Unannounced Primary Inspection

Name of Establishment:	**Queenscourt**
Establishment ID No:	**1389**
Date of Inspection:	**24 September 2014**
Inspectors Names:	**Bridget Dougan and Karen Scarlett**
Inspection No:	**IN017060**

The Regulation and Quality Improvement Authority
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1.0 General Information

Name of Home:	Queenscourt
Address:	36 Doagh Road Ballyclare Co Antrim BT38 9BG
Telephone Number:	028 9334 1472
E mail Address:	info@manorhealthcare.org
Registered Organisation/ Registered Provider:	Manor Healthcare Mr Eoghain King
Registered Manager:	Mrs Geraldine Borelan
Person in Charge of the Home at the time of Inspection:	Ms E Carson, Nurse in Charge in am Ms A Colgan, Nurse in Charge in pm
Registered Categories of Care and number of places:	Nursing - Learning Disability 43
Number of Patients/Residents Accommodated on Day of Inspection:	39 patients
Date and time of this inspection:	24 September 2014: 10.00 – 19.45 hours
Date and type of previous inspection:	12 September 2013 Secondary Unannounced

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 a primary announced 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 the inspection visit by the inspector.

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

- analysis of pre-inspection information
- discussion with the nurse in charge
- examination of records

- consultation with stakeholders
- 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	**25**
Staff	**12**
Relatives	**0**
Visiting Professionals	**0**

Questionnaires were provided, during the inspection, to patients, their representatives and staff to seek their views regarding the service. Matters raised from the questionnaires were addressed by the inspector in the course of this inspection.

Issued To	Number issued	Number returned
Patients	**4**	**0**
Relatives / Representatives	**2**	**0**
Staff	**4**	**0**

6.0 Inspection Focus

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

The 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 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

Queenscourt is situated close to Ballyclare town centre, including all local amenities and public transport links.

The home is a two storey building with a central communal area linking an original building with a more recently built facility to the rear. Two patio areas are provided at each side of the home. Bedroom accommodation is located on both floors comprising of single and shared rooms.

In October 2007, the home was purchased by Manor Healthcare Limited; Mr Eoghain King is the Registered Provider.

The home is registered to accommodate a maximum of 43 persons requiring nursing care within the category LD (learning disability) over and under the age of 65 years.

The certificate of registration issued by the RQIA was appropriately displayed in the main reception area of the home.

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (unannounced) to Queenscourt Nursing Home. The inspection was undertaken by Bridget Dougan and Karen Scarlett on 24 September 2014 from 10.00 to 19.45 hours.

The inspectors were welcomed into the home by Ms E Carson, Nurse in Charge who was available until 14:00 hours. Verbal feedback of the issues identified during the inspection was given to Ms A Colgan who was the nurse in charge in the afternoon of the inspection. Feedback was also provided to the Registered Manager, Mrs Geraldine Borelan by telephone following the inspection.

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

During the course of the inspection, the inspectors met with patients and staff. The inspectors 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.

Questionnaires were sent to the home for patients, staff and relatives to seek their views regarding the service, however, at the time of writing this report none were returned to RQIA.

The inspectors spent a number of extended periods 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 is designed to help evaluate the type and quality of communication which takes place in the nursing home. A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix two.

As a result of the previous inspection conducted on 12 September 2013, one requirement and one recommendation were issued. This requirement and the recommendation were reviewed during this inspection. The inspectors evidenced that the requirement was moving towards compliance, however the recommendation was not compliant. Details can be viewed in the section immediately following this summary.

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)

Inspection Findings:

- **Management of Nursing Care – Standard 5**

The inspectors can confirm that at the time of the inspection there was evidence to validate that patients receive safe and effective care in Queenscourt.

The inspectors inspected three patients care records and there was evidence of detailed assessments of patient needs from date of admission. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of the patients' needs was evidenced to inform the care planning process.

Inspectors however were unable to evidence that comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis and as required.

There was 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

- **Management of Wounds and Pressure Ulcers –Standard 11**

The inspectors were informed by the registered nurse that there was one patient with wounds in the home.

While there was evidence of assessment of risk of development of pressure ulcers, there was a lack of comprehensive review of these assessments.

