Unannounced Primary Inspection

Name of establishment:	**Movilla House**
Establishment ID No:	**1270**
Date of inspection:	**29 July 2014**
Inspector's name:	**Carmel McKeegan**
Inspection No:	**18271**

The Regulation And Quality Improvement Authority
9th Floor, Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 90 517 500 Fax: 028 890 517 501

1.0 General information

Name of home:	Movilla House
Address:	51 Movilla Road Newtownards BT23 8RG
Telephone number:	028 91819399
E mail address:	doreen.movilla@btconnect.com
Registered organisation/ Registered provider / Responsible individual	Movilla House Ltd Mr Derek Alfred Bell & Mr James Gordon Walker
Registered manager:	Mrs Doreen Bingham
Person in charge of the home at the time of inspection:	Registered Nurse Ryan Kelly
Categories of care:	NH-I ,NH-PH ,NH-PH(E) ,NH-TI, RC-I
Number of registered places:	50
Number of patients / residents accommodated on day of inspection:	47
Scale of charges (per week):	£692.00
Date and type of previous inspection:	29 January 2014, Secondary unannounced inspection
Date and time of inspection:	29 July 2014 10.00 - 17.00
Name of inspector:	Carmel McKeegan

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 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 inspection visit by the inspector.

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

- analysis of pre-inspection information
- discussion with the registered nurse in charge, Ryan Kelly

- observation of care delivery and care practices
- discussion with staff
- examination of records
- consultation with patients individually and with others in groups
- tour of the premises
- evaluation and feedback.

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

5.0 Consultation Process

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

Patients	8
Staff	8
Relatives	4
Visiting Professionals	0

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

Issued To	**Number issued**	**Number returned**
Patients / Residents	5	1
Relatives / Representatives	5	2
Staff	10	4

6.0 Inspection Focus

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

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

Movilla House Private Nursing Home is located on the Movilla Road in the outskirts of Newtownards. Public transport facilities are directly outside the home.

The nursing home is owned and operated by Mr Derek Bell and Mr James Walker, Movilla House Ltd.

Mrs Doreen Bingham is the home manager and has been the registered manager since April 2005.

The home is purpose-built and provides accommodation on two floors for 50 residents (46 bedrooms with single accommodation and two bedrooms with accommodation for two people sharing). There are en-suite facilities in the majority of bedrooms. Access to the first floor is via a passenger lift and stairs.

Communal lounge and visitors areas are provided on both floors. The main dining area is a bright and spacious room that is easily accessible, located on the ground floor beside the main reception area.

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 is registered to provide care for a maximum of 50 persons under the following categories of care:

<u>Nursing care</u>

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
TI	terminally ill

<u>Residential care</u>

I	old age not falling into any other category to a maximum of two residents

8.0 Summary of Inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Movilla House Nursing Home. The inspection was undertaken by Carmel McKeegan on 29 July 2014 from 10.00 to 17.00 hours.

The inspector was welcomed into the home by the registered nurse in charge, R. Kelly, who was available until 14.00hours. Registered Nurse E. Kitchen commenced duty at 14.00 hours and was the designated nurse in charge thereafter. The inspector also had discussion with Mrs Jenny Bell who had recently been recruited as the new general manager for the nursing home. Mrs Bell confirmed that she is being inducted into this position by the existing general manager who is planning retirement in the near future.

Verbal feedback of the issues identified during the inspection was given to Mrs Bell and Registered Nurse E. Kitchen at the conclusion of the inspection. The inspector also spoke with the registered manager, Mrs Doreen Bingham, by telephone on 13 August 2014.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. This self-assessment was received by the Authority in June 2014.

The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector met with patients, staff and relatives, who commented positively on the care and services provided by the nursing home. There were no concerns raised with the inspector.

The inspector observed care practices, examined a selection of records, issued patient, staff and representative questionnaires and carried out a general inspection of the nursing home environment as part of the inspection process.

The inspector also 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 was designed to help evaluate the type and quality of communication which takes place in the nursing home.

As a result of the previous inspection conducted on 29 January 2014, four requirements and three recommendations were issued.

These were reviewed during this inspection. The inspector was able to evidence that all requirements and recommendations had been fully complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed. (Selected criteria)

Standard 8: Nutritional needs of patients are met. (Selected criteria)

Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)

Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria).

