Unannounced Primary Care Inspection

Name of establishment:	**Stewart Memorial House**
RQIA number:	**1278**
Date of inspection:	**17 October 2014**
Inspector's name:	**Linda Thompson**
Inspection number:	**20124**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of establishment:	Stewart Memorial House
Address:	39 Downshire Road Bangor BT20 3RD
Telephone number:	028 91465211
Email address:	john.miskimmon@niid.co.uk
Registered organisation/ Registered provider / Responsible individual	NI Institute for the Disabled Mr William John Miskimmon
Registered manager:	Ms Lyndsey Paul
Person in charge of the home at the time of inspection:	Ms Lyndsey Paul
Categories of care:	NH-I ,NH-PH ,NH-PH(E) ,NH-TI
Number of registered places:	30
Number of patients / residents (delete as required) accommodated on day of inspection:	17
Scale of charges (per week):	£581.00 - £609.00
Date and type of previous inspection:	7 January 2014, Secondary Unannounced inspection
Date and time of inspection:	17 October 2014 08.30 – 14.30
Name of inspector:	Linda Thompson

2.0 Introduction

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

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

3.0 Purpose of the inspection

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

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

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

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008).

Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/process

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for the preliminary assessment of achievement by the Provider of the DHSSPS Nursing Homes Minimum Standards 2008.

The inspection process has three key parts; self-assessment (including completion of self- declaration), pre-inspection analysis and inspection visit by the inspector.

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

- review of any notifiable events submitted to RQIA, in accordance with Regulation 30 of the Nursing Homes Regulations (NI) 2005, since the previous inspection
- analysis of pre-inspection information submitted by the registered person/s

- discussion with the registered manager
- review of the returned quality improvement plan (QIP from the previous care inspection conducted in January 2014)
- observation of care delivery and care practices
- discussion with staff on duty at the time of this inspection
- examination of records pertaining to the inspection focus
- consultation with patients individually and with others in groups
- tour of the premises
- evaluation and feedback.

5.0 Consultation process

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

Patients/Residents	17
Staff	10
Relatives	0
Visiting professionals	0

Questionnaires were provided by the inspector, during the inspection, to staff to seek their views regarding the quality of the service.
The inspector did not issue questionnaires to patients/residents on this occasion and instead held discussions regarding satisfaction of quality of care.

Issued to	**Number issued**	**Number returned**
Patients / residents	0	0
Relatives / representatives	0	0
Staff	10	10

6.0 Inspection focus

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

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

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

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

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

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

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

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

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

7.0 Profile of service

Stewart Memorial House is situated in a quiet residential area of Bangor, Co Down. It is set overlooking Belfast Lough and many of the rooms have coastal views. There are grounds to the rear of the building and an open area at the front, which is popular with patients.

The nursing home is owned and operated by NI Institute for the Disabled (NIID)

The current registered manager is Ms Lyndsey Paul.

Accommodation for patients/ residents is provided over two floors with the majority of bedrooms on the ground floor. Communal toilet and bathroom facilities are located throughout the home. The upper floors are serviced by a passenger lift.

A dining room is provided on the ground floor of the home. There are two lounges and a conservatory, all of which have a bright outlook onto views of the coast.

The home also provides for catering and laundry services *on the ground floor*.

The home is registered to provide care for a maximum of 30 persons under the following categories of care:

<u>Nursing care</u>

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

The Home's 'Certificate of Registration' issued by the Regulation and Quality Improvement Authority (RQIA) was appropriately displayed in the main entrance hall of the Home and was confirmed as accurate on the day of the inspection.

8.0 Executive summary

The unannounced primary care inspection of 17 October 2014 was undertaken by Linda Thompson between the hours of 08.30 and 14.30 hours. The inspection was supported by Ms Lyndsey Paul registered manager who facilitated the inspection and was available for verbal feedback at the conclusion of the inspection. Mr Miskimmon, registered person was unavailable during the inspection visit.

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

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

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

Prior to the inspection, the registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. This self-assessment was received on 2 October 2014. The comments provided by the 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.

The inspector reviewed the submitted self-assessment documents prior to the inspection visit. The self-assessment against the standards inspected was professionally completed and provided comprehensive and detailed examples of how the home has achieved compliance.

Other documents submitted were also of a high standard and provided the inspector with an assurance of the governance arrangements maintained in the home.

The inspector can confirm that patients appeared to be well groomed and were observed to be treated with dignity and respect.

