Unannounced Secondary Care Inspection

Name of Establishment:	**Mullaghboy Nursing Home**
RQIA Number:	**1271**
Date of Inspection:	**16 February 2015**
Inspector's Name:	**Norma Munn**
Inspection ID:	**017077**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Mullaghboy Nursing Home
Address:	86 Warren Road Donaghadee BT21 0PQ
Telephone Number:	02891883596
Email Address:	nursemanager@mullaghboy-pnh.co.uk
Registered Organisation/ Registered Provider:	Mr Robert Maxwell Duncan, Ms Heather Duncan, Mrs Anne Duncan
Registered Manager:	Ms Anne Dugan
Person in Charge of the Home at the Time of Inspection:	Ms Anne Dugan
Categories of Care:	NH-I, NH-PH, NH-PH(E), NH-TI
Number of Registered Places:	32
Number of Patients Accommodated on Day of Inspection:	29
Scale of Charges (per week):	£611 - £641
Date and Type of Previous Inspection:	31 March 2014 Unannounced Secondary Inspection
Date and Time of Inspection:	16 February 2015 10.30 – 16.15 hours
Name of Inspector:	Norma Munn

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)
- Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/Process

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

- discussion with the Registered Manager
- discussion with staff
- discussion with patients individually and to others in groups
- review of a sample of care plans
- review of a sample of policies and procedures
- observation during a tour of the premises
- evaluation and feedback.

5.0 Consultation Process

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

Patients	**13 patients individually and to others in groups**
Staff	**9**
Relatives	**1**
Visiting Professionals	**1**

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**1**	**0**
Relatives/Representatives	**1**	**0**
Staff	**7**	**7**

6.0 Inspection Focus

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible person/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

However, due to workload pressures and contingency measures within the Regulation Directorate, the themes/standards within the self-assessment were not inspected on this occasion.

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

Standard 19 - Continence Management

Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

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

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

7.0 Profile of Service

Mullaghboy Private Nursing home is situated on a very pleasant site overlooking the sea within half a mile from the local village of Donaghadee

The nursing home is owned and operated by Mr Robert Maxwell Duncan, Ms Heather Duncan and Mrs Anne Duncan.

The current registered manager is Ms Anne Dugan.

Accommodation is provided over two floors with bedroom accommodation on both levels. Access to the first floor is via a passenger lift and stairs. Communal lounge and dining areas are provided on the ground floor. The home also provides for catering and laundry services. Toilet and bathroom facilities are located throughout the home. There is a patio area and garden with ample car parking spaces available at the front of the building.

The home is registered to provide care for a maximum of 32 persons under the following categories of care:

Nursing care

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
PH(E)	physical disability other than sensory impairment over 65 years
TI	terminally ill

8.0 Executive Summary

This unannounced inspection of Mullaghboy Private Nursing Home was undertaken by Norma Munn, inspector, on 16 February 2015 between 10 30 and 16 15 hours. The inspection was facilitated by Ms Anne Dugan, registered manager who was available throughout the inspection. Verbal feedback was given to Ms Dugan at the conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection of 31 March 2014.

As a result of the previous inspection four requirements and five recommendations were made. These were reviewed during this inspection and it was evidenced that the requirements and recommendations have been fully complied with. Details can be viewed in the section immediately following this summary.

Assessments and care plans were reviewed with regard to the management of continence in the home. Review of care records evidenced that continence assessments had not been fully completed for all patients. A recommendation has been made.

Not all patients and/or their representatives had been involved in discussions regarding the ageeing and planning of nursing interventions. A recommendation has been made.

Nursing staff spoken with on the day of the inspection were knowledgeable regarding the management of continence care, urinary catheters and the frequency with which the catheters within the home required to be changed.

From a review of the available evidence, discussion with relevant staff and observation, it was evidenced that the level of compliance with the standard inspected is substantially compliant.

Additional Areas Examined

Care Practices
Staffing
Patients Comments
Staff Comments
Environment

Details regarding the inspection findings for these areas are available in the main body of the report. Areas for improvement were identified in relation to policies and procedures and staffing. Two recommendations have been made**.**

Conclusion

At the time of this inspection, the delivery of care to patients was evidenced to be of a good standard and patients were observed to be treated by staff with dignity and respect. Good relationships were evident between staff and patients. Patients were well groomed, appropriately dressed and appeared comfortable in their surroundings.

As a result of this inspection four recommendations have been made.