Inspection findings

- **Management of nursing care – Standard 5**

The inspector can confirm that at the time of the inspection there were auditing processes in place to audit the standard of care and service provided for patients/residents in Movilla House Nursing Home.

Policies and procedures relating to patients' admissions were available in the home. It is recommended that the 'Admission Policy' is further developed as discussed.

The inspector spoke with the registered manager, post inspection, who confirmed that management was unaware that written confirmation should be provided to the prospective patient that the home is suitable to meet their needs. The registered manager stated that arrangements would be implemented to meet this regulation. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 15 (1) (d) that the registered person has confirmed in writing to the patient that having regard the assessment the nursing home is suitable for the purpose of meeting the patient's needs in respect of health and welfare.

Review of two patients' care records, who had been recently admitted to the nursing home, revealed that patients' individual needs were not fully established on the day of admission to the nursing home; the following areas were identified for improvement.

It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 15 (1) (a) that the registered person shall not provide accommodation to a patient at the nursing home unless the needs of the patient have been assessed by a suitably qualified or suitably trained person.

It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 16 (2) (a) that the registered person shall ensure that the assessment of the patient's needs is undertaken at the time of admission and is kept under review.

Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart and continence and if required, pain assessment, and wound assessment should be completed on admission in order to establish the patient's health and welfare needs.

The inspector was unable to evidence that care plans for patients had been prepared by a nurse in consultation with the patient or patient' representative as to how the patient's needs in respect of his health and welfare are to be met. The inspector spoke with the nurse in charge on the ground floor and the first floor both of whom stated that they always consult with patients and their families when generating care plans, the inspector advised that this process needs to be recorded in each patient's care records. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 16 (1) that the registered person shall ensure that a written care plan is prepared by a nurse in consultation with the patient or patient's representative as to how the patient's needs ins respect of his health and welfare are to be met.

The inspector observed that a named nurse system was operational in the home. The roles and responsibilities of the named nurse were not outlined in the patient's guide. It is recommended the patient's guide is further developed to inlcuded the roles and responsibilities of named nurse so that prospective patients and their representative are informed and understand the function of the named nurse.

Care records reviewed did not clearly provided the identity of the named nurse, it is recommended that patients and their representative are informed of the identity of their named nurse.

The inspector reviewed a further two patient's care records,(long term care), which revealed that the pressure relieving equipment in place on the patients' beds and when sitting out of bed was addressed in patients' care plans on pressure area care and prevention.

There was also evidence that the referring health and social care trust (HSCT) maintained appropriate reviews of the patient's satisfaction with the placement in the home, the quality of care delivered and the services provided.

- **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 the risk of development of pressure ulcers which demonstrated timely referral to tissue viability specialist nurses (TVN) for guidance and referral to the HSCT regarding the supply of pressure relieving equipment if appropriate.

Care plans for the management of risks of developing pressure ulcers and wound care were maintained to a professional standard. A recommendation was made in relation to recording the prescribed frequency of dressing change in one patient's wound care records.

Discussion with care staff confirmed they were knowledgeable on best practice in relation to pressure area prevention and skincare.

Discussion with registered nurses and review of 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 nurses confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local healthcare Trust.

- **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 General Practitioners (GP's), speech and language therapists (SALT) and or dieticians being made as required.

The inspector also observed the serving of the lunch time meal and can confirm that patients were offered a choice of meal and that the meal service was well managed and supervised by registered nurses.

Patients were observed to be assisted with dignity and respect throughout the meal.

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

The inspector examined the management of dehydration during the inspection which evidenced that fluid requirement and intake details for patients were recorded and maintained for those patients assessed at risk of dehydration.

Patients were observed to be able to access fluids with ease throughout the inspection. Staff were observed offering patients additional fluids throughout the inspection. Fresh drinking water/various cordials were available to patients in lounges, dining rooms and bedrooms.

The inspector can confirm that based on the evidence reviewed, presented and observed; that the level of compliance with the standards inspected was substantially compliant.

