



The Regulation and  
Quality Improvement  
Authority

## **Unannounced Care Inspection**

<b>Name of Establishment:</b>	<b>Stormont</b>
<b>RQIA Number:</b>	<b>1298</b>
<b>Date of Inspection:</b>	<b>25 November 2014</b>
<b>Inspector's Name:</b>	<b>Linda Thompson</b>
<b>Inspection ID:</b>	<b>20120</b>

**The Regulation And Quality Improvement Authority  
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Tel: 028 9051 7500 Fax: 028 9051 7501**

## 1.0 General Information

<b>Name of Establishment:</b>	Stormont
<b>Address:</b>	8 Summerhill Avenue Belfast BT5 7HD
<b>Telephone Number:</b>	028 90487217
<b>Email Address:</b>	stormont@fshc.co.uk
<b>Registered Organisation/ Registered Provider:</b>	Four Seasons Health Care Mr James McCall
<b>Registered Manager:</b>	Mrs Joly Shibu
<b>Person in Charge of the Home at the Time of Inspection:</b>	Lizy Joseph registered nurse Mrs Shibu joined the inspection shortly after commencement.
<b>Categories of Care:</b>	NH-I ,NH-PH ,NH-PH(E) ,NH-TI
<b>Number of Registered Places:</b>	39
<b>Number of Patients Accommodated on Day of Inspection:</b>	29
<b>Scale of Charges (per week):</b>	£550.00 - £618.00
<b>Date and Type of Previous Inspection:</b>	12 September 2013, Primary Unannounced Inspection
<b>Date and Time of Inspection:</b>	25 November 2014 08.30 – 10.30 hours
<b>Name of Inspector:</b>	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 are required.

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

## **3.0 Purpose of the Inspection**

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

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

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

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

## **4.0 Methods/Process**

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

- Discussion with the Registered Nurse Manager
- Discussion with staff
- Discussion with patients individually and to others in groups
- Consultation with relatives
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- Review of a sample of care plans
- Review of the complaints, accidents and incidents records
- Observation during a tour of the premises
- Evaluation and feedback

## 5.0 Consultation Process

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

Patients/Residents	15
Staff	6
Relatives	0
Visiting Professionals	0

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

Issued To	Number Issued	Number Returned
Patients/Residents	4	4
Relatives/Representatives	0	0
Staff	10	9

## 6.0 Inspection Focus

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

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

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

### Standard 19 - Continence Management

**Patients receive individual continence management and support.**

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

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

<b>Guidance - Compliance Statements</b>		
<b>Compliance Statement</b>	<b>Definition</b>	<b>Resulting Action in Inspection Report</b>
<b>0 - Not applicable</b>		A reason must be clearly stated in the assessment contained within the inspection report
<b>1 - Unlikely to become compliant</b>		A reason must be clearly stated in the assessment contained within the inspection report
<b>2 - Not compliant</b>	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
<b>3 - Moving towards compliance</b>	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
<b>4 - Substantially compliant</b>	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
<b>5 - Compliant</b>	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

Stormont Care Home is a purpose built nursing home situated in its own grounds in Summerhill Avenue just off the Upper Newtownards Road in Belfast.

The home is situated in an attractive residential area within easy reach of shops and other amenities and public transport.

The nursing home is owned and operated by Four Seasons Healthcare

The current registered manager is Ms Joly Shibu

Accommodation for patients/ residents is provided over two floors.

Access to the first floor is via a passenger lift and stairs.

The majority of bedroom accommodation is provided in single bedrooms and in a designated number of double bedrooms. Nurse call systems were available in all bedrooms.

Areas have been created to allow for small group living, and there are a total of five lounges, and two dining rooms throughout the home.

A range of assisted bathrooms and toilets were positioned throughout the home and one passenger lift is available. Catering and laundry services are undertaken on the premises.

Car parking spaces are available to the front and side of the premises.

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

The home is registered to provide care for a maximum of 39 persons under the following categories of care:

### Nursing care

I	old age not falling into any other category.....if required... to a maximum of 31 patients
PH	physical disability other than sensory impairment under 65
PH (E)	physical disability other than sensory impairment over 65 years
TI	terminally ill

The certificate of registration was appropriately displayed in the foyer of the home.

