Unannounced Care Inspection

Name of Establishment:	**Gillaroo Lodge Nursing Home**
Establishment ID No:	**1387**
Date of Inspection:	**04 December 2014**
Inspector's Name:	**Bridget Dougan**
Inspection No:	**IN017858**

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:	Gillaroo Lodge Nursing Home
Address:	134 The Roddens Larne Co Antrim BT40 1DN
Telephone Number:	028 2826 0033
E mail Address:	nursemanager.gillaroo@gmail.com
Registered Organisation/ Registered Provider:	Gillaroo Lodge Nursing Home Ltd Mr Tom and Mrs Margaret Boyle and Mrs Elizabeth Rowan
Registered Manager:	Mrs Nicola McCrudden
Person in Charge of the Home at the Time of Inspection:	Mrs Nicola McCrudden
Categories of Care:	NH-I, NH-PH, NH-PH (E)
Number of Registered Places:	25
Number of Patients Accommodated on Day of Inspection:	24
Scale of Charges (per week):	£615.00 - £658.00
Date and Type of Previous Inspection:	07 November 2013: Primary Unannounced
Date and Time of Inspection:	04 December 2014: 14.00 hours – 17.00 hours
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 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 the registered manager
- Discussion with staff
- Discussion with patients individually and to others in groups
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- Review of a sample of care plans
- Observation during a tour of the premises
- Evaluation and feedback.

5.0 Consultation Process

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

Patients/Residents	**20**
Staff	**7**
Relatives	**4**
Visiting Professionals	**0**

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**1**	**1**
Relatives/Representatives	**4**	**4**
Staff	**7**	**7**

6.0 Inspection Focus

The 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

Gillaroo Lodge Private Nursing Home has been adapted and extended to provide nursing home accommodation. The property is surrounded with landscaped gardens overlooking Larne town.

Accommodation is on two floors which are accessed by passenger lifts and a staircase. Bedroom accommodation is provided in both single and double rooms. There is a range of toilets, bath and shower facilities, communal lounges and dining areas throughout the home.

The home is registered to provide care for a maximum of 25 persons under the following categories of care:

Nursing Care

I - Old age not falling into any other category
PH - Physical disability other than sensory impairment
PH (E) - Physical disability other than sensory impairment under 65 years.

8.0 Executive Summary

The unannounced secondary inspection of Gillaroo Lodge Nursing Home was undertaken by Bridget Dougan on 04 December 2014 between 14.00 – 17.00 hours. The inspection was facilitated by Mrs Nicola McCrudden, Registered Manager who was available for verbal feedback at the conclusion of the inspection.

During the course of the inspection, the inspector met with patients, relatives and staff who commented positively on the care and services provided by the nursing home. Some staff were concerned regarding the provision of activities and a requirement has been made for a review of activities and to give consideration to employing an activities co-ordinator.

As a result of the previous inspection conducted on 07 November 2013 nil requirements and two recommendations were issued. These were reviewed during this inspection and evidence was available to confirm that all recommendations have been fully complied with.

Details can be viewed in the section immediately following this summary.

Conclusion

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

The management of continence within the home was of a good standard and one requirement and one recommendation have been made in respect of the assessment of continence needs. The inspector‘s overall assessment of the level of compliance in this area is recorded as ‘Substantially Compliant’.

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

Therefore, two requirements and no recommendation have been made following this inspection. These are detailed throughout the report and in the quality improvement plan (QIP).

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

9.0 Follow-Up on Previous Issues – 03 June 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
1	10.7	It is recommended that the policy for the management of restraint is further developed to reflect and reference the RCN guidelines "Let's Talk About Restraint" and also provide best practice guidance for staff on the use of sensor/alarm mats and crash mattresses.	The inspector reviewed the restraint policy and can confirm that this recommendation had been complied with.	**Compliant**
2	11.7	The registered nurse's competency and capability assessment should include pressure ulcer/wound care management and be reviewed annually by the registered manager.	Review of a sample of nurse competency assessments confirmed that this recommendation had been complied with.	**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.

There have been no notifications to RQIA regarding potential safeguarding of vulnerable adults (SOVA) incidents since the previous 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 not undertaken for all patients. While continence care plans were in place for all patients, the type of continence products to be used had not been specified. A requirement has been made in accordance with Regulation 15 (2) (a) of The Nursing Homes Regulations (Northern Ireland) 2005. There was evidence in three patients care records that 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. Review of three patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. The care plans reviewed generally 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.	Substantially compliant

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 • catheter care • stoma care. The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines • 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
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	
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 registered manager and review of training records confirmed that all relevant staff were trained and assessed as competent in continence care. Registered nurses received training in male and female catheterisation and had been deemed competent in this area.	Compliant

The inspector was informed that regular audits of the management of incontinence were included in care plan audits and the findings acted upon to enhance standards of care.	