Patient/resident, representatives and staff questionnaires

Some comments received from patients and their representatives:

“I am happy in this home, the staff are very kind and caring, I have nothing to complain about”
“I prefer to spend the time in my bedroom, staff pop in and out all the time, and my family can visit any time. Everybody is very helpful and good at their work”
“I have no complaints at all; the nurses and carers are all very good”.
The meals are good, and we have several choices each day for all our meals”.

“The staff are very attentive, always take time to talk to the patients and have a bit of fun”
“This home is very homely, and welcoming when you visit, there is always some of the staff about to talk to”
“We have no complaints and are more than satisfied with the care and attention shown to all the residents”.

Some comments received from staff:

“High standards of care. Excellent staff teamwork to provide the best care to every resident’s needs. Excellent home and staff management.”
“All staff work well to care for all patients “.
“I am very impressed by the level of care the residents receive. They seem happy and well looked after. The food provided is also a very high standard which the residents seem to enjoy. The staff also work well together and go the extra mile.”
“I feel the care in the home is good, every effort is made to make the residents feel comfortable and to give extra touches and care for the individual.”

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

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

Conclusion

The inspector can confirm that at the time of this inspection the delivery of care to patients/residents was evidenced to be of a good standard. There were processes in place to ensure the effective management of the themes inspected.

The home's general environment was well maintained and patients were observed to be treated with dignity and respect

Therefore, four requirements and four recommendations are made. These requirements and recommendations are detailed throughout the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients/residents, 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 the requirements and recommendations issued as a result of the previous inspection on 29 January 2014

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1.	29 (1) (2) & (3)	It is required that a report is prepared by the registered person in respect of the monthly unannounced monitoring visits in accordance Regulation 29. This requirement is now raised for the third and final time. Further non-compliance with result in enhanced enforcement action.	The inspector reviewed Regulation 29 reports from February 2014 to June 2014 and can confirm that monthly unannounced monitoring visits in accordance with Regulation 29 have been undertaken. This requirement is assessed as compliant.	Compliant
2.	29 (4) (a,b,&c)	It is required that Regulation 29 reports provides evidence that the registered person has: • interviewed a selection of patients, with their consent, in private • interviewed a selection of patient representatives/relatives • interviewed a selection of staff on duty at the time of the visit • inspected the premises • reviewed the record of events, for example	Review of the Regulation 29 reports confirmed that detail was provided in each of the areas required. This requirement is assessed as compliant	Compliant

		incidents and accident records • reviewed the record of complaints • recorded their opinion as to the standard of nursing provided in the home at the time of their visit • evidenced that deficits were identified and an action plan developed to address the deficits • evidenced that previous action plans issued had been reviewed to ensure deficits previously identified were addressed or improved • evidenced that where deficits had not been addressed, in a timely manner, appropriate follow up action had been taken.		

3.	29 (5) (a-d) (6) (a) (b)	It is required that a copy of the report required under regulation 29 is held in the home and made available on request to patients and/or their representatives, the referring Healthcare Trust and RQIA. **A copy of the monthly Regulation 29 report should be forwarded to the aligned inspector Linda Thompson, by the 5th of each subsequent month. This should continue until further notice.**	The inspector was able to confirm that a copy of the monthly Regulation 29 report has been provided to RQIA. Regulation 29 reports were available in the nursing home. A notice was displayed stating that Regulation 29 reports were available. This requirement is assessed as compliant. Regulation 29 reports no longer need to be forwarded to RQIA.	Compliant

4.	16 (2) (b)	It is required that; • any discussions about cardiopulmonary resuscitation (CPR) and any decisions made should be documented in the patient's record. • any decision about whether or not to attempt CPR must be readily accessible to all healthcare professionals who may need to know it, e.g. agency/ temporary nursing staff. GPs and ambulance personnel and • the patient's healthcare record should contain clear documentation of the decision and how it was made, date of decision, reasons for it and the name and position of the person responsible for the decision.	Review of two patient's care records confirmed that the required detail regarding cardiopulmonary resuscitation (CPR) for each patient was documented in the patient's record as required. This requirement is assessed as compliant	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1.	20.2	The finger pulse oxometer should be included in the emergency equipment weekly check.	Review of the emergency equipment weekly check record confirmed that this recommendation is compliant.	Compliant
2.	6.1	It is recommended that the views of residents' views included in the regulation 29 report are annonymised in order to protect their identity.	Review of Regulation 29 reports confirmed that view's or residents were annonymised to protect their identity. This recommendation is assessed as compliant.	Compliant
3.	30.1	It is recommended that staffing provision at meal times is reviewed; a record should be kept of the review process and should show how the needs of the patients are to be met at meal times.	Discussion with three registered nurses and four care staff indicated that patients' needs at meal times was reviewed on a daily and weekly basis. Nursing and care staff were very knowledgeable on each patient's dietary requirements and preferences and confirmed that would inform management if they had any concerns regarding meeting patient's needs at meal times. This recommendation is assessed as compliant.	Compliant

