the internal weight monitoring systems in place in the home. However, as discussed in section A the MUST assessment was not undertaken for one patient and the patient's weight was not recorded on return from hospital. The patient was found to have lost 10.5kg. It is required that patients are weighed on at least a monthly basis or more often if required. A requirement had been made that this shortfall is addressed.

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

Review of wound care in two patients' care plans evidenced that the dressing regime was 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 were also referred to the speech and language therapist. The patient's care plan had been reviewed to address the dietician's and speech and language recommendations.

Discussion with the manager revealed that training had taken place in relation to wound management, pressure area care and prevention and the management of nutrition, PEG feeding regimes and dysphagia. The inspector did not review the training records on this occasion.

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.

Registered nurses informed the inspector that pressure ulcers were graded using an evidenced based classification system.

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

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

Section C - Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans. Standard criteria 5.4 examined.
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. However, as discussed in section A review of one patient's care records evidenced that the Malnutrition Universal Screening Tool (MUST) assessment was not undertaken following a readmission from hospital. Nursing staff, from both day and night duty, recorded evaluations in the daily progress notes on the delivery of care including wound care for each patient. Review of four patients' care records evidenced that care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. Review of two patients' care records in relation to wound care indicated that these care records were reviewed each time the dressing was changed and also when the dressing regime was 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 registered nurses and a review of governance documents evidenced that a number of care records were audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

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

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

Section D – All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. Standard criterion 5.5, 8.4 and 11.4 examined.
The inspector examined five 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 staff 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 staff and a review of governance documents evidenced that the quality of pressure ulcer/wound management was audited each time dressings were changed and discussed at each hand over report. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process. Staff 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. Staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs was held in the dining room for easy access by staff.

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

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

Section E – 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 criterion 5.6, 12.11 and 12.12 examined.

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.

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

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

Entries were noted to be timed, dated 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 of being at risk of inadequate or excessive food and fluid intake. This review confirmed that:

- daily records of food and fluid intake were being maintained
- the nurse in charge had discussed with the patient/representative their dietary needs
- where necessary a referral had been made to the relevant specialist healthcare professional
- a record was made of any discussion and action taken by the registered nurse
- care plans had been devised to manage the patient's nutritional needs. However, previously one patient's care plan for nutrition had not been reviewed following a readmission from hospital.

Review of a sample of fluid balance charts for two patients' demonstrated that the patients were offered fluids on a regular basis throughout the day.

The fluid intake records evidence:

- the total fluid intake 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.

Staff spoken with were evidenced to be knowledgeable regarding patients' nutritional needs.

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

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

Section F – 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. Standard criteria 5.7 examined.
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 criteria assessed	**Substantially compliant**

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

Section G – The management and involvement of patients and/or their representatives in review of care. Standard criterion 5.8 and 5.9 examined.
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 38 patients in the home had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014. The 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 two 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 criterion assessed	**Substantially compliant**

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

Section H – Management of nutrition including menu choice for all patients. Standard criterion 12.1 and 12.3 examined.
A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance. There was a four weekly menu planner in place. The staff informed the Inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home. The inspector discussed the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients with a number of staff. Staff spoken with were knowledgeable regarding the individual dietary needs of patients and to include their likes and dislikes. Observation during lunch, discussion with staff and review of the record of the patient's meals confirmed that patients were offered choice prior to their meals. Staff spoken with were knowledgeable regarding the indicators for onward referrals to the relevant professionals e.g. speech and language therapist or dieticians. As previously stated under Section D relevant guidance documents were in place. Observation during the serving of the lunch time meal and discussion with staff revealed that choices were available at each meal time. The staff confirmed 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 criterion assessed	**Substantially compliant**

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

Section I – Knowledge and skills of staff employed by the nursing home in relation to the management of nutrition, weight loss, dehydration, pressure area care and wounds. Standard criterion 8.6, 11.7, 12.5 and 12.10 examined.
The inspector discussed the needs of the patients with the staff. It was determined that a number of patients had swallowing difficulties. Review of training records revealed that staff had attended training in dysphagia awareness. Review of three patient's care record evidenced that the care plan failed to fully reflect the instructions of a recent speech and language swallow assessment. The inspector observed five containers of thickening agent in the dining area of the dementia unit which were prescribed for several patients but were not individually labelled with the patient's name. Staff advised the inspector that these containers would be removed and labelled correctly. Discussion with staff and the cook 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 staff 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. Staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs was held in the dining room for easy access by staff. On the day of the inspection, the inspector observed the lunch meal in the dementia unit. 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.