Care plans for the management of risks of pressure ulcers and wound care were maintained, however these had not been reviewed on a regular basis in response to changes in the patient's condition.

Pain assessments and care plans were not in place for patients with pressure ulcers/wounds or patients in receipt of prescribed analgesia.

Inspection of staff training records evidenced that staff as appropriate required training in relation to pressure area care and the prevention of pressure ulcers. While a number of registered nurses had completed training in wound care, it is recommended all registered nurses undertake this training and their competency is assessed to ensure training has been embedded into practice.

Compliance level: Moving towards compliance

- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**

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

There were systems and processes in place to manage risk and evidence of appropriate referrals to GP's, speech and language therapists and /or dieticians being made as required. However, as previously stated, inspectors were unable to evidence that all risk assessments and care plans had been reviewed on a regular basis.

The inspectors also observed the serving of the lunch meal and can confirm that the patients were offered a choice of meal and that the meal service was well delivered. Patients were observed to be assisted with dignity and respect throughout the meal. The inspectors evidenced that the quality of interactions between staff and patients was mostly positive with one neutral interaction observed during lunch. This was discussed with the registered manager following the inspection and a need for further training has been identified.

Compliance level: Moving towards compliance

- **Management of Dehydration – Standard 12**

The inspectors examined the management of dehydration during the inspection which evidenced that fluid requirements and intake details for patients were in the main well recorded 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. A recommendation was made in relation to the recording of fluids.

Compliance level: Substantially compliant

Patients / their representatives and staff consultation

Some comments received from patients:

“I’m very happy here.”
“staff are very good to me.”
“I enjoy the food.”

No relatives/patients representatives were present in the home during this inspection.

Some comments received from staff:

“I have had a good induction and plenty of training.”
“I have had behaviour management training, however I feel it would be better if it was focused on the challenging behaviour of actual patients in the home.”
“This is a lovely home to work in, I am happy here.”

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) DHSSPS and Deprivation of Liberty Safeguards (DOLS)
- patient and staff quality of interactions (QUIS)
- complaints
- patient finance pre-inspection questionnaire
- NMC declaration
- staffing and staff comments
- comments from representatives/relatives
- environment.

Full details of the findings of inspection are contained in section 11 of the report.

Conclusion

The inspectors can confirm that at the time of inspection the delivery of care to patients was evidenced to be of a good standard. In the main, there were processes in place to ensure the effective management of the themes inspected.

The home’s general environment was maintained to a high standard of hygiene and patients were observed to be treated with dignity and respect. However, areas for improvement were identified in relation to: care records; care practice in the

prevention and management of pressure ulcers; training; the décor of some areas of the home and the availability of evidence based / best practice literature.

Therefore, three requirements and eleven recommendations are made as a result of this inspection together with one requirement and one recommendation which have been stated for the second time. These requirements and recommendations are detailed throughout the report and in the quality improvement plan (QIP).

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

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

No	Regulation Ref.	Requirement	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	27 (2) (b) (d)	The registered person shall, having regard to the number and needs of the patients, ensure that- The premises to be used as the nursing home are of sound construction and kept in a good state of repair externally and internally.	The inspectors were informed that Manor Healthcare have in place a rolling programme for the maintenance and décor of the homes both internally and externally. A general inspection of the premises evidenced that the décor of the lounge, dining room and corridors appeared tired and worn.	**Moving towards compliance**

No	Minimum Standard Ref.	Recommendation	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	20.4	The registered manager should ensure there is an identified first aider on duty for each shift.	The inspectors reviewed four weeks duty rotas and were unable to evidence that this recommendation had been met.	**Not compliant**

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

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated minimum standards, it will review the matters and take whatever appropriate action is required; this may include an inspection of the home. Please also refer to section 10.5 of the report.

Since the previous care inspection, RQIA have received no notifications of potential safeguarding of vulnerable adult (SOVA) incidents or complaints in respect of Queenscourt.

10.0 Inspection Findings

Section A – On admission a registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Standard criterion 5.1, 5.2, 8.1 and 11.1 examined.
Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance. The inspectors reviewed three patients care records which evidenced that patients' individual needs were established on the day of admission to the nursing home, through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that procedures were in place to manage any identified risks. Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart, pain, infection control and continence were also completed on admission. Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure ulcer/wound and if required, the specific care plans regarding the management of the pressure ulcer/wound. Review of three patients' care records evidenced that an assessment of the patients care needs was completed within 11 days of admission to the home. In discussion with the nurse in charge she demonstrated a good awareness of the patient who required wound management intervention and the number and progress of patients who were assessed as being at risk of weight loss and dehydration.

