Announced Primary Inspection

Name of establishment:	**Oakridge Clinic (EMI Unit)**
Establishment ID No:	**1276**
Date of inspection:	**23 May 2014**
Inspector's name:	**Lorraine O'Donnell**
Inspection No:	**17168**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of home:	Oakridge Clinic Nursing Home (EMI Unit)
Address:	14 Magheraknock Road Ballynahinch BT24 8TJ
Telephone number:	(028) 9756 5322
E mail address:	oakridge@fshc.co.uk
Registered organisation/ Registered provider / Responsible individual	Four Seasons Health Care Mr James McCall
Registered manager:	Mrs Rachel McCaffrey
Person in charge of the home at the time of inspection:	Sister Aida Oliveira
Categories of care:	Nursing - Dementia (DE)
Number of registered places:	40
Number of patients / residents (delete as required) accommodated on day of inspection:	38
Scale of charges (per week):	£537 - £636
Date and type of previous inspection:	27 June 2013 09 45 – 16 30 hours
Date and time of inspection:	23 May 2014 09 15 -16 45 hours
Name of inspector:	Lorraine O'Donnell

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 nurse in charge
- 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	5 individually and others in groups
Staff	5
Relatives	3
Visiting Professionals	0

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

Issued To	**Number issued**	**Number returned**
Patients / Residents	5	0
Relatives / Representatives	3	0
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

Oakridge Clinic is a purpose built home located on the outskirts of the town of Ballynahinch. There are three registered units contained within the building. The dementia unit is located on the first floor and is registered to provide nursing care for a maximum of 40 patients. The dementia unit is managed as two smaller units, the Murlough and Tyrella suite, each of which have bedroom accommodation for 20 patients. There are a number of small lounge areas, a dining room, bath, toilet and shower rooms in each suite. Many of the bedrooms provide en suite shower and toilet facilities. Bedroom accommodation is provided in both single and shared rooms.

The home is owned by Four Seasons Health Care Ltd.

The registered manager Mrs Rachel McCaffrey. Mrs McCaffrey has been in post since 2011.

The inspector reviewed the Certificate of Registration issued by The Regulation and Quality Improvement Authority (RQIA). It was appropriately displayed in the entrance hall of the home.

8.0 Summary of Inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Oakridge Clinic EMI unit. The inspection was undertaken by Lorraine O'Donnell on 23 May 2014 from 09 15 to 16 45 hours.

The inspector was welcomed into the home by Sister Aida Oliveira, who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Sister Aida Oliveira and to the registered manager by phone at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. This self-assessment was received by the Authority. 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 three relatives. 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 27 June 2014 two requirements and five recommendations were issued.

These were reviewed during this inspection. The inspector evidenced that one requirement and four recommendations had been fully complied with. One requirement was substantially complied with and one recommendation was not compliant. 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 was evidence to validate that patients received safe and effective care in Oakridge Clinic.

The inspector examined six patients' care records and there was evidence of comprehensive and detailed assessment of patient needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patient need was evidenced to inform the care planning process. However these records were not consistently person centred, therefore a recommendation is made.

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 six patients were examined by the inspector, review of these patients' records confirmed they were reviewed on a monthly or more often basis as required. Care plans for the management of risks of pressure ulcers were maintained to a professional standard. However the inspector found a number of repositioning charts had not been recorded for periods during the night to evidence the care was delivered. Therefore this requirement will be restated until fully compliant.

The inspector examined the notifications to RQIA and these evidenced the home to be compliant with the requirement to inform RQIA of pressure sores of grade 2 or above. Discussions with staff indicated they had received training in wound care and they could identify the wound care link nurse for the home.

- **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 examined food charts for eight residents, these charts contained information relating to the type of diet, the portion size consumed, if food had been refused. It also indicated if any special equipment or assistance was required. These booklets also contained information for staff on how to complete this booklet to ensure consistency in recording.

The inspector was informed by the registered manager a residents' questionnaire had been completed on 16 May 2014, to gain their opinions and ideas before the planning of a new menu. This has resulted in some positive feedback from residents and their representatives.

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

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

Review of a sample of fluid balance charts for patients revealed that these charts were accurately maintained and totalled for the 24 hour period. There was evidence that the patients were offered fluids on a regular basis.