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

Since the previous care inspection on 29 January 2014, RQIA have received nil notifications of safeguarding of vulnerable adult (SOVA) incidents in respect of Movilla House Nursing Home.

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. It is recommended that the 'Admission Policy' is further developed to include the following;

- The arrangements to ensure referral forms from the referring Health and Social Care (HSC) Trust prior to admission are signed on admission.
- The arrangements to provide written confirmation to the prospective patient that the home is suitable to meet their needs.
- The arrangements to respond to any unplanned admission.
- The arrangements to respond to self-referred patients.
- Detail of the specific clinical risk assessments to be undertaken on the day of admission.

The inspector spoke with the registered manager, post inspection, who confirmed that management was unaware that written confirmation should be provided to the prospective patient that the home is suitable to meet their needs. The registered manager stated that arrangements would be implemented to meet this regulation. It is required in accordance with the Nursing Home Regulations (Northern

Ireland) 2005, regulation 15 (1) (d) that the registered person has confirmed in writing to the patient that having regard the assessment the nursing home is suitable for the purpose of meeting the patient's needs in respect of health and welfare.

Review of two patients' care records, who had recently been admitted to the home, identified the following;

Patient C (identity known to the registered manager)

- there was no pre-admission assessment record available for this patient. Discussion with two registered nurses confirmed that this patient had been admitted for a period of respite and stated that a pre-admission assessment had been completed prior to a previous period of respite to the nursing home; however this pre-admission assessment referred to was not available on the day of the inspection. There was no reference or record made in the patient's care records that a previous pre-admission assessment had taken place.
- the patient's admission details did not state the patient's first name.
- a validated nursing assessment had not been undertaken on admission.
- clinical risk assessments, such as the Malnutrition Universal Screening Tool (MUST), Braden scale pressure risk assessment, falls risk, safe moving and handling assessment or a continence assessment had not been undertaken.

Patient D (identity known to the registered manager)

- general nursing needs assessment and the Braden scale pressure risk assessment were seen to have been completed on the day of admission
- other clinical risk assessments such as such as the Malnutrition Universal Screening Tool (MUST), falls risk assessment, safe moving and handling assessment and continence assessment had not been undertaken until four/five days post admission.
- the patient's pre-admission assessment stated the patient previously had pressure sores which were healing; the inspector was unable to evidence that this information was recorded in the patient's care plan as a potential risk.
- the patient's admission general nursing needs assessment stated that the patient had sight and hearing impairment however this sensory impairment was not recorded in the patient's communication care plan.
- the patient's records indicated that the palliative care team were involved in this patient's care, a pain assessment or pain management care plan were not available.
- a care plan had been generated, and was dated 15 days post admission.

It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 15 (1) (a) that the registered person shall not provide accommodation to a patient at the nursing home unless the needs of the patient have been assessed by a suitably qualified or suitably trained person.

It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 16 (2) (a) that the registered person shall ensure that the assessment of the patient's needs is undertaken at the time of admission and is kept under review.

Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart and continence and if required, pain assessment, and wound assessment should be completed on admission in order to establish the patient's health and welfare needs.

The inspector was unable to evidence that care plans for ether patient had been prepared by a nurse in consultation with the patient or patient' representative as to how the patient's needs in respect of his health and welfare are to be met. The inspector spoke with the nurse in charge on the ground floor and the first floor both of whom stated that they always consult with patients and their families when generating care plans, the inspector advised that this process needs to be recorded in each patient's care records. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 16 (1) that the registered person shall ensure that a written care plan is prepared by a nurse in consultation with the patient or patient's representative as to how the patient's needs ins respect of his health and welfare are to be met.