The inspector undertook two separate 20 minute periods of observation during the inspection. From these observations the inspector evidenced that staff interact very well with patients. There was evidence of a relaxed atmosphere and staff were knowledgeable of patients' likes and dislikes. It was evident that patients' needs were prioritised.

Refer to section 11.0 for further details about patients and residents.

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

The inspector examined the staff duty rota as part of the inspection process. Staffing levels were evidenced to be maintained above the requirements of the Rhys Hearn dependency assessment.

The homes general environment was evidenced to be well maintained. All areas were clean and fresh. No malodours were evidenced throughout the home.

The inspector discussed the Control of Substances Hazardous to Health (COSHH) with the registered manager in respect of the chemicals stored in the sluice areas in the home. A requirement is raised to ensure that the sluice areas are locked at all times.

There were systems and processes in place to ensure the effective management of the standards inspected. However, areas for improvement were identified in relation to the enrichment of foods with cream or butter, the need for full fat milk and the availability of fruit especially for those on a modified diet.

The inspector reviewed and validated the home's progress regarding the one requirement and five recommendations carried forward from the last inspection in January 2014. Full compliance was evidenced in all areas.

Verbal feedback of the inspection outcomes was given to the registered manager throughout the inspection and at the conclusion of the inspection process.

Conclusion

As a result of this inspection, two requirements were made; nil requirements or recommendations are re stated.

Details can be found under Section 10.0 in the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, the registered manager, registered nurses and staff for their assistance and co-operation throughout the inspection process.

The inspector would also like to thank the staff who completed questionnaires.

9.0 Follow-up on the requirements and recommendations issued as a result of the previous secondary unannounced care inspection conducted on 7 January 2014

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
1.	20(1)(c)(i)	The responsible individual must ensure that; • a system of validation that training received is fully embedded into practice must be developed and used after each and every training session	The inspector can confirm that a system of validation that training is embedded into practice has been developed and is in use in the home.	Compliant

No	Minimum Standard Ref.	Recommendations	Action taken – as confirmed during this inspection	Inspector's validation of compliance
C/F	25.2	The responsible individual must ensure that a policy and procedure be developed which outlines the purpose, content and process of the Regulation 29 unannounced visits and be reflective of the statutory requirements contained therein.	The inspector can confirm that the policy on the management of the regulation 29 visits is appropriately updated.	Compliant
C/F	25.6	The responsible individual must ensure that patients and their representatives are made aware of the availability of the Regulation 29 monthly monitoring report.	The inspector can confirm that the regulation 29 reports are discussed at patient/resident and relative meetings and signage is maintained on the home's notice boards.	Compliant
C/F	25.13	It is recommended that the responsible individual ensures that an annual quality report for the home is completed in format suited to the needs of the patients accommodated and that a copy is held in the home and made available to all relevant persons.	The inspector can confirm that the annual quality report is completed in a suitable format and is made available to patients/residents.	Compliant
C/F	25.13	It is recommended that the responsible individual ensures that result of the most recent patient satisfaction survey conducted in 2013 is displayed in the home.	The inspector can confirm that this is appropriately displayed in the home.	Compliant

C/F	10.7	It is recommended that responsible individual must ensure that the policy and procedure for the management of restraint is further developed to also include guidance on any form of restraint that may be used in the home and in general, be reflective of the RCN guidelines "Let's Talk About Restraint".	The inspector can confirm that this policy has been updated and is now reflective of the appropriate professional guidance.	Compliant

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

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

Since the previous inspection on 7 January 2014, RQIA have been kept informed of a continued safeguarding investigation which has been ongoing in the home for the past year. The South Eastern HSC Trust safeguarding team are managing the SOVA issues under the regional adult protection policy/procedures.

RQIA is satisfied that the registered manager has dealt with SOVA issues in the appropriate manner and in accordance with regional guidelines and legislative requirements.

10.0 Inspection findings

Section A – On admission a registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Standard criterion 5.1, 5.2, 8.1 and 11.1 examined.
Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance. The inspector reviewed three patients' care records which evidenced that patients' individual needs were established on the day of admission to the nursing home, through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks. Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart and continence were also completed on admission. Review of three patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 11 days of the patient's admission to the home. Discussion with the registered manager, demonstrated a good awareness of the risks of patients who were at high risk of developing pressure wounds, malnutrition or dehydration. However at the time of the inspection the registered manager confirmed that there were no patients with pressure wounds in the home.

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

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

The inspector observed that a named nurse 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 three 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 appropraitely recorded in care records.

The inspector was able to confirm that pain assessments were appropriately used for patients.