Discussion with the registered nurses clearly evidenced their knowledge in the assessment, management and treatment of wounds. However, as previously discussed, a visiting podiatrist revealed to the inspector that one patient had not been repositioned in bed in accordance with the advice and guidance from the tissue viability nurse. A review of the patient's care plan evidenced that instructions detailed in their care plan on pressure area care and prevention had not been carried out.

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

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

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11.0 Additional areas examined

11.1 Records required to be held in the nursing home

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

- sample of staff duty rosters
- record of complaints
- record of food and fluid provided for patients
- sample of incident/accident records.

11.2 Patients/residents 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.

There were no patients accommodated at the time of inspection in the home who were subject to guardianship arrangements.

11.3 Quality of Interaction Schedule (QUIS)

The inspector observed the mid-day meal being served in the dementia unit and the afternoon tea being served in the first floor of the home. Each period of observation lasted for approximately twenty minutes each.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area. A description of the coding categories of the Quality of Interaction Tool is appended to this report.

Total number of observations	22
Positive interactions	21
Basic care interactions	1
Neutral interactions	0
Negative interactions	0

The inspector evidenced that the quality of interactions between staff and patients was of a very high standard.

Observation confirmed that meals were served promptly and assistance required by patients was provided in a timely manner. Staff were observed preparing and seating patients for their meal in a caring, sensitive and unhurried manner. Staff were seen to speak directly to each patient, making eye contact and actively communicating with each person. Care staff were also noted assisting patients with

their meals, staff sat down beside the patient they were assisting and were fully engaged in the activity of providing the patient's meal, offering encouragement and prompting as required.

Feedback was provided to nursing staff and care assistants working in the dementia unit who were commended by the inspector for how they interacted with patients. The staff were observed treating patients with dignity, respect and compassion, offering choice and encouraging independence.

During the serving of afternoon tea, the inspector evidenced that the quality of interactions between staff and patients was in the main positive. Staff were polite and courteous when speaking with patients, conversation was relaxed and respectful. Staff were observed to offer a variety of drinks and different choice of snacks it was evident the staff in attendance were familiar with patient's individual preferences.

11.4 Complaints

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

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 discussed the management of complaints with the manager. This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements.

11.5 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.

11.6 NMC declaration

Prior to the inspection the acting 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.

11.7 Questionnaire findings

11.7.1 Staffing levels and staff comments

Discussion with the manager and review of the duty roster for week commencing 22 September 2014 and 29 September 2014 evidenced that the registered nursing and care staffing levels were in line with the RQIA's recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection.

However, discussion with staff and a review of staff questionnaires returned indicated a lack of provision of activities in the dementia unit. Discussion with staff revealed to the inspector that a personal activity leader had not been assigned to the dementia unit and activities were provided by care staff. Care staff spoken with felt that they did not always have time to carry out activities to meet the needs of the residents. As a result of a previous inspection carried out on 28 and 30 August 2013 the inspector recommended that the hours allocated to the personal activities leader of the home would be utilised so as to provide maximum recreational/social opportunities for patients. However, as a result of this inspection, discussion with staff and a review of staff questionnaires a recommendation has been made to review the provision of activities to ensure the needs of patients who have dementia are met.

Discussion with the manager and staff confirmed that staff were provided with training in, Dementia Care, Person Centred Care, Dysphagia and PEG tube feeding.

During the inspection the inspector spoke with 16 staff in total which included, team leader, deputy manager, registered nurses, care and ancillary staff. The inspector was able to speak to a number of these staff individually and in private. Four staff completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

Comments were as follows:

"Good staff, who have a lot to give"
"Some come in on days off to take residents out on activities"
"Staff are a brilliant team"
"It can be difficult for care staff to provide activities""
"more staff is needed to have more time to listen to and interact with residents".

11.7.2 Patients/residents and relatives comments

During the inspection the inspector spoke with 16 patients individually and with the majority of others in smaller groups.