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

Section B – Standard 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.**

Standard 11.2

- **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.**

Standard 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.**

Standard 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**

Standard 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.**

The inspectors observed that a named nurse and key worker system was operational in the home. The roles and responsibilities of named nurses and key workers were outlined in the patient's guide.

Review of a sample of care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Records also evidenced discussion with patients and/or their representatives following changes to the plans of care.

The inspectors reviewed three patients' care records and were unable to confirm that where a patient was assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention plan and treatment programme.

Appropriate pressure relieving equipment was in place for the majority of patients; however this was not reflected in the patients' care plans. The inspectors observed one patient assessed as being at risk of developing a pressure ulcer where appropriate pressure relieving equipment was not in place. This patient was also observed to have no footplate on their wheelchair causing the patient to slide down with

the potential to cause friction and sheer.

Repositioning charts were in place for the majority of identified patients and evidenced that patients' skin condition was inspected at each positional change. One patient identified as being at risk of developing a pressure ulcer had no repositioning chart in place and no evidence of skin checks having been completed.

The nurse in charge informed the inspectors that there was one patient in the home who required wound management. Review of this patient's care records and the records of two other patients who had been assessed as being at risk of developing pressure ulcers evidenced the following:

- there was lack of consistency in the management of care records
- pain assessments were not in place for patients with pressure ulcers/wounds or patients in receipt of prescribed analgesia
- care plans for the management of pain were not in place for patients with pressure ulcers/wounds or patients in receipt of prescribed analgesia
- not all risk assessments or care plans were reviewed at least monthly or more frequently in response to changes in the patient's condition
- body mapping charts had not been completed for all patients on admission and reviewed and updated when any changes occurred to the patient's skin condition
- Braden risk assessments had not been reviewed and updated on a regular basis
- the frequency of wound dressings and an assessment of the wound following each dressing renewal had been recorded in nursing progress notes, however the descriptions were subjective, for example "dressing changed and healing well"; "less oedematous". It is recommended that wound observation charts are maintained for all patients with pressure ulcers/wounds. The assessment recorded after each dressing renewal should include the dimensions of the wound, descriptions of the wound base, exudate, odour and the appearance of surrounding skin.

Procedures were in place for staff on making referrals to the tissue viability specialists in the local healthcare Trust. The nurse in charge was knowledgeable regarding the referral process and of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

The patients' weights were recorded on admission and on at least a monthly basis or more often if required. While there was evidence of nutritional assessments having been completed, these were not always reviewed on a monthly basis.

Records were maintained regarding patients' daily food and fluid intake. Fluid intake was monitored over a 24 hour period and recorded in

nursing progress notes. It is recommended that nutritional care plans should specify the target fluid intake for individual patients.

Review of care records for one patient evidenced that the patient was referred to the dietician in a timely manner. There was also evidence that the patient's care plan had been reviewed to incorporate the recommendations made by the other professionals.

Discussion with staff and review of training records evidenced that training in relation to pressure area care and the prevention of pressure ulcers has not yet been provided for all relevant staff. A recommendation has been made in this regard. Two registered nurses had received tissue viability training in the management of wounds/pressure ulcers. It is recommended that all nurses receive this training.

Patients' moving and handling needs were assessed and addressed in their care plans. There was evidence that equipment such as a hoist was used to minimise the risk of friction. There were no issues identified during the inspection regarding moving and handling practices.

The registered nurse informed the inspectors that pressure ulcers if present were graded using an evidenced based classification system.

Two requirements and four recommendations are made in regard to shortfalls in patients' care records inspected and one recommendation has been made with regard to staff training in the prevention and management of pressure ulcers.

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

Section C – Standard 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 Homes Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16

There was evidence that day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care for each patient.

As previously stated inspectors were unable to evidence that all care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required.

While there was evidence that care records had been audited in August 2014, there was no evidence that action was taken to address any deficits or areas for improvement identified through the audit process. A recommendation has been made in this regard.