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.

In discussion with three registered nurses, they demonstrated a good awareness of the 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 assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially 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.**

The inspector observed that a named nurse system was operational in the home. The roles and responsibilities of the named nurse were not outlined in the patient's guide. It is recommended the patient's guide is further developed to inlcude the roles and responsibilities of named nurse so that prospective patients and their representative are informed and understand the function of the named nurse.

Care records reviewed did not clearly provided the identity of the named nurse, it is recommended that patients and their representative are informed of the identity of their named nurse.

The inspector reviewed a further two patient's care records,(long term care), which revealed that the pressure relieving equipment in place on the patients' beds and when sitting out of bed was addressed in patients' care plans on pressure area care and prevention.

The inspector reviewed two patient's care records that required wound management for wound care. Review of patient's care records revealed the following;

- A body mapping charts were completed and were reviewed and updated when any changes occurred to the patient's 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 Tissue Viability Nurse (TVN) had undertaken an assessment for both patients. The TVN's recommendations were recorded in each patient's wound care plan.
- Patient B (identity known to the registered manager), daily progress record documented when the patient's dressing was renewed, the inspector was able to establish that this regime was in keeping with the TVN's recommendations.
- Patient A (identity known to the registered manager), daily progress record documented when the patient's dressing was renewed however the inspector could not establish from the wound care records available how often this patient's wound should be redressed. It is recommended that wound care records clearly state how often the patient's wound is to be redressed.

Discussion with three registered nurses and 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. Care records included details of the type of mattress in use for the patient, which 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 patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these charts revealed that patients' skin condition was inspected for evidence of change at each positional change. It was also revealed that patients were repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention.

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 nurses informed the inspector that pressure ulcers were graded using an evidenced based classification system; this was evidenced in the care records reviewed at the time of this inspection.

The 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 patient. 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**.**

As stated in Section 1, Malnutrition Universal Screening Tool (MUST), was not recorded on admission for two patients, this nutritional baseline assessment which includes the patient's weight, must be undertaken at the time of admission and on at least a monthly basis or more often if required.

Patient's nutritional status was reviewed on at least a monthly basis or more often if required.

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

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 one patient evidenced that the patient was referred for a dietetic assessment in a timely manner. This patient was also referred to the speech and language therapist. The patient's care plan was reviewed to address the dietician's and the language therapist's recommendations.

Discussion with registered nurses, care staff and review of the staff training records revealed that three nurses had attended training in wound care awareness. Care staff are facilitated to attend the Royal College of Nursing (RCN) Fundamentals of Care programme in Nutrition and Pressure Ulcers and Infection Control.

Staff training records show the mandatory training is provided with a good attendance rate, the registered manager has a system in place to monitor training attendance and further training is planned throughout the year.

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

Section C

Standard 5.4 • **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**
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. Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. Review of one patient's 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. Review of care records also evidenced that nutritional care plans for patients were reviewed monthly or more often as deemed appropriate. The evaluation process included the effectiveness of any prescribed treatments, for example prescribed analgesia. Discussion with three registered nurses and review of governance documents evidenced that a number of care records were audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

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

Section D

Standard 5.5

- **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)

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

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

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

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

Discussion with 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 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.

Eight 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 for easy access by staff. This is good 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.**
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. 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 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 three patients identified of being at risk of inadequate or excessive food and fluid intake. This review confirmed that;

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

Review of a sample of fluid balance charts confirmed that there was evidence that patients were offered fluids on a regular basis throughout the day and night time period. Discussion with the nurse in charge of each floor confirmed that they were aware of patients at risk of dehydration, fluid intake charts were in place for these patients. A random sample of three patient's records confirmed ;

- 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

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

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.**
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.**

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 all the 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.

Registered nurses 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.

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 inspector spoke with the head cook who 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 dated to show when this menu was implemented.

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

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

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

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. The head cook confirmed choices were also available to patients who were on therapeutic diets. The menu plan also included choices for snacks for patients 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.**

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

Discussion with the registered nurse in charge revealed that one of the nursing sisters had attended swallowing awareness training. It is recommended that swallowing awareness training is provided to all staff involved in assisting patients with meals and drinks.