The registered manager informed the inspector that there were no patients in the home who required wound management. The inspector was able to examine the preventative measures taken by staff to maintain skin integrity and therefore prevent pressure area damage. Review of this patient's care records revealed the following:

- A body mapping chart was completed for all patients 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 patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these charts revealed that patients' skin condition was inspected for evidence of change at each

positional change. It was also revealed that patients were repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention.

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

The registered manager and registered nurses confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local healthcare Trust. Staff spoken with were knowledgeable regarding the referral process. Discussion with two registered nurses evidenced that they were knowledgeable of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

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

Patient's weight was recorded on admission and on at least a monthly basis or more often if required.

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.

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

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

Discussion with the registered manager, registered nurses, care staff and review of the staff training records, revealed that staff were trained in wound management and pressure area care and prevention. Staff were also trained in the management of nutrition.

Patients' moving and handling needs were assessed and addressed in their care plans. There was evidence that manual handling aids were used to minimise risk of friction. Staff consulted confirmed there was sufficient nursing equipment available to move and handle patients' appropriately.

The registered manager and registered nurses informed the inspector that pressure ulcers were graded using an evidenced based classification system.

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

Section C - Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans. Standard criteria 5.4 examined.
Review of three 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 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 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 one registered nurse and a review of governance documents evidenced that a number of care records were audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

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

Section D – All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. Standard criterion 5.5, 8.4 and 11.4 examined.

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

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

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

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

Discussion with the registered manager and registered nurses confirmed that they had a good awareness of these guidelines. Review of patients' care records evidenced that registered nurses implemented and applied this knowledge.

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.

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

Section E – Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients. Standard criterion 5.6, 12.11 and 12.12 examined.

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

Stewart Memorial House use electronic record keeping.

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

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

Entries were noted to be timed and signed with the signature accompanied by the designation of the signatory.

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

The inspector reviewed the care records of three patients identified of being at risk of inadequate or excessive food and fluid intake. This review confirmed that:

- daily records of food and fluid intake were being maintained
- the nurse in charge had discussed with the patient/representative their dietary needs

- where necessary a referral had been made to the relevant specialist healthcare professional
- a record was made of any discussion and action taken by the registered nurse
- care plans had been devised to manage the patient's nutritional needs and were reviewed on a monthly or more often basis.

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

Staff had attended training in the management of nutrition.

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

Section F – The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives. Standard criteria 5.7 examined.
Please refer to criterion examined in Section E. In addition, the review of three patients' care records evidenced that consultation with the patient and/or their representative had taken place in relation to the planning of the patient's care. This is in keeping with the DHSSPS Minimum Standards and the Human Rights Act 1998.

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

Section G – The management and involvement of patients and/or their representatives in review of care. Standard criterion 5.8 and 5.9 examined.
Prior to the inspection, a patients' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that all the patients in the home had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014. The registered manager informed the inspector that patients' care reviews were held post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff preferably the patient's named nurse attends each care review. A copy of the minutes of the most recent care review was held in the patient's care record file. The inspector viewed the minutes of three care management care reviews which evidenced that, where appropriate, patients and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended, an updated assessment of the patient's needs and a record of issues discussed. Care plans were evidenced to be updated post care review to reflect recommendations made where applicable.

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

Section H – Management of nutrition including menu choice for all patients. Standard criterion 12.1 and 12.3 examined.
A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance. There was a 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 inspector discussed the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients with the registered manager and a number of staff. Staff spoken with were knowledgeable regarding the individual dietary needs of patients and 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 B &E, a review of one patient's care records evidenced that the patient was referred for a dietetic assessment in a timely manner. This patient was also referred to the speech and language therapist. The patient's care plan addressed the speech and language therapist's recommendations. As previously stated under Section D relevant guidance documents were in place. From a review of the menu planner and records of patients' choices and discussion with a number of patients, registered nurses and care staff, it was revealed that choices were available at each meal time. The registered manager confirmed choices were also available to patients who were on therapeutic diets. A recommendation is made that the menu plan be reviewed to include choices for snacks for patients on therapeutic diets.

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

Section I – Knowledge and skills of staff employed by the nursing home in relation to the management of nutrition, weight loss, dehydration, pressure area care and wounds. Standard criterion 8.6, 11.7, 12.5 and 12.10 examined.

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

Review of training records revealed that staff had attended training in dysphagia awareness during the previous three years and further training was planned as required.