The patients' recommended daily fluid intakes and the action to be taken if targets were not being achieved were addressed in the patients care plans. The patients' fluid intakes for the 24 hour period were recorded in the patients' daily evaluations of care and treatment provided to the patients.

During the inspection staff were observed offering patients fluids on a regular basis and patients were observed to be able to access fluids with ease throughout the inspection.

Patient, representatives and staff questionnaires

Some comments received from patients and their representatives:

“staff respond well to my mother’s needs”
“staff are very attentive”
“I am happy with the care”
“I have no complaints”

Some comments received from staff:
“my training has been very good”
“I really enjoy working here”
“I would like to have more time to spend talking to the residents”

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
- 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. However, areas for improvement were identified. Therefore, one requirement and one recommendation have been restated. One requirement and one recommendation 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, relatives, registered manager, registered nurses and staff for their assistance and co-operation throughout the inspection process.

The inspector would also like to thank the patients, relatives and staff who completed questionnaires.

9.0 Follow-up on the requirements and recommendations issued as a result of the previous inspection on _____

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	19(1)(a), schedule 3, 2(k)	The registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence the care delivered.	The inspector examined the repositioning charts for seven patients and found that four of the records were not accurately maintained to evidence the care was delivered.	Substantially Compliant
2	27(2)(b)	It is required that the nursing home is kept in a good state of repair externally and internally. It is required that the décor in the identified dining room is upgrade to an acceptable standard.	The inspector found the nursing home décor had been updated in the areas outlined in the previous inspection and the gardening work to the external areas had commenced.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	5.1	It is recommended that patients who are transferred from another unit within the home are fully assessed and risk assessments and care plans reviewed and updated on transfer to accurately reflect the changing needs of the patient.	The records of one patient who had recently transferred from another unit were examined and they evidenced the risk assessments and care plans had been reviewed to accurately reflect the changing needs of the patient.	Compliant
2	25.11	It is recommended that the registered manager completes any audit process by reviewing the completed audit record and signing that the area for improvement was compliant.	The inspector examined records held in the home audit file which the home's registered manager had documented, discussed with staff and signed when areas for improvement were compliant.	Compliant

3	16.2	It is recommended that all induction programmes are reviewed, and where required developed, to include awareness and reporting responsibilities for all grades of staff. Induction records should be further developed to include a general awareness of the correct use of restraint.	The inspector examined records of staff meetings during which staff were awareness of the use of restraint and they were informed of their reporting responsibilities. The registered manager informed the inspector that the recommendation had been forwarded to FSHC Wales-NI Quality Team for review and a response had not been received.	Not Compliant
4	10.7	It is recommended that the management of alarm mats is reviewed to include: • care plans to prescribe the use of an alarm mat • records to evidence that the use of alarm mats is discussed with the patient, where appropriate, and if the patient is unable to give their consent then consultation with relatives and, if required, healthcare professionals in regard to best interest decisions for the patient.	The inspector examined the records of three patients requiring the use of pressure mats. They each contained evidence of risk assessments, care plans and that the use of the pressure mat had been discussed with the patients' relatives/representatives and their consent was recorded.	Compliant

5	32.1	It is recommended that the storage of condiments, crockery etc., are reviewed to minimise the cluttered appearance in the dining room.	The inspector found the dining room was tidy and free from clutter.	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 of 27 June 2013, RQIA have received nil notifications of safeguarding of vulnerable adult (SOVA) incidents in respect of Oakridge Care Home EMI unit.

10.0 Inspection Findings

Section A

Standard 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment** **Standard 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission** **Standard 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent** **Standard 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.**
Inspection Findings:
Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance. The inspector reviewed six patients' care records which evidenced that patients' individual needs were established on the day of admission to the nursing home through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks. However one patient's care records who had a Do Not Attempt Resuscitation directive had not been reviewed by the GP within the last twelve months, while another did not include all the appropriate documents relating to the directive. A recommendation is made. Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart and continence were also completed on admission. However these records were not consistently person centred and on some

occasions did not include the date or a signature. A recommendation is made that this shortfall be addressed.

Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure ulcer/wound and if required, the specific care plans regarding the management of the pressure ulcer / wound.

Review of six patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 11 days of patient's admission to the home.

In discussion with the nurse in charge she demonstrated a good awareness of the patient 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	**Substantially 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 and key worker system was operational in the home. The roles and responsibilities of named nurses and key workers were outlined in the patient's guide.

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

Patients' care records revealed that the pressure relieving equipment in place on the patients' beds and when sitting out of bed was available.

The inspector was able to confirm that pain assessments were appropriately used for these patients. It is acknowledged that care plans on pain management were in place for these patients.

The nurse in charge informed the inspector that there were patients in the home who required wound management for a wound. Review of two patients' care records revealed the following;

- The patient's care plan on personal care and dressing was not consistently person centred.
- A body mapping chart was completed for the patient on admission. This chart was 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 type of mattress in use was based on the outcome of the pressure risk assessment. The specialist mattresses in use were being safely used and records were available to reflect they were appropriately maintained.
- A daily repositioning and skin inspection chart was in place for the patient with the wound and also for patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these charts revealed that patients' skin condition was inspected for evidence of change at each positional change. However this had not been recorded consistently throughout a twenty four hour period. Therefore the inspector was unable to evidence the care was in accordance to instructions detailed in their care plans on pressure area care and prevention.

Discussion with two registered nurses and six patients' care records confirmed that where a patient was assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention plan and treatment programme.

The two 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.

Discussion with two registered nurses confirmed they were aware that the incidence of pressure ulcers, grade 2 and above, are required to

be reported to the RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005**.**
The patient's weight was recorded on admission and on at least a monthly basis or more often if required.

The patient's nutritional status was also 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

Review of wound care in a patient's care plan evidenced that the dressing regime was recorded appropriately.

Policies and procedures were in place for staff on making referrals to the dietician. These included indicators of the action to be taken and by whom. All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment.

Review of care records for one patient evidenced that the patient was referred for a dietetic assessment in a timely manner. The patient's care plan included the dietician's recommendations.

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 two registered nurses informed the inspector that pressure ulcers were graded using an evidenced based classification system. The home has two wound care nurses, who have received additional training in wound care.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially 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 six 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 two registered nurse 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; • 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 two 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 two 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.

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

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially 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 six 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. Review of six patients' care records revealed that a number of entries were not dated and a recommendation is made that this shortfall be addressed.

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 one patient identified of being at risk of inadequate 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.

There was evidence that the patient was offered fluids on a regular basis throughout the day.

Staff spoken with were evidenced to be knowledgeable regarding patients' nutritional needs. The home holds a file on nutrition, which includes information listing all those patients with special dietary requirements. It also contains information relating to special equipment available to assist patients.

The inspector examined records which evidenced staff had attended training sessions in how to use thickening agents, this was an ongoing programme

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially 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 six 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	**Substantially 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'/residents' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that all patients / residents had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014. The registered manager informed the inspector that patients' care reviews were held six weeks post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff preferably the patient's named nurse attends each care review. A copy of the minutes of the most recent care review was held in the patient's care record file. The inspector viewed the minutes of two care management care reviews which evidenced that, where appropriate patients and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended an updated assessment of the patient's needs and a record of issues discussed. Care plans were evidenced to be updated post care review to reflect recommendations made where applicable.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially 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 registered manager informed the Inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home. The current menu planner commenced in April 2014. The inspector was informed this menu was planned following the completion of a questionnaire by patients, discussions on a one to one basis and group discussions during residents meetings.

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

Staff spoken with were knowledgeable regarding the individual dietary needs of patients to include their likes and dislikes. Discussion with staff and review of the record of the 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.

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. The inspector was unable to determine from training records the number of staff who had attended training in dysphagia awareness during the previous three years. Thirty staff had attended training in first aid during the previous 12 months. The inspector was shown records to demonstrate that the registered nurses were training the care assistants in the use of thickening agents. Discussion with registered manager confirmed that meals were served at appropriate intervals throughout the day and in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes. The registered manager confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning afternoon and at supper times. The inspector observed that a choice of fluids to include fresh drinking water were available and refreshed regularly. Staff were observed offering patients fluids at regular intervals throughout the day.