Patients spoken with and the questionnaire responses confirmed that patients were treated with dignity and respect, that staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home.

Patients' comments were as follows:

"I like it here"
"The food is good and edible"
" Good care"
" I like it alright, I like bingo"
"Very caring people here who try to make you well"

The inspector spoke with two relatives during the inspection .

Relatives' comments were as follows:

" I am very pleased, everything is fine here"
"They ring me if there are any changes"
"I have no problems with the staff"
" I bring my complaints to the manager and they are dealt with"
" The staff in general are excellent".

Discussion with one relative confirmed that they have brought complaints to the manager and these complaints have and are being actioned to their satisfaction. These issues were discussed with the acting manager during feedback.

11.7.3 Professionals' comments

One professional visited the home during the inspection. This professional expressed levels of satisfaction with the quality of care, facilities and services provided in the home. However, discussion with a visiting professional revealed that although staff adhere to their recommendations in relation to a patient with wounds the visiting professional raised a concern regarding the Tissue Viability's advice not been adhered to by staff in relation to pressure area care. The inspector discussed this concern with the manager during the inspection, who agreed to address the matter.

11.8 Record keeping

Review of five patient care records evidenced that generally a good standard of record keeping was maintained.

11.9 Environment

The inspector undertook a tour of the home and viewed a number of patients' bedrooms, lounges, dining rooms, bathrooms, toilets facilities and sluices. The home was found to be clean, fresh smelling, warm and comfortable. Bedrooms presented as homely and comfortable, some patients had added some personal items of furnishings which contributed to a homely ambience.

The following issues in relation to health and safety were discussed with the manager and required to be addressed as a matter of urgency:

- bed mattresses were being used as crash mats or fall out mats. Staff were advised that a bed mattress is not designed to be used in this way and staff should be made aware of the risks when using equipment outside of its purpose/use.
- the electric room in the dementia unit was unlocked and used as a store for mattresses, bins and other items
- sluices on the first and second floors were unlocked.

A requirement has been made in relation to the matters above.

The dementia unit environment was discussed the manager and it was agreed that attention needs to be given to the further enhancement of this unit to afford a more enabling and interesting environment for patients who have dementia. The manager informed the inspector that this had been discussed with senior management and it is proposed the unit goes forward to dementia care accreditation. In order to achieve this the environment will be reviewed and upgraded. A dementia audit is to be carried out and the outcome of the audit to be used to develop the environment. Due to the lack of progress a recommendation was made in this regard.

12.0 Infection Control

The following issue in relation to infection prevention and control requires to be addressed:

- patients' clothing and belongings were being stored in a bathroom in the dementia unit.

A Requirement has been made in this regard.

12.1 Care Practices

The inspector observed a patient seated in a wheelchair with a lap belt in place. Discussion with the patient and staff confirmed that the lap belt was in place to prevent the patient from falling out of the chair. The patient's care records did not contain a care plan for the use of restraint and there was no evidence that the patient, their representative and relevant professionals had been consulted.

This issue was discussed with the deputy manager and manager and it was agreed that the manager review the use of restraint within the home. A requirement was made.

Policies, procedures and best practice guidance in the use of restraint were available in the home for staff to refer to. The manager was unable to confirm if training in the use of restrictive practice had taken place as a result of this a requirement has been made.

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12.0 Quality Improvement Plan

The details of the quality improvement plan appended to this report were discussed with Karen Agnew, 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:

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The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
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Belfast
BT1 3BT

Appendix 1

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 a designated representative from the home carries out a pre admission assessment. Information gleaned from the resident/representative (where possible), the care records and information from the Care Management Team informs this assessment. Risk assessments such as the Braden Tool are carried out, if possible, at this stage. Following a review of all information a decision is made in regard to the home's ability to meet the needs of the resident. If the admission is an emergency admission and a pre admission is not possible in the resident's current location then - a pre admission assessment is completed over the telephone with	Substantially compliant