## **8.0 Executive Summary**

This summary provides an overview of the services examined during an unannounced secondary care inspection to Stormont Care Home. The inspection was undertaken by Linda Thompson inspector on 25 November 2014 from 08.30 to 10.30 hours.

The inspector was welcomed into the home by Ms Lizy Joseph registered nurse in charge of the home. The registered manager Ms Joly Shibu joined the inspection shortly after commencement and received formal feedback at the conclusion of the inspection.

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

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 on 25 September 2014. The inspector has reviewed the responses provided however due to a change in inspection focus the inspector was unable to validate the statements provided by the registered manager.

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

As a result of the previous inspection conducted on 12 September 2013 one recommendation was issued. Compliance with this recommendation was reviewed during this inspection. The inspector evidenced that the recommendation had been fully complied with. Details can be viewed in the section immediately following this summary.

### **Conclusion**

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

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

Therefore, nil requirements or recommendations are made following inspection.

The inspector would like to thank the patients, the registered nurse in charge of the home, the registered manager and staff for their assistance and co-operation throughout the inspection process.

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

## 9.0 Follow-Up on Previous Issues

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	34	Items surplus to requirement should not be stored in a bathroom, or any other sanitary area.	The inspector can confirm that the home is compliant in this regard.	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 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 in 12 September 2013, RQIA have been notified by the home of ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues. The South Eastern Health and Social Care Trust (SEHSCT) 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**

<b>STANDARD 19 - CONTINENCE MANAGEMENT</b> <b>Patients receive individual continence management and support</b>	
<b>Criterion Assessed:</b>	<b>COMPLIANCE LEVEL</b>
<p>19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.</p>	
<b>Inspection Findings:</b>	
<p>Review of two patients' care records evidenced that bladder and bowel continence assessments were undertaken for both patients. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care.</p> <p>There was evidence in patients care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate.</p> <p>The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate.</p> <p>Review of 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.</p> <p>The care plans reviewed addressed the patients' assessed needs in regard to continence management.</p> <p>Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.</p>	<p>Compliant</p>

**STANDARD 19 - CONTINENCE MANAGEMENT**  
**Patients receive individual continence management and support**

**Criterion Assessed:**

19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.

**COMPLIANCE LEVEL**

**Inspection Findings:**

The inspector can confirm that the following policies and procedures were in place;

- continence management / incontinence management
- stoma care
- catheter care

The inspector can also confirm that the following guideline documents were in place:

- RCN continence care guidelines
- British Geriatrics Society Continence Care in Residential and Nursing Homes
- NICE guidelines on the management of urinary incontinence
- NICE guidelines on the management of faecal incontinence

Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.

Compliant

**STANDARD 19 - CONTINENCE MANAGEMENT**  
**Patients receive individual continence management and support**

<b>Criterion Assessed:</b> 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	<b>COMPLIANCE LEVEL</b>
<b>Inspection Findings:</b> Not applicable	Not applicable
<b>Criterion Assessed:</b> 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	<b>COMPLIANCE LEVEL</b>
<b>Inspection Findings:</b> Discussion with the registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care. The registered manager confirmed that all the registered nurses in the home were deemed competent in urinary catheterisation and the management of stoma appliances.	Compliant

<b>Inspector's overall assessment of the nursing home's compliance level against the standard assessed</b>	<b>Compliant</b>
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## **11.0 Additional Areas Examined**

### **11.1 Care Practices**

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

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

### **11.2 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.

### **11.3 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.

### **11.4 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.

### **11.5 Patients' Views**

During the inspection the inspector spoke to 15 patients individually and to others in groups. These patients expressed high levels of satisfaction with the standard of care, facilities and services provided in the home. A number of patients were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients' comments were as follows:

"I am very happy with everything here."

"Food is very good."

"The home is clean and tidy."

"My room is always kept clean and I am happy with everything."

### **11.6 Questionnaire Findings/Staff Comments**

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. Nine 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. There were nil negative comments raised by any staff during the inspection visit.

Examples of staff comments were as follows;

"I am very happy working in the home."

"This is a good home we work well as a team."

"I like to work here, the staff work well as a team and the work ambience is very good."

"It is a pleasure as a nurse to be able to provide a high standard of care."

"I enjoy working in Stormont care home."

