Unannounced Primary Inspection

Name of establishment:	**Three Islands Private Nursing Home**
RQIA number:	**1386**
Date of inspection:	**26 September 2014**
Inspector's name:	**Bridget Dougan**
Inspection number:	**IN017061**

The Regulation And Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544

1.0 General information

Name of Home:	Three Islands
Address:	62-66 Main Street Toomebridge BT41 3NJ
Telephone Number:	028 7965 0650
E mail Address:	three.islands@virgin.net
Registered Organisation/ Registered Provider:	Mr D McAteer and Mrs A McAteer
Registered Manager:	Mr David Joseph McAteer
Person in Charge of the Home at the Time of Inspection:	Mr David Joseph McAteer
Categories of Care:	Nursing - LD, LD (E) with associated disabilities
Number of Registered Places:	40
Number of Patients Accommodated on Day of Inspection:	40
Scale of Charges (per week):	£775.83 - £1840.00
Date and Type of Previous Inspection:	11 February 2014 Secondary Unannounced
Date and Time of Inspection:	26 September 2014: 9am – 1pm
Name of Inspector:	Bridget Dougan

2.0 Introduction

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

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

3.0 Purpose of the inspection

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

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

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

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

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

4.0 Methods/process

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

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

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

- Review of any notifiable events submitted to RQIA since the previous inspection
- analysis of pre-inspection information
- discussion with the registered manager
- observation of care delivery and care practices
- discussion with staff
- examination of records

- consultation with patients individually and with others in groups
- tour of the premises
- evaluation and feedback.

Any other information received by RQIA about this registered provider has also been considered by the inspector in preparing for this inspection.

5.0 Consultation process

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

Patients	**20 individually and to others in small groups**
Staff	**8**
Relatives	**0**
Visiting Professionals	**0**

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

Issued to	**Number issued**	**Number returned**
Patients / residents	**0**	**0**
Relatives / representatives	**4**	**4**
Staff	**6**	**0**

6.0 Inspection focus

The inspection sought to establish the level of compliance achieved regarding the selected DHSSPS Nursing Homes Minimum Standards.

Criteria from the following standards are included;

- management of nursing care – Standard 5
- management of wounds and pressure ulcers –Standard 11
- management of nutritional needs and weight Loss – Standard 8 and 12
- management of dehydration – Standard 12

An assessment on the progress of the issues raised during and since the previous inspection was also undertaken. The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.

The registered persons and the inspector have rated the home's compliance level against each criterion of the standard and also against each standard.

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

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

7.0 Profile of service

Three Islands is situated in the centre of Toomebridge village. It is registered to provide accommodation for 40 adults with a learning disability.

The home is a modern purpose built building, which has a large reception area, ancillary area with offices and storage rooms, and four patient accommodation modules. Each module has 10 single bedrooms, lounges and dining rooms, kitchen, bathrooms, nursing office and store rooms.

All patient accommodation is provided on ground floor level, whilst the ancillary block comprises of two stories, accommodating nursing and administration offices, staff changing areas, store rooms, and an en-suite bedroom for relatives/ staff.

A large day care unit for patients in the home is situated in a separate building to the rear of the home.

The home is surrounded by landscaped gardens and features a memorial garden. Car parking is available at the front and side of the home.

The home is currently registered to provide care under the following categories:

Nursing Care

LD	Learning disability under 65 years
LD (E)	Learning disability over 65 years

The RQIA 'Certificate of Registration' was appropriately displayed in the entrance hall of the home.

8.0 Summary of inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Three Islands. The inspection was undertaken by Bridget Dougan on 26 September 2014 from 9am to 1pm.

The inspection sought to establish the level of compliance achieved regarding the selected DHSSPS Nursing Homes Minimum Standards.

The inspector was welcomed into the home by Mr David Joseph McAteer, Registered Manager. Verbal feedback of the issues identified during the inspection was given to Mr McAteer at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector met with patients and staff to seek their opinions of the quality of care and service delivered. The inspector also examined the returned questionnaires from patients' representatives, observed care practices, examined a

selection of records, and carried out a general inspection of the nursing home environment as part of the inspection process.

The inspector spent an extended period observing staff and patient interaction. Discussions and questionnaires are unlikely to capture the true experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience.

These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool was designed to help evaluate the type and quality of communication which takes place in the nursing home.

As a result of the previous inspection conducted on 11 February 2014 no requirements or recommendations were issued.