written comprehensive, multidisciplinary information regarding the resident being faxed or left into the home. Only when the Manager is satisfied that the home can meet the residents needs will the admission take place. On admission to the home an identified nurse completes initial assessments using a patient centred approach. The nurse communicates with the resident and/or representative, refers to the pre admission assessment and to information received from the care management team to assist her/him in this process. A Needs Assessment which includes 16 areas of need is completed .In addidtion to this document, the nurse completes validated risk assessments within the first 24 hours of admisson. These include a skin assessment using the Braden Tool, a body map, an initial wound assessment (if required), a moving and handling assessment, a falls risk assessment, bed rail assessment, a pain assessment and nutritional assessments including the MUST tool, FSHC nutritional and oral assessment. Other risk assessments that are completed within seven days of admission are a continence assessment and a bowel assessment.Following discussion with the resident/representative, and using the nurse's clinical judgement, a plan of care is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations with 11 days of the date of admisson.This can be evidenced in the care plan and consent forms. The Home Manager and Regional Manager will complete audits on a regular basis to quality assure this process	

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**
A named nurse completes a comprehensive and holistic assessment of the resident's care needs using the assessment tools as cited in section A, within 11 days of admission. The named nurse devises care plans to meet	Substantially compliant

identified needs and in consultation with the resident/representative. The care plans demonstrate the promotion of maximum independence and focuses on what the resident can do for themselves as well as what assistance is required. Any recommendations made by other members of the mutidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable. Registered nurses in the home are fully aware of the process of referral to a TVN when necessary. There are referral forms held in a designated file in the nurse's office, the Tissue Viability Nurse's details are also held in this file - name, address and telephone no. Once the form has been sent it, is then followed up by a telephone call to the TVN where advice can be given prior to their visit. Referrals are also made via this process in relation to residents who have lower limb or foot ulceration to either the TVN or a podiatrist. If necessary, a further referral is made to a vascular surgeon by the G.P, TVN or podiatrist. Where a resident is assessed as being 'at risk' of developing pressure ulcers, a Pressure Ulcer Management and Treatment plan is commenced. A care plan will be devised to include skin care, frequency of repositioning, mattress type and setting,nutritional needs and continence management. The care plan will give due consideration to advice received from other multidisciplinary members. The treatment plan is agreed with the resident/representative, Care Management and relevant members of the MDT. The Regional Manager is informed via a monthly report and during the Reg 29 visit. The Registered Nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Dietician referral forms are held within the home. These forms can be completed by staff in the home and faxed directly to the dietician for referral. The dietician is also available over the telephone for advice until she is able to visit the resident. All advice, treatment or recommendations are recorded on the MDT form with a subsequent care plan being compiled or current care plan being updated to reflect the advice and recommendations. The care plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in the home and other members of the MDT are kept informed of any changes	

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 Needs Assessment, risk assessments and care plans are reviewed and evaluated at a minimum of once a month or more often if there is a change in the resident's condition. The plan of care dictates the frequency of review and re assessment, with the agreed time interval recorded on the plan of care. The resident is assessed on an ongoing daily basis with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the Home Manager's attention. The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.	Substantially compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
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**
The home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to. The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading sysytem. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime or if the condition of the pressure ulcer changes. There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', ' PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in	Substantially compliant

relation to nutritional care, diabetic care, care of subcuteanous fluids and care of percutaneous endoscopic gastrostomy (PEG).	

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 nursing interventions, activities and procedures that are carried out in relation to each resident. These records are comtemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines - Record keeping:Guidance for nurses and midwives. Records of the meals provided for each resident at each mealtime are recorded on a daily menu choice form. The Catering Manager also keeps records of the food served and include any specialist dietary needs. Residents who are assessed as being 'at risk' of malnutrition, dehyration or eating excessively have all their food and fluids recorded in detail on a daily basis using a FSHC food record booklet or fluid record booklet. These charts are	Substantially compliant

recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. The nurse utilises the information contained in these charts in their daily evaluation. Any deficits are identified with appropriate action being taken and with referrals made to the relevant MDT member as necessary. Any changes to the resident's plan of care is discussed with them and/or their representative. Care records are audited on a regular basis by the Manager with an action plan compiled to address any deficits or areas for improvement - this is discussed during supervision sessions with each nurse as necessary	

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 on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan of care or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their represenatatives are involved in the evaluation process	Substantially 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 generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the resident's file. Any recommendations made are actioned by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals.	Substantially 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 policy and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs on admission and review on an ongoing basis. The care plan reflects type of diet, any special dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if necessary. The home has a 4 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied. Copies of instructions and recommendations from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs.The outcome of the monthly audit of residents weights is shared with the cooks in the kitchen and the identified residents needs are discussed.	Substantially compliant

Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything from the daily menu an alternative meal of their choice is provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room and on picture menu boards in each unit.	

