Unannounced Care Inspection

Name of Establishment:	**Tudordale Nursing Home**
Establishment ID No:	**1304**
Date of Inspection:	**27 October 2014**
Inspector's Name:	**Norma Munn**
Inspection ID	**IN017014**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Tudordale Nursing Home
Address:	294 Holywood Road Belfast BT4 1SG
Telephone Number:	0289065 1336
Email Address:	tudordale@fshc.co.uk
Registered Organisation/ Registered Provider:	Mr James McCall
Registered Manager:	Ms Jewel Isip (acting manager)
Person in Charge of the Home at the Time of Inspection:	Ms Jewel Isip
Categories of Care:	Nursing - Dementia (De)
Number of Registered Places:	45
Number of Patients Accommodated on Day of Inspection:	42
Scale of Charges (per week):	£581.00
Date and Type of Previous Inspection:	Unannounced Primary Inspection 11 February 2014
Date and Time of Inspection:	27 October 2014 10:15 – 15:55
Name of Inspector:	Norma Munn

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- Discussion with Lorraine Kirkpatrick, Regional Manager
- Discussion with Stella Law, Peripatetic Manager
- Discussion with Jewel Isip, Acting 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 duty rotas
- Review of a sample of care plans
- 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	**15 individually and others in groups**
Staff	**5**
Relatives	**2**
Visiting Professionals	**1**

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

Issued To	**Number Issued**	**Number Returned**
Patients	**1**	**0**
Relatives/Representatives	**0**	**0**
Staff	**6**	**4**

6.0 Inspection Focus

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

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

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

Standard 19 - Continence Management

Patients receive individual continence management and support.

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

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

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

7.0 Profile of Service

Tudordale Care home is situated in its own grounds on the Holywood Road, Belfast.
The nursing home is owned and operated by Four Seasons Health Care. The current acting manager is Jewel Isip.

Accommodation for patients is provided on the ground floor of the home. The bedroom accommodation comprises of single bedrooms, and adequate numbers of bath/shower/toilet facilities are appropriately located throughout the home.

Communal lounge and dining areas are provided for patients to enjoy. The home also provides for catering and laundry services on the ground floor.

A number of communal sanitary facilities are available throughout the home. The home has extensive grounds. A secure garden/patio area is provided with direct access from the unit.

The home is registered to provide care for a maximum of 45 persons under the following categories of care:

Nursing care

DE dementia care

8.0 Executive Summary

The unannounced inspection of Tudordale Care Home was undertaken by Norma Munn on 27 October 2014 between 10:15 and 15:55 hours. The inspection was facilitated by Jewel Isip acting manager

Verbal feedback of the issues identified during the inspection was given to Jewel Isip, acting manager, Lorraine Kirkpatrick, regional manager and Stella Law, peripatetic manager at the conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection on 11 February 2014

Review of pre-inspection information submitted by the acting manager indicated that notifiable events were provided to RQIA in accordance with legislation. Analysis of other documentation including the returned QIP from the previous care inspection on 11 February 2014 confirmed that sufficient information had been provided.

During the course of the inspection, the inspector met with patients, staff, one visiting professional and relatives, who commented positively on the care and services provided by the nursing home. Refer to section 11 for further details about patients, staff and relatives.

Standard 19:

There was evidence that a continence assessment had been completed for the majority of patients. This assessment formed part of a comprehensive and detailed assessment of patient needs from the date of admission and was found to be updated on a regular basis and as required. The assessment of patient needs was evidenced to inform the care planning process. However, one patient's continence assessment had not been fully completed. A requirement has been made to ensure that continence assessments have been carried out for all patients who require continence management and support.

Comprehensive reviews of both the assessments of need and the care plans were maintained on a regular basis and as required in two of the three care records reviewed. One patient who had been assessed for urinary incontinence did not have a care plan for continence management. A review of another patient's care records evidenced that neither the patient or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. A requirement has been made to ensure that care plans have been written for all patients who require continence management and kept under review in consultation with the patient or representative.

Discussion with the acting manager confirmed that staff were assessed as competent in continence care.

Policies, procedures and guidelines in the promotion of continence and the management of incontinence were available in the home.

Discussion with the acting manager confirmed that regular audits of the management of incontinence are undertaken and the findings acted upon to enhance already good standards of care.

From a review of the available evidence, discussion with relevant staff and observation, the inspector can confirm that the level of compliance with the standard inspected was moving towards compliance.

Additional areas were also examined including:

- care practices
- patients' views
- staffing and staff views
- environment

Details regarding these areas are contained in section 11 of the report.

Observation and discussion with staff identified that several patients who were nursed in bed required to be repositioned. However, review of two patients' repositioning charts indicated that staff were not always recording the times when the patients were being repositioned. A recommendation has been made.