Standards inspected:

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

Standard 8: Nutritional needs of patients are met. (selected criteria)

Standard 11: Prevention and treatment of pressure ulcers. (selected criteria)

Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (selected criteria).

8.1 Inspection findings

8.1.1 Management of nursing care – Standard 5

The inspector can confirm that at the time of the inspection there was evidence to validate that patients received safe and effective care in Three Islands.

There was evidence of comprehensive and detailed assessment of patient needs from date of admission. A variety of risk assessments were also used to supplement the general assessment tool. The majority of assessments were found to be updated on a regular basis and as required. The assessment of patient need was evidenced to inform the care planning process.

Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis for the majority of patients. There was evidence however that one patient's assessments and care plans had not been updated on a regular basis. One requirement has been raised accordingly.

There was also evidence that the referring health and social care trust (HSCT) maintained appropriate reviews of the patient's satisfaction with the placement in the home, the quality of care delivered and the services provided.

COMPLIANCE LEVEL: Moving towards compliance

8.1.2 Management of wounds and pressure ulcers – Standard 11 (selected criteria)

The inspector was informed that there were no patients with a wound currently accommodated in the home.

There was evidence of appropriate assessment of the risk of development of pressure ulcers which demonstrated timely referral to tissue viability specialist nurses (TVN) for guidance and referral to the HSCT regarding the supply of pressure relieving equipment if appropriate.

Care plans for the management of risks of developing pressure ulcers were in place. There was evidence of a policy and procedure for the prevention and treatment of pressure ulcers. A recommendation has been made for the management of pressure ulcers to be included in nurse competency assessments.

Discussion with staff and review of training records evidenced that training in relation to pressure area care and the prevention of pressure ulcers has been provided for all relevant staff. The registered manager confirmed that training had also been provided for registered nurses in the management of wounds/pressure ulcers. A tissue viability link nurse was employed in the home and was involved in the provision of staff training and review of care. This is good practice.

COMPLIANCE LEVEL: Compliant

8.1.3 Management of nutritional needs and weight loss – Standard 8 and 12 (selected criteria)

The inspector reviewed the management of nutrition and weight loss within the home.

Robust systems were evidenced with risk assessments and appropriate referrals to General Practitioners (GP's), speech and language therapists (SALT) and or dieticians being made as required.

The inspector also observed the serving of the lunch time meal and can confirm that patients were offered a choice of meal and that the meal service was well managed and supervised by registered nurses.

Patients were observed to be assisted with dignity and respect throughout the meal.

COMPLIANCE LEVEL: Compliant

8.1.4 Management of dehydration – Standard 12 (selected criteria)

The inspector examined the management of dehydration during the inspection which evidenced that fluid requirements and daily intake were recorded and maintained for those patients assessed at risk of dehydration.

Patients were observed to be able to access fluids with ease throughout the inspection. Staff were observed offering patients additional fluids throughout the inspection. Fresh drinking water/various cordials were available to patients in lounges, dining rooms and bedrooms.

COMPLIANCE LEVEL: Compliant

8.3 Patient, representatives and staff consultation

Some comments received from patients and their representatives:

- “This is a great home.”
- “I am very happy here.”
- “The food is good and I always have enough to eat.”
- “We are very satisfied with the care our relative is getting.”
- “The home is a happy and welcoming place.”

Some comments received from staff:

- “I am very happy working here.”
- “The care provided in the home is excellent.”
- “I have had a good induction experience and felt well prepared for my role.”

8.4 A number of additional areas were also examined.

- records required to be held in the nursing home
- Human Rights Act 1998 and European Convention on Human Rights (ECHR)
- Patient and staff quality of interactions (QUIS)
- Complaints
- patient finance pre-inspection questionnaire
- NMC declaration
- staffing and staff comments
- environment

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 robust processes in place to ensure the effective management of the themes inspected.

The home’s general environment was well maintained and patients were observed to be treated with dignity and respect. Areas for improvement were identified in relation to the review of risk assessments and care plans.

Therefore, one requirement and one recommendation have been raised as a consequence of this inspection. This requirement and recommendation are detailed throughout the report and in the quality improvement plan (QIP).

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

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

9.0 Follow-up on the requirements and recommendations issued as a result of the previous inspection on 11 February 2014

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
		No requirements were made as a result of this inspection		

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
		No recommendations were made as a result of this inspection		

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

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

There have been no notifications to RQIA regarding potential safeguarding of vulnerable adults (SOVA) incident since the previous inspection.