### **11.7 Environment**

The inspector undertook an inspection of the premises and viewed the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a high standard of hygiene. There were no malodours evident throughout the home.

## **12.0 Quality Improvement Plan**

Where the inspection resulted in no recommendations or requirements being made the provider/manger is asked to sign the appropriate page confirming they are assured about the factual accuracy of the content of the report.

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

Enquiries relating to this report should be addressed to:

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The Regulation and Quality Improvement Authority  
9th Floor  
Riverside Tower  
5 Lanyon Place  
Belfast  
BT1 3BT**

**Appendix 1**

<b>Section A</b>	
<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.</b>	
<p><b>Criterion 5.1</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>Criterion 5.2</b></p> <ul style="list-style-type: none"> <li>A comprehensive, holistic assessment of the patient’s care needs using validated assessment tools is completed within 11 days of admission.</li> </ul> <p><b>Criterion 8.1</b></p> <ul style="list-style-type: none"> <li>Nutritional screening is carried out with patients on admission, using a validated tool such as the ‘Malnutrition Universal Screening Tool (MUST)’ or equivalent.</li> </ul> <p><b>Criterion 11.1</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul>	
<b>Nursing Home Regulations (Northern Ireland) 2005 : Regulations 12(1) and (4); 13(1); 15(1) and 19 (1) (a) schedule 3</b>	



<b>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
<p>Prior to admission to the home, the Home Manager or a designated representative from the home carries out a pre admission assessment. Information gleaned from the resident/representative (where possible), the care records and information from the Care Management Team informs this assessment. Risk assessments such as the Braden Tool are carried out, if possible, at this stage. Following a review of all information a decision is made in regard to the home's ability to meet the needs of the resident. If the admission is an emergency admission and a pre admission is not possible in the resident's current location then - a pre admission assessment is completed over the telephone with written comprehensive, multidisciplinary information regarding the resident being faxed or left into the home. Only when the Manager is satisfied that the home can meet the residents needs will the admission take place.</p> <p>On admission to the home an identified nurse completes initial assessments using a patient centred approach. The nurse communicates with the resident and/or representative, refers to the pre admission assessment and to information received from the care management team to assist her/him in this process.</p> <p>There are two documents completed within twelve hours of admission - an Admission Assessment which includes photography consent, record of personal effects and a record of 'My Preferences' and a Needs Assessment which includes 16 areas of need - the additional comments section within each of the 16 sections includes additional necessary information that is required to formulate a person centred plan of care for the Resident.</p> <p>In addition to these two documents, the nurse completes risk assessments immediately on admission. These include a skin assessment using the Braden Tool, a body map, an initial wound assessment (if required), a moving and handling assessment, a falls risk assessment, bed rail assessment, a pain assessment and nutritional assessments including the MUST tool, FSHC nutritional and oral assessment. Other risk assessments that are completed within seven days of admission are a continence assessment and a bowel assessment,</p> <p>Following discussion with the resident/representative, and using the nurse's clinical judgement, a plan of care is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations. This can be evidenced in the care plan and consent forms.</p> <p>The Home Manager and Regional Manager will complete audits on a regular basis to quality assure this process.</p>	<p>Compliant</p>

**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 : Regulations 13 (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
<p>A named nurse completes a comprehensive assessment of the resident's care needs using the assessment tools as cited in section A, within 7 days of admission. The named nurse devises care plans to meet identified needs and in consultation with the resident/representative. The care plans demonstrate the promotion of maximum independence and focuses on what the resident can do for themselves as well as what assistance is required. Any recommendations made by other members of the Mutidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable.</p> <p>Registered nurses in the home are fully aware of the process of referral to a TVN when necessary. The Tissue Viability Nurse's details are also in the file - name, address and telephone no. The nurse in on duty make a telephone call to the TVN through call management where advice can be given prior to their visit. Referrals are also made for residents who have lower limb or foot ulceration to either the TVN or a podiatrist. If necessary, a further referral is made to a vascular surgeon by the G.P, TVN or podiatrist.</p> <p>Where a resident is assessed as being 'at risk' of developing pressure ulcers, a Pressure Ulcer Management and Treatment plan is commenced. A care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. The care plan will give due consideration to advice received from other multidisciplinary members. The treatment plan is agreed with the resident/representative, Care Management and relevant members of the MDT. The Regional Manager is informed via a monthly report and during the Reg 29 visit.</p> <p>The Registered Nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Dietician referrals are made through the GP surgery during working hours..Then the Dietition will contact the nursing home with the next available date to visit the resident. The dietician is also available over the telephone for advice until she is able to visit the resident. All advice, treatment or recommendations are recorded on the MDT form with a subsequent care plan being compiled or current care plan being updated to reflect the advice and recommendations. The care plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in the home and other members of the MDT are kept informed of any changes.</p>	<p>Compliant</p>