Review of two patient's care record evidenced that the care plan fully reflect the instructions of a recent speech and language swallow assessments undertaken.

Discussion with registered nurses 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.

Registered nurses 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. Eight 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 patient's bedrooms for easy access by staff. This is good 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.

A tissue viability link nurses was employed in the home.

Discussion with the registered nurses clearly evidenced their knowledge in the assessment, management and treatment of wounds. Review of the template used to undertake competency and capability assessments for the registered nurses revealed that pressure ulcer/wound care was addressed.

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

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.

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/residents currently resident at the time of inspection in the home.

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 two registered nurses. The inspector can confirm that copies of these documents were available in the home.

Registered nurses demonstrated an awareness of the details outlined in these documents and were 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 (DOLs) with the registered nurses including the recording of best interest decisions on behalf of patients. A copy of DOLS was also available in the home**.**

11.4 Quality of interaction schedule (QUIS)

The inspector undertook two periods of observation in the home which lasted for approximately 20 minutes each.

The inspector observed the lunch meal being served in the dining room and the interactions between patient and staff during this time. The inspector also observed care practices in the main sitting room following the lunch meal.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area being observed.

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

The inspector observed staff preparing for and serving the mid-day meal. 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 appropriate.

Following lunch patients were respectfully offered assistance to move to whatever area of the home they preferred. Some patients chose the communal lounge areas whilst others chose to go to their own bedrooms or other areas of the home.

The activity therapist was observed to attend to patients in small groups and on a one to one basis throughout the morning informing patients of the planned activity for that afternoon. Patients were observed to respond positively to the gentle and individual attention being offered by the activity therapist.

The inspector evidenced that the quality of interactions between staff and patients was positive. Staff were polite and courteous when speaking with patients, conversation was relaxed and respectful.

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

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. This review evidenced that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought.

The registered nurses in charge 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. This was also evidenced by the inspector on the day of inspection.

11.8 Questionnaire findings

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 currently in the home. An activity therapist is employed to provide additional hours for the provision of activities to patients/residents, this is commendable practice.

The ancillary staffing levels were found to be satisfactory; the home was organised, clean and tidy throughout.

Staff were provided with a variety of relevant training including mandatory training since the previous inspection.

During the inspection the inspector spoke to eight staff. The inspector was able to speak to these staff individually. On the day of inspection four staff completed

questionnaires, a review of which indicated that staff were ‘very satisfied ‘ or ‘satisfied’ in relation to their induction, training provision and with the general standard of care provided in the home. The following are examples of staff comments during the inspection and in questionnaires;

“High standards of care. Excellent staff teamwork to provide the best care to every resident’s needs. Excellent home and staff management.”
“All staff work well to care for all patients “.
“I am very impressed by the level of care the residents receive. They seem happy and well looked after. The food provided is also a very high standard which the residents seem to enjoy. The staff also work well together and go the extra mile.”
“I feel the care in the home is good, every effort is made to make the residents feel comfortable and to give extra touches and care for the individual.”

Patients’ comments

During the inspection the inspector spoke with eight patients individually and with a number in groups. In addition, on the day of inspection, one patient completed questionnaire.

The following are examples of patients’ comments made to the inspector and recorded in the returned questionnaires.

“I am happy in this home, the staff are very kind and caring, I have nothing to complain about”
“I prefer to spend the time in my bedroom, staff pop in and out all the time, and my family can visit any time. Everybody is very helpful and good at their work”
“I have no complaints at all; the nurses and carers are all very good”.
The meals are good and we choices each day for all our meals”.

Patient Representative/relatives’ comments

During the inspection the inspector spoke with four representatives/relatives/visitors. In addition, on the day of inspection, two representatives/relatives competed and returned questionnaires.