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Four staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held in the dining room for easy access by staff. This is commendable practice.

On the day of the inspection, the inspector observed the breakfast. Observation confirmed that meals 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.

Two wound care link nurses are employed in the home, these nurses have received enhanced wound care training.

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

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 one of the registered nurse. The inspector can confirm that these documents were available to view on the e-learning site used for training.

The registered nurse demonstrated an awareness of the details outlined in these documents.

The registered manager informed the inspector that these documents will be discussed with staff during staff meetings and that staff will be made aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patients care and accompanying records.

The inspector also discussed the Deprivation of Liberty Safeguards (DOLs) with the registered nurse including the recording of best interest decisions on behalf of patients. A copy of DOLS was also available on the e-learning site**.**

11.4 Quality of interaction schedule (QUIS)

The inspector undertook one period of observation in the home which lasted for approximately thirty minutes.

The inspector observed the breakfast being served in the dining room and in the interactions between patient and staff in upstairs sitting room.

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	12
Basic care interactions	0
Neutral interactions	0
Negative interactions	0

The inspector evidenced that the quality of interactions between staff and patients/residents was generally positive.

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.

The registered manager informed the inspector that lessons learnt from investigations were acted upon.

11.6 Patient finance questionnaire

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

11.7 NMC declaration

Prior to the inspection the registered manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC. This was also evidenced by the inspector on the day of inspection.

11.8 Questionnaire findings

Staffing/Staff Comments

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

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

“I would like to have more time to engage with the residents”
“I have received a lot of support since I started working here”
“we can be very busy especially when new staff are counted after a short induction”

Patient Representative/relatives’ comments

During the inspection the inspector spoke with three representatives/relatives/visitors.
The following are examples of relatives’ comments during inspection.

“staff respond well to my mother’s needs”
“staff are very attentive”
“I am happy with the care”
“I have no complaints”

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Rachel Caffrey, *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:

Sharon Mc Knight
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**
Prior to admission to the Home, the Registered Manager carries out a pre admission assessment. Information is gathered from the resident/respresentative, the care records and information from the Care Management teams. Following a review of all information a decision is made in regard to the Home's ability to meet the residents needs. If the admission is an emergency and a pre admission assessment is not possible, a pre admission assessment is completed over the telephone. Multi disciplinary information is requested, a copy of the residents medical history and current medication list from their GP. When the Registered Manager is satisified that the Home can meet the needs,	Substantially compliant

the admission will take place. On admission to the Home, the receiving Registered Nurse completes initial assessment using a patient centred approach, the Registered Nurse communicates with the resident and/or representative, refers to the pre admission assessment and any other information obtained to assist her/him with this process. There are 2 documents completed within 12 hours of admission, an admission assessment which includes photography consent, record of personal effects and a needs assessment which includes 16 areas of need. The additional comments section within the needs assessment includes additional necessary information that is required to formulate a person centred plan of care for the resident. In addition to these 2 documents the Registered Nurse completes risk assessments on admission, these include a skin assessment using a braden tool, a body map and initial wound assessment, if required, a moving and handling assessment, a falls risk assessment, bedrail assessment if applicable, and nutritional assessments including MUST tool, FSHC nutritional and oral assessments. Other risk assessments that are completed, within 7 days of admission are Continence assessment. Following discussion with the respresentative/resident and using the Registered Nurses clinical judgement a plan of care is developed to meet the residents needs in relation to any identified risks, or requests. The Registered Manager and Regional Manager do complete audits on a regular basis to quality assure this process.	