.

10.0 Additional areas examined

10.1 Records required to be held in the nursing home

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

10.2 Patients/residents under guardianship

There were no patients currently under guardianship resident at the time of inspection in the home.

10.3 Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspector discussed the Human Rights Act and Human Rights Legislation with the home manager and one of the registered nurses. The inspector can confirm that copies of these documents were available in the home.

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

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

10.4 Quality of interaction schedule (QUIS)

The inspector undertook one period of observation in the home which lasted for approximately 20 minutes.

The inspector observed the interactions between patient and staff during the serving of lunch in the dining room.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area being observed.

Positive interactions	All positive
Basic care interactions	0
Neutral interactions	0
Negative interactions	0

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

A description of the coding categories of the Quality of Interaction Tool is appended to the report.

10.5 Complaints

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

The inspector reviewed the complaints records. This review evidenced that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought.

10.6 Patient finance questionnaire

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

10.7 NMC declaration

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

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

10.8 Questionnaire findings

10.8.1 Staffing/staff comments

Discussion with the registered manager and a number of staff and review of a sample of staff duty rosters evidenced that the registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients currently in the home. The care and ancillary staffing levels were also found to be satisfactory.

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

During the inspection the inspector spoke to eight staff. The inspector was able to speak to a number of these staff individually and in private. The following are examples of staff comments during the inspection:

- "I am very happy working here."
- "The care provided in the home is excellent."
- "I have had a good induction experience and felt well prepared for my role."

10.8.2 Patients' comments

During the inspection the inspector spoke with 20 patients individually and with a number in groups. Some patients were unable to communicate verbally. The inspector observed that patients appeared relaxed and content in their environment. Some comments received from those patients who were able to verbalise their views:

- "This is a great home."
- "I am very happy here."
- "The food is good and I always have enough to eat."

10.8.3 Patient representative/relatives' comments

No relatives were available during this inspection. However four relatives competed and returned questionnaires following the inspection.

The following are examples of relatives' comments in questionnaires:

- "We are very satisfied with the care our relative is getting."
- "The home is a happy and welcoming place."

10.9 Review of care records

The inspector examined a number of patient care records as part of the inspection process to validate the providers self-assessment. The inspector identified that assessments and care plans had not been updated on a regular basis for one out of the three care records reviewed

One requirement has been made with regard to care records.

10.10 Nurse competency assessments

Discussion with the registered manager and review of a sample of nurse competency assessments evidenced that the management of wounds had not been included in the competency assessments. A recommendation has been made accordingly.

11.0 Quality improvement plan

The details of the quality improvement plan appended to this report were discussed with Mr David Joseph McAteer, Registered Manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider / manager is required to record comments on the quality improvement plan.

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

Enquiries relating to this report should be addressed to:

Bridget Dougan
The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS

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**
For all planned admissions an application form is completed by the care manager, giving detailed information on all aspects of daily living. This information, along with assessments made by the nurse manager when visiting the patients prior to admission, and various information received from relatives and/ or former care staff, will form the basis for this assessment.	Compliant

A policy documenting this process is included in the Nursing Home's admissions policy Each patient has a completed braden scale, MUST, manual handling and any other identified risk assessment in place before their admission to the home. This is reviewed every 3 months by the named nurse(monthly for MUST) .In the 11 years of my employment in Three islands, there has been no pressure sores in the nursing home. On one occasion a patient returned from hospital with a pressure sore and we were able to restore the skin in a short period of time, It should be noted that we are a learning Disability home and a very small percentanage are confined to bed	

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**
As per policy, the designated named nurse will ensure: The accurate completion of all risk assessments. Accurate recording in daily progress notes The setting of realistic achievable goals with the input of the patient's family and multidisciplinary team Discussing, planning and agreeing nursing interventions takes place Promoting independence and rehabilitation Care plans are reviewed at agreed time intervals and changed and updated appropriately Adherence to the set standards and policy of the home If staff have concerns regarding pressure sores, we would disscuss this with the GP who would make a referral on our behalf to the Tissue Viability Nurse in Magherafelt and Dietican if required. This would be incorporated into their care plan. Historically any patient returning with a wound has had information and instructions handed over to a member of staff who then cascaded and demonstrated the procedure to all colleagues dressing the wound. Advice and guidance was available to staff until the wound heals. If a patient is at high risk this is discussed with the care manager who will coordinates any referals or equipment needed. The Braden scores are updated at least 3 monthly or when required For wounds requiring dressings changed daily, a short term care plan is drawn up with clear instructions for the nurse. The state of the wound will be documented until it is completely healed. The advice from the Tissue Viability nurse will be followed completely at all times.	Compliant