The following are examples of relatives’ comments during inspection and in questionnaires;

“The staff are very attentive, always take time to talk to the patients and have a bit of fun”
“This home is very homely, and welcoming when you visit, there is always some of the staff about to talk to”
“We have no complaints and are more than satisfied with the care and attention shown to all the residents”.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Doreen Bingham, registered manager, following the inspection, 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:

Carmel McKeegan
The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
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**
On admission to Movilla House the designated nurse will carry out an initial assessment within 24 hours using Roper Logan Tierney Assesment Tool. Information is taken from the pre admission assessment carried out by Matron or Sister prior to adminssion. Information is also obtained from the multi disciplinary assesments from the Care Manager. As the staff get to know the resident further information is collated and all risk assesment tools completed in the first week. These inclde MUST assesment, BRADEN SCORE, Movilng and Handling - falls risk, bed rail protocols, pain and contenance assessments.	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**
At Movilla House a names nurse is appointed to each resident at time of admission. This nurse will draw up care plans and risk assessments with the resident and/or their representative. The care plans will set realistic and reasonable goals which are discussed and agreed with the resident and/or their representative. Specific care interventions are evidence based and comply with residents wishes and are in keeping with organisational policies and protocols. The	Compliant

care plans will be communicated to all members of the Care Team. If required referrals will be made to other disciplines eg physiotherapy, speech & language therapy, dieticians, dentist or specialist nurses (for support eg tissue vialbility, diabetic nurse, respiratory nurse etc). Movilla House is taking part in the First Food Project. A dietician visits the home on a monthly basis and record all residents' weights and MUST scores. Nutritional treatment plans are discussed with nurses and cooks to ensure calories are added to modified food and less nutritional supplements. The cooks at Movilla House have carried our traning sessions for cooks in other homes and the Trust staff.	

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 condition of each resident and the care given is recorded on the daily evaluation sheet. Each entry is dated, timed and signed by the nurse. Any change in condition is recorded at the time of occurance and at the end of each shift. Changes are cross referenced in the residents care plans. Care plans are re assessed monthly or if there is a significant change in the residents condition. All entries and records are made according to the NMC guidelines for records and record keeping.	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**
At Movilla House medications are administered as per NMC guidelines and RQIA guidelines on Control of Administration of medicines in Nursing Homes. Records and record keeping as per NMC guidelines for Record and Record Keeping. Nutritional status is monitored using MUST tool. Wound management as per NICE guidelines. Confidentiality and consent are in keeping with the NMC Code of Professional Conduct Standard for Conduct Performance and Ethics. All records are kept as per Data Potection Act 1998. EPUAP grading system is used to screen patients who have skin damage and appropriate treatment plans implemented and this is recorded is Resident Care Plan. The HSC 2014 Nutritional Guidelines and menu checklists are used by staff and chefs 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**
Written care plans and daily evaluations of change and outcomes of care provided are maintained. Care Plans are updated monthly or as necessary as needs change. Wound charts, Fluid Balance, Blood Sugar Monitoring, Repoitional Charts and Clinical Observations are recored in black ink. Corrections and changes are easily seen. Correction fluid is not permitted. Recordsare kept of medication ordered, administered, refused, wasted or disposed of. Al records are in keeping with NMC guidelines on Record and Record Keeping. All entries are dated, times, signed and include the designation of signatory. Recors are also kept of the meals provided and are available for inspection. Fluid and Food records are recorded daily on all residents who are at risk of either overeating or not taking adequate meals or fuids. This is recorded in the residents daily evaluation. Records are monitored and referrals made to GP or dietician.	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**
Daily and nightly evaluations are carried out on all residents and the outcome of care recorded. Care plans are reviewed monthly or if there is a change in the residents condition. Monthly audits are carried out on accidents, untoward incidents, antibiotic use and residents records. Care management reviews take place 6 weeks after a resident has been admitted and then yearly unless requested by the home, resident or Care Management.	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/Multi Disciplinary reviews take place 6 weeks after residents admission to the home and yearly thereafter unless there is a change in the residents condition or the resident expresses dissatisfation with their caare or at the request of the family. Residents and relatives/representatives are encouraged to attend or contribute to the meeting. The results of the review meeting are recorded on the multidisciplinary notes and where appropriate in the reidents medical file. Changes are made to the nursing care plan with the agreement of residents and their representatives. Changes are disseminated to all care staff, referrals are made if necessary and residents/relatives informed of any changes.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Menus are planned ona 4 weeks cycle taking into account the nutritional guidelines and menu checklist. The menus are varied and offer residents choice and take nto account guidance from Dieticians and Speech & Language Therapists. Menus offer residents a choice of three meals at lunch, breakfast and tea time. If a resident does not like any of the choices, an alternative meal is provided. Menus for those on theraputic or specfic diets also have three choices each meal time.	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Breakfast is available from 7.30am-10.30am, lunch is served from 12.30pm-1.30pm and tea from 4.30pm-5.30pm. Morning tea /coffee is at 11.00am, afternoon tea/coffee at 2.30pm and supper at 8pm. Fresh cakes, biscuits are served. Residents may have hot drinks at any time on request. Jugs are changed each morning and as necessary throughout the day. Each longe also has jugs of water.	Compliant