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The Registered Nurse completes a comprehensive and holistic assessment of the residents care needs using the assessment tools as mentioned in Section A within 7 days of admission. The Registered Nurse devises care plans to meet identified needs in consultation with the resident/representative. the care plan demonstrates the promotion of maximum independence as well as what assistance is required. Any recommendations made by any other member of	Substantially compliant

the Multi Disciplinary Team are included in the care plan. The care plans have goals that are realistic and achievable. Registered Nurses in the Home are fully aware of the process of referral to a TVN, when necessary. There are referral forms available in the home as well as contact details for the TVN. All staff nurses are aware to contact the TVN by phone for advanced advice while awaiting visit. Referrals are also made using this process in relation to residents who have lower limb ulceration to either TVN or podiatrist. If necessary a further referral is made to a vascular surgeon by the GP, TVN, or podiatrist. Where a resident is assessed as been "at risk" of developing pressure ulcers, a care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. The care plan will include any advice received from other MDT members. The treatment plan is agreed with the resident/relative, care management and relevant members of the MDT. The Regional Manager is made aware monthly during the REG 29 visit. The registered nurse makes a decision to refer a resident to the dietician based on the score of the MUST tool and their clinical judgement. Dietician referral forms are held within the home. These forms can be completed by staff in the home and faxed directly to the dietician. All registered nurses are aware that they can contact the dietician by telephone for advice while awaiting visit. All advice, treatment or recommendations are recorded on the MDT form and a subsequent care plan is compiled or current care plan is updated to reflect advice or any changes to care. The care plan is reviewed and evaluated on a monthly basis or as often as is necessary. Residents, representatives, staff and other members of the MDT are kept informed of changes.	

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The needs assessment, risk assessments and care plans are reviewed and evaluated at a minimum of once a month or more often if there is a change in the residents condition. The care plan indicates the frequency of review with an agreed time interval recorded. The resident is assessed on a daily basis, any changes are noted in the d aily progress notes and evaluation forms. Any changes to the resident is reported on a 24 hour shift report for the Registered Managers attention. The Registered Manager and Regional Manager will complete audits to quality assure the above process and comply action plans if required.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to. The validated pressure ulcer grading tool by the home to screen residents who have skin damage is the EPUAP grading system. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change o the dressing regime or if the condition of the pressure ulcer changes. There are up to date Nutritional Guidelines such as "Promoting Good Nutrition", RCN - "Nutrition now", PHA - "Nutritional Guidelines and Menu Checklist for Residential and Care Homes" and NICE Guidelines - Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to the FSHC Policies and Procedures in relation to nutritional care, diabetic care, care of subcuteanous fluids and care of percutaneous endoscopic gastrostomy (PEG).	Substantially 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**
Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are comtemporaneous and are in accordance with the NMC guidelines. All care delivered is evaluated. The Registered Nurses have access to Policy and Procedures in relation to good record keeping and have their own copys of the NMC guidelines. Records of meals provided for each resident at each meal time are recorded on a daily menu choice form. The catering manager keeps records of foods served and includes any specialist dietery needs. All residents have all their food and fluids recorded in detail on a daily basis. If a resident is identified at risk of dehydration there will be a separate fluid chart recorded. These charts are recorded over a 24 hour basis, the fluid intake is totalled at the end of the 24 hour period and the nurse will record this information in the daily evaluation. Any	Substantially compliant

deficit will be identified and appropriate action taken and with referrals made to the relevant MDT member as required. Any and all changes are discussed with the resident/representative. Care records are audited by the Registered Manager and an action plan issued to address any defiicits or areas for improvement. This is discussed at senior team meetings.	

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care delivered is monitored and recorded on a daily basis in the progress notes with a minimum of one entry during the day and one entry at night. The outcome of care is reviewed at intervals indicated in the care plan and as required if there is a change in the residents condition or when there are recommendations made by the MDT. Residents and/or representatives are included in this process.	Substantially compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care Management reviews are held 6 weeks after admission and then annually. Reviews are also arranged in response to changing needs, expressions of dissatisfaction with care, Home's request or at the request of the resident or representative. The Trust are responsible for organising these reviews and the letter of invitation is sent to the resident or representative. A member of the nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative by the trust representative, the trust representative will forward a copy to the Home for the residents file. Any recommendations made during the review are actioned by the home and care plans will reflect any changes. The resident/representative is kept informed of progress towards goals.	Substantially compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The Home follows FSHC Policy and Procedure in relation to nutrition and follows best practice guidelines. Registered Nurses assess each patients dietary needs on admission and review on an ongoing basis. The care plan reflects the type of diet any special dietary requirements, personal preferences with regards to likes and dislikes, if any, any specialised equipment required and if the resident is independent or requires assistance and to what level. Also included are any recommendations made by dietician or SLT. The plan of care is evaluated on a monthly basis or more often as required. The Home has a 3 week menu which was last reviewed on 1st April 2014 and commences week beginning 14th April 2014. The menu was compiled following consultation with residents meetings, one to one meetings and Food questionnaires. The PHA document, Nutritional and Menu Checklist for Nursing and Residential Homes is used to ensure that meals are varied and nutritious. Copys of instructions and recommendations from the dietician and SLT are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's dietary needs. Residents are offered a choice of 2 meals at each mealtime, if the resident does not want what is on the daily menu,	Compliant