There is a copy of 'Pressure ulcers, the managment of pressure ulcers in primary and secondary care' avaialble as a reference for staff, should any problem arise. At all times we follow the instructions given to us by the Tissue Viability nurse.	
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**
Staff record in each patient's care plans on a daily basis. These records are contemporaneous in accordance with NMC guideline. Reviewing dates are included in the lay out.. We have incorporated advice from the previous inspections	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**
We have a standard of care folder compiled with references from the "Royal Marsden Manual of Clinical Nursing Procedures" We have separate folders with up to date information on epilepsy, wound care, nutrition and diabetes amoung others, We have a grading system based on the European pressure grading system. This is kept in the staff information folder and also the policy for pressure care Staff refer to "Nutritional Guidlines and menu checklist" when discussing nutriton The balance of good health 5 food group model is central	Compliant

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

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Each patient has at least yearly reviews of the care given; although six monthly reviews occur frequently.. This is organised by the care managers. The relatives and the patient are included in the review process.The care manger then completes a full summary of minutes and agreed actions and circulates it to the relevant people. Relatives are also encouraged to meet up with the named nurse outside of the care manager's review to take part in specific needs identified, especially when the need requires a consistant approach from both family and nursing home staff Each care plan is reviewed by the named nurse every 3 months	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**
The patients are encouraged to attend their annual review although this is not always possible due to the severity of some patients cognitive impairments, When this is the case, the patients' named nurse and representaives will act in their best interest to ascertain any expressed wishes given before any deterioration in health Each patient has at least yearly reviews of the care given, often 6 monthly. This is organised by the care managers, and the relatives and the patients are included in the review process.The care manger then completes a full summary of minutes and agreed actions and circulates it. Relatives are also encouraged to meet up with the named nurse outside of the care manager's review to take part in specific needs identified, especially when the need requires a consistant approach from both family and nursing home staff	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**
Three Islands offers a varity of food to the patients which meets their dietary needs. In each individual careplan preferences are recorded along with Speech and Language Therapist or Dietician recommendations All patients regardless of any specialiseed diet are given a choice of twomeals each mealtime. If they do not like either the cook will offer another alternative	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** 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**
Staff are observed feeding patients by the Speech and language therapists. They receive up to date information from staff education and directives that are given out by the manager. Staff receive inhouse trianing regarding nutrition every two years. The manager observes staff feeding the patients as part of their appraisal.	Compliant

Breakfast is served between 8am and 10am Lunch is served between 12pm and 1pm Tea is served between 4pm and 5pm Supper is between 7.30 and 8.30pm Hot drinks are available after 9pm when requested Drinks and snacks are provided at 11am and 3pm or when requested. There is always water available Patients can have a snack when they request it unless stated otherwise in their careplan. The people we care for have learning disability and often accompanying mental health problems and may have insatiable appetites. A summary of each patient's Nutritional needs are available in each food preparation area. Any changes are discussed at the hand over and highlighted on the sheet. The sheet tells what consistency is required, what aids are necessary and the level of help required. The manager and staff attended wound care training in 2013. Representatives from Three Islands attended a pressure care seminar in Apri 2014.	

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

Appendix 2

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

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

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

References

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

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

Quality Improvement Plan

Primary Unannounced Care Inspection

Three Islands

26 September 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 Mr David Joseph McAteer either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirement	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	16 (2) (b)	The registered person shall ensure that the patients risk assessments and care plans are kept under review. **Reference: Section 10.9**	One	The patients risk assessments and care plans will be reviewed every month	From date of this inspection

Recommendations

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

No.	Minimum Standard Reference	Recommendation	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	11.7	It is recommended that the management of wounds is included in the competency assessments for registered nurses. **Reference: Section 10.10**	One	The management of wounds is now included in the competency assessments for registered nurses.	From date of this inspection

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

NAME OF REGISTERED MANAGER COMPLETING QIP	David Joseph McAteer
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Anne McAteer

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Bridget Dougan	07 January 2015
Further information requested from provider			