The inspector would like to thank the patients, registered manager, registered nurses and staff for their assistance and co-operation throughout the inspection process.
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9.0 Follow-Up on Previous Issues from Care Inspection 31 March 2014

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	20 (1) (a)	The registered person shall, having regard to the size of the nursing home, the statement of purpose and number and needs of patients – (a) Ensure that at all times suitably qualified, competent and experienced persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients, specifically in relation to; • staff to patient ratios throughout the 24hour period must meet with RQIA staffing guidance. • the required care hours per patient per day should be calculated using the Rhys Hearn (1970) dependency tool and care hours provided accordingly. • calculated care hours should be provided with a staffing arrangement of 35% registered nurses and 65%. • care assistant hours should be protected to provide direct care, if care assistants are to be involved in providing meaningful activities for	Discussion with the registered manager, observation of care practices and a review of the duty rotas evidenced that the number of staff on duty was in line with RQIA'S recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection. The registered manager has given assurances that the staffing levels and skill mix will be kept under continuous review to ensure the needs of the patients are met. Care hours are calculated in accordance with the Rhys Hearn Dependency Tool. Review of the duty rotas and discussion with the registered manager confirmed that the registered manager has between 20 to 25 hours per week dedicated to managerial duties. The remainder of her time is spent working as a second nurse due to recruitment difficulties. These hours vary according to the availability of registered nurses, staff annual leave and sickness.	Compliant

		patients, care assistants will require training in this area and care assistant hours should be provided at a level above the minimum staffing guidance in order to protect the provision of direct care hours. • the registered manager should not be counted as the second nurse on duty on a consistent basis. It is the expectation of RQIA that the registered manager should have adequate dedicated managerial time which should be in excess of 23 hours per week. • the weekly duty rota is to be submitted to RQIA until further notice.		

2	13 (1) (a)	It is required a system to re-evaluate any shortfalls noted during audits undertaken in the home is introduced. Audits undertaken as recommended by the registered provider's governance arrangements of the home should evidence that areas identified for action are reviewed to ensure deficits previously identified were addressed. Audits should be undertaken on a regular basis and include: • comprehensive infection control audits • patients care records	Discussion with the registered manager confirmed that a system is in place to evaluate any shortfalls identified during audits in relation to infection control and patient care records. Review of infection control audits evidenced that shortfalls identified had been addressed. Review of care plan audits evidenced that the majority of shortfalls identified had been addressed. One care plan audit undertaken did not have the deficits identified addressed. This issue was discussed with the registered manager who has agreed to continue to monitor care plan audits to ensure that deficits identified are addressed and actioned.	Compliant

3	16 (1)	It is required that clarity is sought and recorded regarding the resuscitation status of Patient B. 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.	Discussion with staff revealed that Patient B was no longer residing in Mullaghboy at the time of the inspection. Review of a sample of patients' resuscitation records evidenced that there was clear information regarding the decision and the person making the decision	Compliant

4	15 (2) (a)	The registered person must ensure that the assessment of patient's needs is kept under review and updated as the patient's condition changes. • Patient A's wound should be reassessed and graded according to the current wound condition. • Recording of clinical observations should provide the actual date the observations were taken.	Discussion with staff revealed that Patient A was no longer residing in Mullaghboy at the time of the inspection. Review of a sample of patients' care records evidenced the recording of the date clinical observations had been taken.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	25.12	It is recommended the policy on quality assurance/governance arrangements of the home is revised to include all aspects of quality monitoring, for example, the annual quality report, consultation with patient and/or representatives.	Discussion with the registered manager confirmed that the policy on quality assurance had been revised. However, a review of the policy evidenced that it had not been dated or signed. A separate recommendation has been made.	Compliant
2	10.7	It is recommended the home's policy on restraint/restrictive practice is revised.	Discussion with the registered manager confirmed that the policy on restraint had been revised. However, a review of the policy evidenced that it had not been dated or signed. A separate recommendation has been made.	Compliant

3	20.3	Guidance documents such as Nursing Midwifery Council (NMC) guidance and the Resuscitation Guidelines 2010 from the Resuscitation Council UK should be available for reference in the home.	Discussion with the registered manager and a review of best practice guidelines evidenced that the NMC guidelines and the Resuscitation Council UK guidelines were available for reference	Compliant
4	20.3	The resuscitation policy document should be revised to provide up to date guidance in keeping with best practice guidelines. This policy document should also detail the frequency of review of the DNR directive in keepi with the Resuscitation Council (UK) guidelines.	Discussion with the registered manager confirmed that the policy on resuscitation had been revised and now refers to the Resuscitation Council (UK) guidelines. However, a review of the policy evidenced that it had not been dated or signed. A separate recommendation has been made.	Compliant

5	5.6	It is recommended that the abbreviation stated in the home's policy documentation in respect of resuscitation is the only abbreviation to be used by registered nurses.	Review of a sample care records evidenced the abbreviation used in the home's policy had been the only abbreviation used in relation to resuscitation.	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.