Review of one patient's care records requiring wound management evidenced an initial wound assessment had been completed. However, the inspector evidenced gaps in the recording of the frequency of the dressing change on the ongoing wound chart. As a result of the previous inspection on 11 February 2014 the inspector identified that the wound chart of a patient had not been fully completed and a recommendation was made. This recommendation has been stated for the second time and a further requirement has been made in relation to wound care.

Review of three care records evidenced that entries were noted to be dated, timed and signed. However, the inspector observed the use of initials in care records as opposed to a full signature. The inspector had identified this issue during the previous inspection on 11 February 2014 and a recommendation had been made. This recommendation has not been addressed and has been stated for the second time.

Patients were observed to be well presented with clothing suitable for the season and several patients had matching accessories of their choosing. The demeanour of patients indicated that they were relaxed in their surroundings. The inspector can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a very satisfactory standard and patients were observed to be treated by staff with dignity and respect.

A review of the staff duty rosters week commencing 27 October 2014 evidenced that the planned number of staff on duty was in line with RQIA'S recommended minimum staffing guidelines.

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. Residents' bedrooms were observed to be homely and personalised. Issues identified in relation to health and safety were identified and a requirement has been made.

The inspector reviewed and validated the home's progress regarding the six recommendations made at the last inspection on 11 February 2014 and confirmed compliance outcomes as follows: Four recommendations had been fully complied with and two recommendations had not been fully complied with and have been stated for the second time

As a result of this inspection, four requirements and one recommendation have been made and two recommendations have been restated.

Details can be found under Sections nine, ten and eleven in the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, acting 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.

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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	11.3	It is recommended that nursing staff; • ensure each wound has a wound chart and multiple wounds are not recorded on one chair • nursing staff should evidence when a wound is dressed in accordance with the dressing frequency • the status of the wound should be reported on, following dressing, in the patient's progress record (daily recording) • repositioning charts should evidence the action taken when a change in the condition of a patient's skin is noted • wound management should be supported by regular photography	Review of care records and discussion with staff identified that several issues had been addressed. However, review of one patient's care records evidenced that the following issues have not been addressed and have been stated for the second time: • nursing staff should evidence when a wound is dressed in accordance with the dressing frequency • the status of the wound should be reported on, following dressing, in the patient's progress record	Moving towards compliance

2	6.2	It is recommended all entries in care records are contemporaneous; dated, times, and signed, with the signature accompanied by the name and designation of the signatory.	Review of care records identified that care records were legible. However, review of three patient's care records evidenced that staff were using initials in care records as opposed to a full signature. Therefore this recommendation has not been fully addressed and has been stated for the second time .	Moving towards compliance
3	32.3	It is recommended furniture, fittings and any equipment in areas accessed by patients are of good standard and fit for purpose; • bath in titanic corridor requires resurfacing or replacement • shower chair in shower room beside the small dining room requires replacing • corridor lighting requires to be assessed with a view to best practice for persons with dementia • a programme of refurbishment of wash bassinettes in bedrooms should be commenced	Observation and discussion with staff confirmed that these issues have been addressed	Compliant

4	12.4	It is recommended that the day's menu in both dining rooms accurately reflects the meals to be served and is displayed in a format suitable for the needs of the patients.	Review of the menus displayed in each dining room confirmed that menus reflect meals served in a suitable format for the needs of the patients	Compliant
5	12.10	It is recommended greater attention is given to the presentation of the dining rooms and dining tables. Dining tables should be appropriately set at each mealtime. Patients should be offered condiments whether they have their meals in the dining room, bedroom or lounge area.	Observation of the lunchtime meal confirmed that dining room tables were well set and patients were offered condiments with their meal.	Compliant
6	1.1	It is recommended that the values that underpin the standards inform the philosophy of care and staff consistently demonstrate the integration of these values within their practice. Greater attention should be given to the personal care needs of patients.	Observation of care practices and the serving of the lunch time meal confirmed the delivery of care was of a very high standard and patients were observed to be treated with dignity, respect and compassion. Interactions were respectful and considerate of patients' abilities and well-being.	Compliant

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

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if there is considered to be a breach of regulation as stated in the Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of three patients' care records evidenced that bladder and bowel continence assessments were undertaken for all three patients. However, one patient's continence assessment had not been fully completed. A requirement has been made to ensure that assessments have been completed for all patients. The outcome of these assessments, including the type of continence products to be used, was incorporated into the two patients' care plans on continence care. One patient who had been assessed for urinary incontinence did not have a care plan for continence management. Review of one patient's care records evidenced that neither the patient or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. A requirement has been made to ensure that care plans have been completed for all patients who require continence management in consultation with consultation with the patient or representative. There was evidence in two 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. 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. The care plans reviewed addressed the patients' assessed needs in regard to continence management. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Moving towards compliance