<b>Section C</b>	
<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.</b>	
<b>Criterion 5.4</b> <ul style="list-style-type: none"> <li>• Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.</li> </ul>	
<b>Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16</b>	
<b>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
<p>The Needs Assessment, risk assessments and care plans are reviewed and evaluated at a minimum of once a month or more often if there is a change in the resident's condition. The plan of care dictates the frequency of review and re assessment, with the agreed time interval recorded on the plan of care.</p> <p>The resident is assessed on an ongoing daily basis with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the Home Manager's attention.</p> <p>The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.</p>	Compliant

<b>Section D</b>	
<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.</b>	
<p><b>Criterion 5.5</b></p> <ul style="list-style-type: none"> <li>• All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.</li> </ul> <p><b>Criterion 11.4</b></p> <ul style="list-style-type: none"> <li>• A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.</li> </ul> <p><b>Criterion 8.4</b></p> <ul style="list-style-type: none"> <li>• There are up to date nutritional guidelines that are in use by staff on a daily basis.</li> </ul> <p><b>Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)</b></p>	

<b>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
<p>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.</p> <p>The validated pressure ulcer grading tool used 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 to the dressing regime or if the condition of the pressure ulcer changes.</p> <p>There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', ' PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in relation to nutritional care, diabetic care, care of subcutaneous fluids and care of percutaneous endoscopic gastrostomy (PEG)</p>	<p>Compliant</p>

**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 and 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**

<b>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
<p>Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are contemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines - Record keeping:Guidance for nurses and midwives.</p> <p>Records of the meals provided for each resident at each mealtime are recorded on a daily menu choice form. The Catering Manager also keeps records of the food served and include any specialist dietary needs.</p> <p>Residents who are assessed as being 'at risk' of malnutrition, dehydration or eating excessively have all their food and fluids recorded in detail on a daily basis using a FSHC food record booklet or fluid record booklet. These charts are recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. The nurse utilises the information contained in these charts in their daily evaluation. Any deficits are identified with appropriate action being taken and with referrals made to the relevant MDT member as necessary. Any changes to the resident's plan of care is discussed with them and/or their representative.</p> <p>Care records are audited on a regular basis by the Manager or Deputy with an action plan compiled to address any deficits or areas for improvement - this is discussed during supervision sessions with each nurse as necessary.</p>	<p>Compliant</p>



<b>Section F</b>	
<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.</b>	
<b>Criterion 5.7</b> <ul style="list-style-type: none"> <li>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.</li> </ul>	
<b>Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16</b>	
<b>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
The outcome of care delivered is monitored and recorded on a daily basis on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan of care or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their representatives are involved in the evaluation process.	Compliant

<b>Section G</b>	
<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.</b>	
<p><b>Criterion 5.8</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>Criterion 5.9</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)</b></p>	
<b>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
<p>Care Management Reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the resident's file.</p> <p>Any recommendations made are actioned by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals.</p>	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 dietitians 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)**

<b>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</b>	<b>Section compliance level</b>
<p>The home follows FSHC policy and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs on admission and review on an ongoing basis. The care plan reflects type of diet, any special dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if necessary.</p> <p>The home has a 3 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives - residents meetings, one to one meetings and food questionnaires. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied.</p> <p>Copies of instructions and recommendations from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs.</p> <p>Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything from the daily menu an alternative meal of their choice is provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room, with the 3 week menu displayed in a menu display folder and on the wall outside the kitchen.</p>	<p>Compliant</p>

**Section I**

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

**Criterion 8.6**

- Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.

**Criterion 12.5**

- Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.

**Criterion 12.10**

- Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:
  - risks when patients are eating and drinking are managed
  - required assistance is provided
  - necessary aids and equipment are available for use.

**Criterion 11.7**

- Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.

**Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
<p>All Registered nurses and care staff have received training on Nutrition and Malnutrition in Older people through ELearning . The Speech and Language therapist and dietician also give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document - 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for feeding, equipment to use and assistance required. The kitchen receive a copy of the SALT's recommendations and this is kept on file for reference by the kitchen.</p> <p>Meals are served at the following times:-                      Breakfast - 9.15am-10.15am                      Morning tea - 11am                      Lunch - 12.30pm-1pm                      Afternoon tea - 2pm                      Evening tea - 4.50pm                      Supper - 7.30pm-9pm</p> <p>There are variations to the above if a resident requests to have their meals outside of these times. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. There are foods available outside of these times for those resident's who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedrooms, these are replenished on a regular basis.</p> <p>Any matters concerning a resident's eating and drinking are detailed on each individual care plan - including for eg. likes and dislikes, type of diet, consistency of fluid, any special equipment required and if assistance is required. Meals are not served unless a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Appropriate aids such as plate guards and specialised cutlery are available as necessary and as indicated in the plan of care.</p> <p>Each nurse has completed an education e-learning module on pressure area care. The home has a link nurse who has received enhanced training, to provide support and education to other nurses. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the home have a competency assessment completed. Competency assessments have a quality assurance element built into the process.</p>	<p>Compliant</p>

<b>PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5</b>	<b>COMPLIANCE LEVEL</b>
	<b>Compliant</b>

**Appendix 2**

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

<p><b>Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.</b></p>	<p><b>Basic care: (BC) – basic physical care e.g. bathing or use of 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.</b></p>
<ul style="list-style-type: none"> <li>• 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)</li> <li>• Checking with people to see how they are and if they need anything</li> <li>• Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task</li> <li>• Offering choice and actively seeking engagement and participation with patients</li> <li>• Explanations and offering information are <input type="checkbox"/> tailored to the individual, the language used easy to understand, and non-verbal used where appropriate</li> <li>• Smiling, laughing together, personal touch and empathy</li> <li>• Offering more food/ asking if finished, going the extra mile</li> <li>• Taking an interest in the older patient as a person, rather than just another admission</li> <li>• 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</li> <li>• 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</li> </ul>	<p>Examples include: Brief verbal explanations and encouragement, but only that which is necessary to carry out the task</p> <p>No general conversation</p>



<b>Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.</b>	<b>Negative (NS) – communication which is disregarding of the residents’ dignity and respect.</b>
<p><b>Examples include:</b></p> <ul style="list-style-type: none"> <li>• Putting plate down without verbal or non-verbal contact</li> <li>• Undirected greeting or comments to the room in general</li> <li>• Makes someone feel ill at ease and uncomfortable</li> <li>• Lacks caring or empathy but not necessarily overtly rude</li> <li>• Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact</li> <li>• Telling someone what is going to happen without offering choice or the opportunity to ask questions</li> <li>• Not showing interest in what the patient or visitor is saying</li> </ul>	<p><b>Examples include:</b></p> <ul style="list-style-type: none"> <li>• Ignoring, undermining, use of childlike language, talking over an older person during conversations</li> <li>• Being told to wait for attention without explanation or comfort</li> <li>• Told to do something without discussion, explanation or help offered</li> <li>• Being told can’t have something without good reason/ explanation</li> <li>• Treating an older person in a childlike or disapproving way</li> <li>• Not allowing an older person to use their abilities or make choices (even if said with ‘kindness’)</li> <li>• Seeking choice but then ignoring or over ruling it</li> <li>• Being angry with or scolding older patients</li> <li>• Being rude and unfriendly</li> <li>• Bedside hand over not including the patient</li> </ul>

## 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.



No requirements or recommendations resulted from the **unannounced** inspection of **Stormont** which was undertaken on **25 November 2014** and I agree with the content of the report. Return this QIP to [nursing.team@rgia.org.uk](mailto:nursing.team@rgia.org.uk).

Please provide any additional comments or observations you may wish to make below:

NONE

<b>NAME OF REGISTERED MANAGER COMPLETING</b>	Joly Shibu
<b>NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING</b>	Jim McCall <i>Carol Cousins</i>

CAROL COUSINS DIRECTOR OF OPERATIONS

Approved by:	Date
<i>hinda Thoms</i>	29/12/14.