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

Discussion with registered manager confirmed that meals were served at appropriate intervals throughout the day and generally in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes. The inspector raised concerns in the following areas;

- the inspector was informed by the cook that only two patients were receiving full fat milk and all others received semi skimmed milk. The registered manager should review the use of semi skimmed milk in the home
- the inspector was informed that the yoghurts provided in the home and used as regular desserts for patients requiring modified diets are 'low fat'. The registered manager should review the availability of enriched yoghurts for those patients requiring modified diets
- the inspector raised concern regarding the availability of fresh fruit for patients. Whilst a fruit bowl sits at the kitchen serving hatch and patients are free to take fruit as required this is insufficient to ensure that adequate fruit is provided.
- The inspector questioned the cook regards the availability of fresh fruit for patients requiring a modified diet and was informed that this is provided in either the yoghurts or via whipped desserts

A requirement is raised that the registered manager review the management of issues identified to ensure that current nutritional guidelines are fully implemented.

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. All 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.

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

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

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

11.0 Additional areas examined

11.1 Records required to be held in the nursing home

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

11.2 Patients/residents under Guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) Order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection.

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

11.3 Quality of Interaction Schedule (QUIS)

The inspector undertook two periods of enhanced observation in the home which lasted for 20 minutes observing breakfast in the dining room and 20 minutes observing lunch in the dining 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. A description of the coding categories of the Quality of Interaction Tool is appended to this report.

Total number of observations	
Positive interactions	43
Basic care interactions	3
Neutral interactions	0
Negative interactions	2

The inspector evidenced that the quality of interactions between staff and patients was in the main positive. The two negative interactions refer to one identified member of staff who on one occasion set a meal down in front of a patient and walked away without any discussion and the second was with the same member of staff who initiated a conversation with a patient and then walked away whilst answering him. Both events were discussed with the registered manager during feedback.

11.4 Complaints

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

A complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being pro-actively managed.

The inspector discussed the management of complaints with the registered manager and reviewed the complaint record. This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements.

11.5 Patient finance questionnaire

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

11.6 NMC declaration

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

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC.

11.7 Questionnaire findings

11.7.1 Staffing levels and staff comments

Discussion with the registered manager and review of the nursing and care staff duty roster for week commencing 13 October 2014 evidenced that the registered nursing and care staffing levels were above the RQIA's recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection.

The registered manager informed the inspector that the home did have staff vacancies for registered nursing staff and that recruitment was on going.

Staff were provided with a variety of training, including mandatory training, since the previous inspection. Attendance at mandatory training was 99.9%. Review of records, discussion with the registered manager and staff evidenced that this attendance level was achieved by proactively managing staff development and training through regular supervision sessions and annual appraisal.

During the inspection the inspector spoke with 10 staff. The inspector was able to speak to a number of these staff individually and in private. Ten 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.

One member of staff raised some concerns regarding the care provided for patients. The inspector spoke with this individual in private and recommended that the staff member raise the concerns with the registered manager directly at the time when concerns occur. This matter was discussed at length with the registered manager.

11.7.2 Patients/residents and relatives comments

During the inspection the inspector spoke with 10 patients individually and with the majority of others in smaller groups.

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

Some comments received from patients are detailed below;

“I enjoy the food”
“I am very happy here”
“I enjoy going out to work”
“I always have enough to eat”
“The staff are very good to me”

There were no relatives present during the inspection visit.

11.7.3 Professionals’ comments

There were no professional visitors present during the inspection visit.

11.8 Record keeping

In accordance with Regulation 19 (2) Schedule 4, a number of records are required to be kept in a nursing home. Prior to this inspection the registered person/s completed and returned a declaration to confirm that these documents were available in the home. If the document was not available an explanation was required.

The returned declaration for Schedule 4 documents confirmed that all documents listed were available in the home. The inspector sampled a number to confirm this as follows:

- The staff duty rota
- The complaints records
- The home's policy on recruitment and selection
- The records of fire drills

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

12.0 Quality Improvement Plan

The details of the quality improvement plan appended to this report were discussed with Ms Lyndsey Paul, 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:

Linda Thompson
Inspector / quality reviewer
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
A comphrenseive Nursing assessment is carried out by Nurses on duty during an admission, in conjunction with the resident and/or their next of kin, using the Roper, Logan, and Tierny model of assessment. The resident is asssigned a Primary nurse on admission who carries out monthly evaluation of the resident along with monthly risk assessments as are appropriate. MUST is carried out on every resident to the home monthly. All needs are acted upon by Nurses in conjunction where required with members of the MDT. All assessments and care plans are documented, and kept confidentially on epiccare and Nurses, care assistants have access to these. A new admission policy is being drawn up currently to provide guidance for all staff within the home.	Compliant