an alternative meal will be provided. The menu offers the same choice as far as is possible to those residents who are on specialised diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments, sauces and drinks are available at each meal. Daily menus are displayed outside each dining room. The home retains a copy of the 3 week menu which resident/representative can see on request.	

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**
The SLT's and Dieticians give informal advice and guidance when visiting the Home. Registered Nurses refer to up to date guidance such as NICE guidelines - Dysphagia Diet food textured descriptors. All recommendations made by the SLT are incorporated in the care plan to include type of diet, consistency of fluids, position of feeding, equipment to use and assistance required. The kitchen receive a copy of the SALT recommendations and this is kept on file for reference by the kitchen.	Substantially compliant

Meals are served at the following times; Breakfast from 9 - 10.30am Morning tea from 11.30am - 12 midday Lunch from 2.00 pm - 3.00 pm Afternoon tea from 4.30 pm Evening meal from 6.00 pm Supper from 9.00 - 10.00 pm There are variations to the above times if a resident requests to have their meal at a different time. Hot and cold drinks and a variety of snacks are available throughout the day on request. Cold drinks are available at all times in the lounges and bedrooms, these are replinished twice daily. Any matters concerning a residents eating and drinking are detailed on an individual care plan including eg likes and dislikes, type of diet, consistency of food, any specialist equipment is required and if assistance is required. A diet notification form is retained in the kitchen. Meals are not served unless a staff member is present in the dining room. Residents who require supervision full or part time assistance are given individual attention and are assisted at a pace suitable to them. Appropriate aids are available as necessary and indicated on the care plan. Each Registered nurse has completed E Learning module on Pressure Area care. The Home has 2 link nurses who have received enhanced training, to provide support and education to the other nurses in the Home. All Registered nurses within the Home have a wound competency assessment completed, which has a quality assurance element built in.	

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

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Primary Inspection

Oakridge Clinic – EMI Unit

23 May 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Rachel Mc Caffrey 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.	19(1)(a), schedule 3, 2(k)	The registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence the care delivered. **Ref: Follow up from previous inspection**	Two	Contemporaneous notes of all nursing provided to patients shall be maintained. Staff have received training on accurately completing repositioning charts to evidence care delivery.	Immediate from the date of inspection
2.	15(2)(a)(b)	The registered person must ensure the patient's Do Not Resuscitate plan is kept under review and revised at any time and in any case not less than annually. **Ref: Section A**	One	Do not resusicitate plan is kept under review and is revised as required and not less than annually.	Immediate from date of 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.	16.2	It is recommended that all induction programmes are reviewed, and where required developed, to include awareness and reporting responsibilities for all grades of staff. Induction records should be further developed to include a general awareness Of the correct use of restraint. **Ref:Follow up from previous inspection**	Two	This cannot be revised at home level and has been forwarded to Quality Services Department for review.	22 August 2014
2.	6.2	It is recommended that all entries in care records be dated and signed with the signature accompanied by the designation of the signatory. **Ref: Section A and E**	One	All entries in care records are dated and signed with the signature accompanied by the designation of the signatory	Immediate from date of inspection

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person and return to nursing.team@rqia.org.uk

Name of Registered Manager Completing Qip	R McCaffrey
Name of Responsible Person / Identified Responsible Person Approving Qip	Jim McCall DIRECTOR OF OPERATIONS 4.11.14

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

QIP Position Based on Comments from Registered Persons				Inspector	Date
		Yes	No		
A.	Quality Improvement Plan response assessed by inspector as acceptable	X		Sharon McKnight	**6-11-14**
B.	Further information requested from provider				