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 guideline • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not applicable	Not applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the acting manager confirmed that staff were trained and assessed as competent in continence care. Discussion with the acting manager revealed that several of the registered nurses in the home were deemed competent in female or male catheterisation and the management of stoma appliances. The acting manager confirmed that regular audits of the management of incontinence are undertaken and the findings acted upon to enhance already good standards of care.	Compliant

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

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. Observation of care practices and the serving of the lunch time meal confirmed the delivery of care was of a very high standard and patients were observed to be treated with dignity, respect and compassion. Interactions were respectful and considerate of patients' abilities and well-being.

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.

Wound Care

Review of a patient's care records requiring wound management evidenced an initial wound assessment had been completed. However, the inspector evidenced gaps in the recording of the frequency of the dressing change. The care plan stated that the wound dressing needed changed every three to four days. However, there was no record in the ongoing wound assessment or the progress notes of a dressing change from 2 October 2014 to 27 October 2014. Discussion with staff indicated that the condition of the wound had improved. However, the inspector was concerned that the patient's wound had not been redressed according to the timescales stated in the care plan. A requirement has also been made to ensure that wounds are redressed according to the timescales directed in the patient's care plan.

During the previous inspection on 11 February 2014 the inspector identified that the wound chart of a patient had not been fully completed and a recommendation was made.
This recommendation has not been addressed and has been stated for a second time.

Repositioning of patients

Observation and discussion with staff identified that several patients who were nursed in bed had been repositioned during the morning of the inspection. However, review of two patients' repositioning charts indicated that staff were not always recording the times when the patients were being repositioned. A recommendation has been made.

11.2 Relatives Comments

During the inspection the inspector spoke with two relatives.
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Relatives spoken with 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.

Examples of relatives comments were as follows;

"The best care here that meets all the standards"
" We are always made to feel welcome"
"Staff are very gentle and caring"
"It is very clean here"

11.3 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 well fed and the staff are very nice."
"Food is good."
"The home is as good as you are going to get."
"I am happy and I get everything I need."

11.4 Questionnaire Findings/Staff Comments

During the inspection the inspector spoke with six staff this included registered nurses, care staff and ancillary staff. The inspector was able to speak to a number of these staff individually and in private. Four staff completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

Examples of staff comments were as follows;

"Residents are treated well all the time"
"Staff work together to give good care"
"Good teamwork"
"Communication is great"
"Tudordale is a lovely caring home to work in"
"We work as a team"
"The environment is great"

11.5 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. Residents' bedrooms were observed to be homely and personalised.

The following environmental issues were identified and require to be addressed:

- Hoists and weigh scales were stored in the residents' communal lounge
- The identified specialist chair in use needs repaired or replaced
- Incontinence products were stored in the electric room
- The electric room was unlocked

Requirements have been made.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Jewel Isip acting manager, Ms Lorraine Kirkpatrick regional manager and Ms Stella Law, peripatetic manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
Prior to admission to the Home, the Home manager or a nominated representative from the home carries out a pre admission assessment. Information gleaned from the resident / representative, the care records and the 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 in the home. Only when the manager is satisfied that the home can meet the resident's needs will the admission take place. On admission to the home an identified nurse completes initial assessments using a patient centred approach, the admission and needs assessments. Also on admission risk assessments are completed, such as the Braden tool, a body map, manual handling assessment, a falls risk assessment, a pain assessment, nutritional assessments including the MUST tool, nutritional and oral assessments. Continence and bowel assessments are also completed following admission. A plan of care is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations The home and regional manager complete audits on a regular basis to quality assure this process	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
A named nurse completes a comprehensive assessment of the resident's care needs using the assessment tools as discussed in section A. Care plans are devised to meet identified needs and in consultation with the resident / representative. Any recommendations made by the multidisciplinary team are included in the care plan. Registered nurses in the home are fully aware of the process of referral to a TVN when necessary. The staff use the call management system to make a telephone call to the TVN where advice can be given prior to their visit. Referrals are also made via this process in relation to residents who have lower limb or foot ulceration to either the TVN or a podiatrist. Where a resident is assessed as being 'at risk' of developing pressure ulcers, a care plan will be devised to include skin care, frequency of repositioning and any pressure relieving equipment used. 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. 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 referral is completed via the GP. 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.	Compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The 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. 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. The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to. The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading sysytem. 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. 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	Substantially compliant

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 subcuteanous fluids and care of percutaneous endoscopic gastrostomy (PEG)..	