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 receiving training on dysphagia and modified textured diets . The Speech and Language therapist and dietician have conducted training on dyshagia and texture descriptors and food fortification on 29th April and will complete a further session on 20th May. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document - 'Dysphagia Diet Food Texture Descriptors'. All recommendations	Substantially compliant

made by the speech and language therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for feeding, equipment to use and assistance required. The kitchen receive a copy of the SALT's recommendations and this is kept on file for reference by the kitchen..	

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

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The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Primary Inspection

Lansdowne Nursing Home

20 October 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 Karen Agnew, manager, 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	14 (5)	The Registered Person must ensure that patients are not restrained unless as a last resort and agreed by a multi-disciplinary team and recorded in accordance with best practice guidance on restraint Ref: Section 12	One	As advised in the letter sent to RQIA on the 15th October,it was the residents own personal choice to utilise the lap belt of the wheelchair while she remained seated in it rather than her armchair.It is acknowledged that her care plan did not reflect her choice stating only that the lap strap be secured during transfers. The residents choice was established following the inspection and her care plan amended to reflect her wishes , care manager and family were advised.	From the date of this inspection
2	15 (2) (a) (b)	The Registered Person must ensure that patients' needs are reviewed and care plans updated following a change in circumstances, for example, on return to the home following a hospital admission Ref: Section 10	One	Staff nurses advised of importance of updating weight charts etc on return from hospital (within the first 24 hours) Further training has been provided for some of new nurses to the home by FSHC training Dept and further role out of this training has been requested.	From the date of this inspection
3	14 (2) (a) (b) (c)	The Registered Person must ensure as far as reasonably practicable that all parts of the	One	All areas identified have been addressed.Communication with	From the date of this

		home to which patients have access are free from avoidable risks • the electric room must remain locked when not in use • the storage of equipment in the electric room must cease • sluices must remain locked when not in use • bed mattresses must not be used as crash mats or "fall out mats" Ref: Section 11		the company responsible for the work being undertaken in the electrical store during the inspection have been contacted and the importance of securing these rooms each time they are exited emphasied. New keypadded locks have been fitted to the sluice doors.	inspection
4	20 (1) (c)	The Registered Person must ensure that staff receive training in relation to the use of restraint Ref: Section 12	One	Training on deprivation of liberty and human rights commenced on 13/11/14 - 18 staff have attended to date.Further training will be rolled out.	From the date of this inspection
5	13 (7)	The Registered Person must make suitable arrangements to minimise the risk of infection • patients clothing and belongings must not be stored in the bathroom Ref : Section 12	One	Resdients clothing removed from identified bathroom and supervision completed with nurses and care staff in this unit.	From the date of this inspection
6	13 (1) (a)	The Registered Person must ensure that recommendations made by the Tissue Viability Nurse are undertaken and recorded in the patients' care records in relation to pressure area care Ref: Section 10 and Section 11	One	Care records pertaining to the identified resident were reviewed immediately following the inspection.. Recommendations made by the TVN were contained within the care plan , however it is acknowledged that on this	From the date of this inspection

				occasion when the podiatrist visited the residents position was not as the TVN had requested. Supervision with the team within this unit has taken place.	

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	13.2	The registered person should review the provision of activities to ensure the needs of patients who have dementia are met Ref: Section 11	One	A 20 hour post for activites within the dementia unit has been agreed and recruitment procedures implemented. It is hoped that a new activity therapist will be in post by 31st January 2014.	Three Months
2	32.3	The registered person should develop the environment in the dementia unit in accordance with best practice guidance to meet the needs of patients who have dementia Ref: Section 11	One	Work in progress - dementia theming of corridors commenced w/c 1st December	Three Months

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 and return to nursing.team@rqia.org.uk

Name of Registered Manager Completing Qip	Karen Agnew
Name of Responsible Person / Identified Responsible Person Approving Qip	Jim McCall CAROL COUSINS DIRECTOR of OPERATIONS

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

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	
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	Norma Munn	8 May 2015
Further information requested from provider			