There have been nil notifications to RQIA regarding safeguarding of vulnerable adults (SOVA) incidents since the previous care inspection.

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10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of three patients' care records evidenced that bladder and bowel continence assessments had not been fully completed as part of the assessment process within the home. A recommendation has been made to ensure that bladder and bowel continence assessments are completed for all patients. . The care plans reviewed addressed the patients' needs in regard to continence management. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Care plans were updated on a monthly basis or more often as deemed appropriate. Review of three patient's care records did not evidence that either the patient or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. A recommendation has been made to ensure that care plans are developed in consultation with the patient and/or their representative. . Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Substantially Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the registered manager and staff evidenced that the following policies and procedures were in place; • continence management/incontinence management • stoma care • catheter care There was evidence that the correct equipment was in place regarding the management of patients' with an indwelling catheter and stoma appliance. The following guidance documents were in place; • RCN continence care guidelines • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not assessed	Not assessed
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the registered manager confirmed that staff were assessed as competent in continence care. Identified registered nurses in the home were deemed competent in female and male catheterisation and the management of stoma appliances. Staff informed the inspector that advice and support for continence management can be sourced from the continence nurse in the local Trust if required. Regular audits of the management of incontinence had been undertaken.	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 Care Practices

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

Patients were well presented with their clothing suitable for the season. Staff were observed to respond to requests promptly. The demeanour of patients indicated that they were relaxed in their surroundings.

11.2 Staffing

Review of the duty rotas weeks commencing 2 February 2015, 9 February 2015 and 16 February 2015 evidenced that the number of staff on duty was in line with RQIA'S recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection.

RQIA had identified issues in relation to the provision of activities during the previous inspection on 31 March 2014 and a requirement had been made. Discussion with staff revealed that senior care staff are continuing to carry out activities with the patients. No concerns were raised by staff or patients during the inspection in relation to the provision of activities. A recommendation has been made to review care assistant hours allocated to activities to ensure that the needs of the patients are met.

11.3 Patients Comments

Thirteen patients were spoken with individually and the majority of others in smaller groups. Patients spoken with confirmed that they were treated with dignity and respect, that staff were polite and respectful, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home.

Examples of patients' comments were as follows:

"I am treated very well"
"The staff are wonderful"
"It is lovely living here"
"I would recommend this place"
"The food is good"

11.4 Questionnaire Findings/Staff Comments

Nine staff including registered nurses, care staff and ancillary staff were spoken with. Seven staff completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

Examples of staff comments were as follows:

“Every resident’s individual needs are met “
“Each resident is treated with respect”
“This is the best nursing home I have worked in”

11.5 Environment

A tour of the premises was undertaken which included the majority of patients’ bedrooms, bathrooms, shower and toilet facilities and communal areas. The majority of bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling and appropriately heated throughout.

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12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Anne Dugan, registered manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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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 the Home the nurse will carry out an initial assessment of the client using Roper Logan Tierney Tool. A plan of care will be drawn up to address the immediate needs of the client. Prior to admission the manager will obtain a copy of the assessments carried out by Care Management Team or Ward Staff. All other specific care plans will be completed within 11 days of admission. Nutritional screening will be done using the MUST Tool. This will include the clients weight, information regarding specific diets and supplements. A pressure ulcer risk assessment will be carried out taking into consideration continence status and level of pain	Compliant

experienced. Clinical assessments carried out prior to admission will ensure that any relevant equipment eg: Pressure Relieving Mattress can be in place for the patients arrival. Risk assessments in relation to MUST, BRADEN SCORE, moving & handling, bed rail protocols, pain & continence assessments will be completed within the first week.	