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are comtemporaneous and are in accordance with 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. 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. Residents who are assessed as being 'at risk' of malnutrition, dehyration 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	Compliant

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. Care records are audited on a regular basis by the Manager with an action plan compiled to address any deficits or areas for improvement ..	

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care delivered is monitored and recorded on a daily basis 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 frequently 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 represenatatives are involved in the evaluation process.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care Management Reviews are 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. 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.	Substantially compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The home follows FSHC policy and 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. The home has a 3 week menu which is usually reviewed on a 6 monthly basis taking into account seasonal foods. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied. 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.	Compliant

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..	

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
Training on dysphagia and the correct use of food thickeners has taken place for the care and catering staff on 17/06/14, 2/10/14 and 15/10/14. 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. Special diets are displayed on a white board in the kitchen. Meals are served at the following times:- Breakfast - 9am-10.30am Morning tea - 11am Lunch - 12.30pm-1.30pm Afternoon tea - 3pm Evening tea - 4.40pm - 5.40pm Supper - 7.30pm-8pm 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. 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. A diet notification form is completed for each resident with a copy given to the kitchen and one held in the care file. 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. Each nurse has completed an education e-learning module on pressure area care. 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.	Compliant

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Secondary Care Inspection

Tudordale Nursing Home

27 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 Jewel Isip, acting manager, Ms Lorraine Kirkpatrick, regional manager and Stella Law, peripatetic manager during the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

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

Statutory Requirements

This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Nursing Homes Regulations (NI) 2005

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	15 (1) (2) (a) (b)	The registered person must ensure that the patients' needs are assessed, reviewed and updated following a change in circumstances, and not less than annually in relation to • Continence care **Ref: Section 10, standard 19.1**	One	Home Manager is continuing to monitor this process. Needs assessment for the patients have been reviewed and updated. All Continence assessements have been reviewed and updated.	By 24 November 2014
2	16 (1) (2)	The registered person must ensure that the patients' care plan is written and kept under review in consultation with the patient or representative in relation to • Continence care **Ref: Section 10, standard 19.1**	One	New care plan has been commenced. All care plans are discussed and agreed with relatives and staff are prompting all relatives to sign. The Home Manager will continue to monitor the process using care plan audits to ensure staff are compliant	By 24 November 2014
3	13 (1) (a)	The registered person shall ensure that the nursing home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients in relation to the following: • Patients' wounds are redressed in accordance with the timescale stated in the patient's care plan **Ref: Section 11.1**	One	The Home Manager will monitor to ensure that ongoing wound assessments are updated each time dressings are renewed. Care plan will be updated within the timescale stated in patient's care plan.	By 24 November 2014

4	14 (2)	The registered person must ensure as far as reasonably practicable that all parts of the home to which patients have access are free from avoidable risks. The registered person must ensure that • the electric room remains locked when not in use • the storage of incontinence products in the electric room must cease • hoists and weigh scales must not be stored in the lounge • the identified specialist chair is repaired or replaced **Ref: Section 11.5**	One	Actioned immediately on the day of inspection. The incontinence products were moved to another storage room and the staff were advised not to use the electric room for storage,the room remains locked. The patient referred to was reassessed for the specialist chair but according to the assessment, the patient no longer needs the chair due to the change in their health condition.	By 24 November 2014

Recommendations

These recommendations are based on The Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	11.3	It is recommended that nursing staff: • nursing staff should evidence when a wound is dressed in accordance with the dressing frequency • the status of the wound should be reported on, following dressing, in the patient's progress record (daily recording) **Ref: Section 9.0 and 11.1**	Two	Nursing staff were advised to redress the wound in accordance with the dressing frequency and update as appropriate on the progress report. Home Manager will continue to monitor, using care plan audits process.	By 24 November 2014
2	6.2	It is recommended all entries in care records are contemporaneous, dated, timed and signed, with the signature accompanied by the name and designation of the signatory **Ref: Section 9.0**	Two	Home Manager had a meeting with the staff nurses to reiterate the importance of good record keeping. The Manager demonstrated how all records be dated, timed and signed in accordance to good record practice also advised the significance for all nursing staff to adhere to NMC codes of record keeping. This process will be monitored using Care plan audits	By 24 November 2014
	5.6	The registered person must ensure that accurate and timely patient records are	One	All staff have been advised that the repositioning chart of the	By 24 November

3		maintained in respect of repositioning charts **Ref: Section 11.1**		patients should be completed accurately, timed and signed. This will be check daily, using the Home Managers check list to ensure compliance.	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	Jewel Isip
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall Carol Cousins Director of Operations

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

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	
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Norma Munn	8/01/2015
Further information requested from provider			