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

11.0 Additional Areas Examined

11.1 Care Practices

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

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

11.2 Patients and Relatives Comments

During the inspection the inspector spoke with 20 patients individually and with the majority of others in smaller groups. One patient completed a questionnaire.

Patients spoken with and the questionnaire responses confirmed that patients were treated with dignity and respect, that staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home. The inspector also met with four relatives who also completed questionnaires. All relatives were very complimentary of the care and services provided.

Some comments received from patients and relatives:

- "The staff look after me very well and sometimes in their own time take me out on various trips. I am very happy to be here with the current staff."
- "My mother is a resident. I am very satisfied with the level of care."
- "We have every confidence in the staff who are caring for our relative. We are delighted with the care she has received and are pleased with her progress since arriving."
- "I couldn't possibly say in words how wonderful the matron, nurses and carers are in Gillaroo, not forgetting the chef and kitchen staff. My relatives are so well looked after."
- "The staff work hard in the care of their patients."

11.3 Staffing/Staff Comments

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 inspector met with seven staff during the inspection and these staff also completed questionnaires. Staff informed the inspector that they were provided with a variety of relevant training including mandatory training since the previous inspection. All staff were very satisfied with the level of care provided to patients. Some staff, however raised concerns regarding the activities provision for patients within the home. The inspector was informed that while staff did not wish to compromise the existing high standards of care in the home, it was difficult to find the time to provide activities, given the high dependency levels of most patients in the home. This was discussed with the registered manager who confirmed that there was currently no activities co-ordinator employed in the home. However, volunteers and local community groups come into the home on a regular basis. The registered person is required to review the

provision of activities within the home and give consideration to the employment of an activities co-ordinator.

The following are examples of staff comments during the inspection and in questionnaires:

- “Gillaroo do provide a high standard of care for their residents.”
- “The hard work and dedication of the nurse manager to both the home and her staff have made us an award winning home.”
- “Good quality care delivered.”
- “Everyone goes the extra mile to take care of the residents.”

11.4 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.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed Mrs Nicola McCrudden, 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.

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

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

Enquiries relating to this report should be addressed to:

Bridget Dougan
The Regulation and Quality Improvement Authority
Hilltop
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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 a pre-assessment is carried out by the Home Manager. This, along with the information received from family and care management team, gives the knowledge in order to ensure we can meet the needs of the resident. On admission the admitting nurse will have received in advance the pre-admission findings and have the resident's basic details already entered in the care management system. The nurse admitting the resident carries out a visual check and an assessment in the following areas: Nursing Needs,	Compliant

Nutrition (CNRST), Pain (Abbey Pain Scale), Pressure (Braden), Mobility/Falls (therapy risk assessment), Moving & Handling Bedrail assessments. A full body map is completed. If wounds are identified, a full wound assessment is carried out. 'At risk' residents will have individualised care plans to manage the risks relating to them and will be referred to appropriate members of the multi-disciplinary team for further treatment / advice. A full and comprehensive person centred care plan will be completed within 11 days.	
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**
There is a policy on the Named Nurse concept which outlines responsibilities of a named nurse. A plan of care is agreed with the resident / representative in discussion with and taking into account advice and directions from other professionals e.g. Tissue Viability, GP and Dieticians. All referrals are made as and when necessary to the relevant health care professionals. We have a good relationship with these persons, and we work closely with them in caring for our residents. Our residents are registered with a private podiatrist who attends the home routinely every month. Should there be any concerns about a resident's feet or lower limbs, we can contact her and she will come and assess the situation. The podiatrist provides training for the staff,and gives advice on any treatments required. Referrals are made as and when required to Tissue Viability personnel. Residents who are 'at risk' have clearly documented care plans to prevent and treat any concerns, Staff have received training in Wound management and prevention and treatment of pressure ulcers. Referrals are made as and when required to Dietician, and we work closely with these professionals. We are also involved in Nursing Home Collaborative with Patient Safety Council, and the focus of our improvement work this year is Nutrition.	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**
Residents are assessed initially prior to admission, and on admission when, in conjuction with the care manager, resident and relatives, a care plan is drawn up that is specific to the resident's needs. The resident is assessed on an ongoing basis and notes are recorded on the care management system at each interval, but at least twice daily. Monthly assessments of care are carried out, and monthly reviews of careplans are the minimum time scale. Reviews take place more often if there is any change to the resident's condition. Monthly audits of care plans are carried out and any deficits addressed with the named nurse. When necessary, an action plan will be drawn up to address any areas requiring improvement.	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**
All care delivered within Gillaroo Lodge Nursing Home is supported by research based evidence Currently we use : Braden Score to assess pressure ulcer risk We also use guidance from the following documents to inform our decisions and policies and procedures in relation to pressure ulcer and wound management: NICE guidelines for prevention of pressure ulcers NPUAP/EPUAP clinical based evidence quick reference guide We have received training in wound care and pressure ulcer awareness. NICE Clinical Guidelines and Public Health Documents on Nutritional Guidelines for Nursing Homes 2014 are available in the Home - 1 in the Kitchen and 1 in the Nurses' Office. Gillaroo Lodge is part of the Nursing Home Collaborative with Patient Safety Council - currently the area of focus for improvement is Nutrition.	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**
There is a policy on records and record keeping - this is held within the policy file. A copy of the NMC document -Record keeping has been distributed to all Staff Nurses. All care records are held on a computerised system. Records are completed in line with legislative requirements,and include all nursing interventions and care provided to the resident. Any concerns are addressed under supervison procedure. Regular audits are carried out of care records, and action plans are drawn up to address any concerns. Records are kept of all meals provided.	Compliant