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
On admission a specific named nurse will be allocated to discuss plan and agree care for the patient. The nurse will involve the patient and their representatives in the care plan, taking advice from MDT in relation to care needs while encouraging as much independence as possible for the patient. The patient will be referred to relevant health professionals for guidance and expert advice in relation to wound care eg: Tissue Viability Spec Nurse or Podiatrist (for lower limbs). The patient will be assessed for level of risk of having tissue damage and a prevention and treatment programme is drawn up. The patient is referred to a dietitian as indicated eg: where there is a history of weight loss, loss of appetite or obvious tissue damage. A nurtitional plan is developed taking into account recommendations from relevant professionals eg: dietitian, speech and language therapist. The care plans will be communicated to all members of the care team.	Compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The Home Manager carries out an assessment of all patients prior to admission. On admission more detailed assessments of all aspects of their care needs will be done. All care plans are discussed with the patient and accurate documentation will be completed, recorded and regulary reviewed on a daily basis. Each entry is dated, timed and signed and any change in condition is recorded at time of occurance and at the end of each shift. NMC guidelines are adhered to on each record.	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**
Medications are administered as per NMC guidelines and RQIA guidelines on Control and Administration of Medicines in Nursing Homes. All records and record keeping as per NMC guidelines. Wound management as per NICE guidelines. Confidentiality and consent are in keeping with NMC Code of Professional Conduct Performace & Ethics. All records are kept as per Data Protection Act 1998. The EPUAP grading system is used to assess patients who have skin damage and to ensure appropiate treatment plans are implemented. This is recorded in the care plan. The HSC Nutritional Guidelines are followed by catering staff when planning menus.	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**
Care records are kept of all nursing interventions, any procedures carried out and their outcomes in accordance with NMC guidelines. Records are kept of meals provided and care staff inform Nurse in Charge if any patient is not consuming a satisfactory amount, or if there is evidence of weight loss. Detailed records of oral intake will be recorded and referrals made to dietition, GP as necessary. Food & fluid records are maintained daily on all patients who are not taking adequate meals or fluids or patients who are at risk of over eating. All entries are dated, timed and signed as per NMC guidelines on records and record keeping.	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**
Day and night evaluations are carried out on all patients and records are made regarding outcomes of care. The care plan is reviewed monthly or if a change occurs in the patients condition. Monthly audits are maintained for accidents, untoward incidents, use of antibiotics, infections and care records. Each patient has a care management review 6 weeks after admission and then annually unless further request for review is made by the Home, the patient 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**
Patients will be included in all aspects of reviewing their care where possible and if able can contribute to and attend formal meetings such as care reviews as arranged by local HSC Trusts 6 weeks after admission and then yearly. The outcomes of the review meeting is recorded in the multi disciplinary notes and in the medical file if necessary. If changes to the care plan are required the information will be disseminated to all nursing and care staff and further referrals made if required. The patient and/or their relatives will be notified of changes made.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Menus are planned on a 3 weekly cycle and regularly reviewed by the cooks and the Home Manager. The food provided is nutritious and varied and takes the patients choices and preferences into consideration. Guidance is taken in relation to special diets, diabetic diets and supplements from dietitians, specialist nurses and speech & language therapists. Each resident is offered a choice at every mealtime and alternative meals are provided to the patients taste if menu choices are not liked.	Compliant

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

Criterion 8.6
• **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.**
Criterion 12.5
• **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.**
Criterion 12.10
• **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:**
  ○ **risks when patients are eating and drinking are managed**
  ○ **required assistance is provided**
  ○ **necessary aids and equipment are available for use.**
Criterion 11.7
• **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.**
 	
Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
All nursing staff are aware and have been trained in managing patients with swallowing problems. Instrustions given by speech & language therapist is followed. Meals are provided at specific times and snacks and drinks are available at set intervals and as requested. Fresh water is available at all times for each patient. All staff are informed to report any problems with patients when they are eating & drinking to the nurse in charge. The manager ensures that there are sufficient staff to assist at meal times and that any necessary equipment is available. Staff are present in dining room and lounges to ensure patients are supervised and assisted as necessary. All staff nurses have attended specific wound management training as organised by the local HSC Trust. Nurses are knowledgeable in relation to assessment of wounds and choice of dressings.	Compliant

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

Quality Improvement Plan

Unannounced Secondary Inspection

Mullaghboy Nursing Home

16 February 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with Ms Anne Dugan, registered manager, during and 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 applicatio

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	19.1	The registered person should ensure that continence assessments are completed for patients who require continence management. **Ref: Section 10.0 Standard 19.1**	One	All now complete.	By 16 March 2015.
2	19.1	The registered person should ensure that care plans for continence management are developed in consultation with the patient and/or their representative. **Ref: Section 10.0 Standard 19.1**	One	Ongoing.	By 16 March 2015.
3	30.1	The registered person should review care assistant hours allocated to activities to ensure that the needs of the patients are met. **Ref: Section 11.2**	One	All client needs are met. Activity time is reviewed daily as necessary.	By 16 March 2015.
4	26.5	The registered person should ensure that policies and procedures are dated when issued, reviewed or revised. **Ref: Section 9.0 follow up section**	One	Commenced and ongoing. All policies have recently been renewed and therefore had not been revised (new policy files October 2014).	By 16 March 2015.

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	Anne Dugan
Name of Responsible Person / Identified Responsible Person Approving Qip	Robert Duncan

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	Norma Munn	9 April 2015
Further information requested from provider			