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

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
Residents are provided with with a named nurse on admission and this Nurse will ensure that the period of monthly assessment is carried out along with the risk assessments.Staff during induction and at ongoing Staff support meetings demonstrate their knowledge of the referral processes including when, why and how to refer to other health professionals. There is a Braden risk assessment in place for all residents which is carried out on admission and at least monthly there after.All referral documentation is available on a shared file for nurses to access and all nurses are aware of the file.	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**
Nurses record daily all care that the residents receive and any changes to the residents condition along with all care received. Assessment and evaluation of care plans is carried out at least monthly or sooner if there are any changes to the residents condition.	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**
Nurses use the Braden pressure risk assessment to assess residents risk of sores. Staff have regular training updates on wound care and there is a copy of the CREST guidelines available within the home for staff to refer to as required. As a reference staff also use the 2014 Nutrition guidelines and Menu checklist from the Public health within the home.	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 plans are fullly in place, implemented and evaluated by all nurses. Daily progress notes are recorded showing all care and treatment a resident required and received along with any therapeutic or non therapeutic effects that were noted. There is a record of all meals provided to the residents within the home. Residents at risk of malnourishment or obesity are placed on detailed Food diairies allowing staff to keep a closer eye on what they are consuming. Food diaries are then reviewed on a daily basis by the nurse in charge of the shift who will follow up with an action plan that may need undertaken.	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care plans are drawn up on admission and also as conditions improve or deteriote in order to accurately reflect a residents needs. Daily progress notes are written to reflect all care required.All residents and /or their next of kins are involved in the drawing up of care plans and this is documented with the care plans	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**
All residents of the home along with their representatives attend annual care reviews. the Nurse carrying out the care review will make an entry on the residents notes to highlight any issues discussed. The nurse will also draw up and implement any new actions required as a result of the reviews. Management in the home encourage more communication between families and nursing staff, although this still needs improvement at times. It is documented within care plans how and when families should be contacted with information about residents.	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**
There is ongoing discussion with the Mount Charles catering staff about the quality of food that is being provided. Meetings are scheduled monthly with Mount Charles and management of NIID in order to agree plans for more nutritious foods. Staff have taken over duties such as menu choices with residents as it appeared that Mount Charles staff were providing residents with "what they wanted" even though it might not have beent the most nutritious foods. Residents are provided with food in line with their current Speech and Language therapy and Dietician recommendations.There are always at least 3 different options at all meals times therefore providing residents with a choice. Primary nurses discuss monthly food choices with residents and update care plans to reflect conversations and their outcomes.	Moving towards compliance

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
All staff attend training and updates anually on Nutrition, feeding and swallow recommendations. It is well documented in care plans regarding the recommendations from SALT and dietetics. A new nutrition and hydration policy is being drafted to give a clearer guide to what is expected of staff. There are tea trolleys at 11am and 3pm and in between these times drinks are available. Fruit is available for snacking on throughout the day also. There is a wound care chart put in place for monitoring and documenting. All staff are given training on how to complete the documentation during Induction.	Compliant

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

Appendix 2

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

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

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

References

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

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

Quality Improvement Plan

Unannounced Primary Care Inspection

Stewart Memorial House

17 October 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Ms Lyndsey Paul registered manager either during or 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.	12(4)(b)	The registered manager must review the menu available in respect of the following; • Full fat milk should be provided for all patients unless medically prohibited • High calorie yoghurts should be available for all as required • Milk puddings such as enriched semolina, custards etc. should be available daily as snacks or desserts for those requiring a modified diet • Potatoes, porridge and milk puddings should be enriched with butter and/or fortified with cream • Fresh fruit should be served daily to all patients in a suitable style to encourage consumption • Fresh fruit should be stewed / pureed and available throughout the day for patients requiring a modified diet. **Ref section 10.0, I**	One	the provision has now been made to ensure that all residents receive full fat milk unless medically prohibited. The catering team are now providing high calorie yoghurts, and fortified foods for all residents except those on a controlled dietary intake. Fresh fruit consumption is encouraged daily to all residents in a variety of forms such as pureed and stewed.	By end October 2014
2.	14(2)(c)	The registered person must ensure that all chemicals in the sluice rooms are stored in keeping with COSHH requirements. **Ref section 10.0,**	One	Keypads have been placed on all sluice room doors	By end October 2014

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Lyndsey Paul
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	John Miskimmon

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	Linda Thompson	17/11/14
Further information requested from provider			