Nutritional charts and Fluid charts are completed for all residents that there is any concern about, and those that score High risk on nutritional assessment. Any actions relating to under-nourishment or over-eating are recorded, and referrals are made Staff also encourage outside professional bodies to record multi-disciplinary notes.	
Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care progress notes are recorded as and when the care is delivered by staff nurses who are fully aware of the NMC guildelines on record keeping. Care plans are updated at least monthly by the named nurse. Any changes to the resident's needs are agreed and documented accordingly. The care plan is adjusted to reflect this. Daily entries are made by the staff nurse on duty that day and reflect the happening of that time. Care Plans are agreed with the resident and/or their representative and a document signed as agreement to care The resident's Human Rights are respected at all times. Any deprivation of liberty is carried out only following assessment and in the resident's best interests.	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 reviews are carried out by a representative of NHSCT, along with a member of the Nursing Staff within Gillaroo Lodge and the resident and/or their representative. Initially following admission this review will be held with 6-8 weeks and then annually, or more often should there be any concerns. Prior to the care review, the manager completes a resident review form in preparation and to assist the representative of the Trust with their completion of documentation. Following the review a typed record signed by all parties will be sent to the Home and this is kept on file. Should there be any action required, an Action plan will be drawn up and actioned accordingly. All care plans are compiled in agreement with Trust representatives and residents and next of kin.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
There is a 5 week rotational menu in place with choices for residents at all meal times. At times due to their condition a resident may refuse the choices available that day, so staff are quick to request the cook in the kitchen to make an alternative meal. Staff in the Home, and most especially in the kitchen, know the idiosyncrasies of the residents' likes and dislikes, and will accommmodate as necessary. Any resident with particular instructions / requirements regarding their diet are recorded in the care plans, and this information is used at hand-over times, especially meal-times to remind staff again. Any special diets / preferences, etc. are given to the Cook for attention. Menu choice sheets are produced daily and contain an extensive amount of information regarding the residents' dietary needs. This assists with choices. These menu choice sheets are kept on file. Kitchen staff are long term employees and have received training in the provision of modified diets in the past. Indeed, in the past, the Head Cook (who has been employed in Gillaroo Lodge for over 20 years) has been used at a Northern Trust event as an example of good practice in nusing home nutrition. Staff also receive training in the preparation of thickened fluids.	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**
All nurses have attended SALT Swallowing Awareness Study Days at some stage. When SALT make assessments, the nurse will take on and follow the instructions, then instruct junior staff in the specific techniques. Meals in the Home are provided at conventional times (Breakfast 8-10 approximately, Lunch 12.45, Tea 5.00) and there is a tea trolley mid-morning and mid-afternoon offering hot tea or a cold drink and a snack. Fresh drinking water and juice is available at all times.	Compliant

One trained member of staff is always available within the main dining area at meal times to reduce risk of adverse effects as a result of choking. All staff have attended first aid training which includes choking. Care and Kitchen staff attend training on preparation of thickened fluids. All Nurses have received training in wound assessment and dressings,recently All care provided is evidence based..	

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

Appendix 2

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

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

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

References

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

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

Quality Improvement Plan

Unannounced Primary Inspection

Gillaroo Lodge

04 December 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Nicola McCrudden, Registered Manager, either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	15 (2) (a)	The registered manager should ensure that bladder and bowel continence assessments have been undertaken for all patients. The outcome of these assessments, including the type of continence products to be used, should be incorporated into the patients' care plans on continence care. Assessment of the patients' needs should be kept under review and revised at any time when it is necessary to do so having regard to any changes in the patients' condition. **Reference: Section 10; Criterion 19.1**	One	All bladder and bowel assessments have now been completed for all residents. Care plans have been updated as required. There are ongoing reviews of residents needs.	From the date of this inspection
2	18 (2)	The registered persons should review the provision of activities and give consideration to employing an activities co-ordinator. **Reference: Section 11.3**	One	The provision of activities has been reviewed. On the daily allocation sheet a member of staff is given specific responsibility for activities on that day.	Within two weeks from receipt of this report

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
		No recommendations were made as a result 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	Nicola McCrudden
Name of Responsible Person / Identified Responsible Person Approving Qip	Liz Rowan

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Bridget Dougan	15 January 2015
Further information requested from provider			