Staff are made aware of any residents eacting and drinking problems during report. Speech and language recommendations are passed to care staff, kitchen staff and relatives. A copy of the recommendations is hung in each residents room and recorded in cae plans. Staff are present in lounges and dining room to ensure residents are supervised or assisted as necessary. Kitchen staff are also aware if specialist cutlery and plate guards ae needed. Staff at Movilla House attend study days and seminars to ensure they have the expertise and skills in wound management (accessing wounds and applying wound dressings unsing the appropriate dressings as per the formula for dressing and NICE guidelines to indentify type and wound grades). The tissue viability nurse/podiatrist wil be contacted for advise if necessary.	

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

Appendix 2

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

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

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

References

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

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

Quality Improvement Plan

Unannounced Primary Inspection

Movilla House

29 July 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 Doreen Bingham, registered 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.	15 (1) (d)	The registered person shall confirm in writing to the prospective patient that having regarded the assessment the nursing home is suitable for the purpose of meeting the patient's needs in respect of health and welfare. **Ref; Section A**	One	The registered person confirms in writing to prospective residents after an assessment has been carried out that the nursing home is suitable for their needs.	From the date of this inspection
2.	15 (1) (a)	The registered person shall not provide accommodation to a patient at the nursing home unless the needs of the patient have been assessed by a suitably qualified or suitably trained person. **Ref; Section A**	One	All prospective residents have an assessment carried out by the Manager or Sisters before admission	From the date of this inspection
3.	16 (2) (a)	The registered person shall ensure that the assessment of the patient's needs is undertaken at the time of admission and is kept under review. **Ref; Section A and B**	One	New residents have an assessment of needs carried out on admission and this is reviewed monthly.	From the date of this inspection

4.	16 (1)	The registered person shall ensure that a written care plan is prepared by a nurse in consultation with the patient or patient's representative as to how the patient's needs ins respect of his health and welfare are to be met. **Ref; Section A**	One	Care plans are prepared by the nurse in consultation with the residents and/or their friend/relative.	From the date of this inspection

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.	26.2	It is recommended that the 'Admission Policy' is further developed to include the following; • The arrangements to ensure referral forms from the referring Health and Social Care (HSC) Trust prior to admission are signed on admission. • The arrangements to provide written confirmation to the prospective patient that the home is suitable to meet their needs. • The arrangements to respond to any unplanned admission. • The arrangements to respond to self-referred patients. • Detail of the specific clinical risk assessments to be undertaken on the day of admission. **Ref; Section A**	One	The 'Admission Policy' has been ammended to include - referral forms from HSC are signed on admission -Written confirmation is given to prospective residents that the home can meet their needs. -Risk assessments are carried out on the day of admission.	30 September 2014

2.	3.1	The patient's guide is further developed to inlcuded the roles and responsibilities of named nurse so that prospective patients and their representative are informed and understand the function of the named nurse. Patients and their representative are informed of the identity of their named nurse. **Ref; Section B**	One	The patients guide will inform residents relatives who is their named nurse and the function of the named nurse Residents and their representatives are informed of the identity of their named nurse..	30 September 2014
3.	6.4	Wound care records should clearly state how often the patient's wound is to be redressed. **Ref; Section B**	One	Wound Care records state how often the residents wounds are to be redressed.	From the date of this inspection
4.	28.4	Swallowing awareness training should be provided to all staff involved in assisting patients with meals and drinks. **Ref; Section I**	One	Swallow Awareness training for all staff is to take place on 16/10/14.	30 September 2014

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	Doreen Bingham
Name of Responsible Person / Identified Responsible Person Approving Qip	Derek Bell

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	Linda Thompson	8/10/14
Further information requested from provider			