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

Section D – Standard 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.**

Standard 11.4

- **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.**

Standard 8.4

- **There are up to date nutritional guidelines that are in use by staff on a daily basis.**

Nursing Homes Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)

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

- the Roper, Logan and Tierney assessment of activities of daily living
- Braden pressure risk assessment tool
- Falls risk assessment tool.

There was evidence that nutritional risk assessments had been completed using a community nutritional risk assessment tool. It is recommended that the Malnutrition Universal Screening Tool (MUST) is used in accordance with the Promoting Good Nutrition Strategy.

It is recommended that the following research and guidance documents should be made available in the home for staff to access:

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

Discussion with the nursing and care staff confirmed that they were knowledgeable regarding the individual dietary needs and preference of patients and the principles of providing good nutritional care.

Care staff consulted was knowledgeable regarding the specific support required by patients with regard to eating and drinking. The cook

was also aware of patients who had specific dietary requirements. However a recommendation has been made for the registered manager to ensure catering staff have received written confirmation of patients on therapeutic diets.

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

Section E – Standard 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.**

Standard 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.**

Standard 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.

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

A review of the training records available on the day of inspection and discussion with registered nurses confirmed that update training on the importance of record keeping had not yet been provided for registered nursing staff or care staff. It is recommended that this training is provided for staff commensurate with their roles and responsibilities in the home.

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

Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patients' status or to indicate communication with other professionals/representatives. Entries were noted to be timed and signed with the signature accompanied by the designation of the signatory.

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

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

- daily records of food and fluid intake were being maintained
- where necessary a referral had been made to the relevant specialist healthcare professional
- care plans had been devised to manage the patient's nutritional needs, however as previous stated under section B, care plans were not always reviewed on a monthly or more often basis.

Review of a sample of fluid balance charts for one identified patient evidenced that:

- the patient was offered fluids on a regular basis throughout the day
- the total fluid intake over 24 hours had been recorded in the daily progress notes.

A recommendation has been made to ensure that, for those patients identified as being at risk of inadequate or excessive food and fluid intake:

- a fluid intake target over 24 hours is recorded in the relevant care plan and on fluid balance charts
- an effective reconciliation of the total fluid intake against the fluid target established
- action to be taken if targets were not being achieved.

Nursing and care staff spoken with were evidenced to be knowledgeable regarding patients' nutritional needs.

Review of staff training records confirmed that in October 2013 staff had attended training on nutrition and the management of dysphagia. The nurse in charge informed the inspectors that arrangements were in place for further nutritional training on two dates in October 2014.

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

Section F – Standard 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.**
Please refer to criterion examined in Section C & E. In addition the review of three patients care records evidenced that consultation with the patient and/or their representative had taken place in relation to the planning of the patient's care. This is in keeping with the DHSSPS Minimum Standards and the Human Rights Act 1998.

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

Section G – Standard 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**

Standard 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.**

Prior to the inspection a patients' care review questionnaire was forwarded to the home for completion by the registered manager. The information provided in this questionnaire evidenced that all the patients in the home had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014.

The nurse in charge informed the inspectors that patients care reviews were held post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff preferably the patients named nurse attends each care review. A copy of the minutes of the most recent care review was held in the patient care record file.

The inspectors viewed the minutes of one care management care review which evidenced that, where appropriate patients and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended an updated assessment of the patient needs and a record of issues discussed.

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

Section H – Standard 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.

Standard 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.

A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance.

There was a three weekly menu planner in place. This was reviewed and updated in accordance with the most recent evidence based guidance and in consultation with patients, their representatives and staff in the home.

It was confirmed by staff that individual dietary preference and choice is accommodated.

The inspectors discussed with the registered nurse and the cook the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients. A recommendation has been made to ensure catering staff receive a written confirmation of patients on therapeutic diets (see section D).

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

Section I – Standard 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.**

Standard 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.**

Standard 12.10

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

Standard 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.**

The inspectors discussed the dietary needs of the patients with the registered nurses, care staff and the cook. As identified in section B, review of the self – assessment (see appendix) and from discussion with staff, it was indicated that staff training had been completed in relation to assisted feeding techniques.

Discussion with the nurse in charge and cook confirmed that meals were served at appropriate intervals throughout the day in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.

The nurse in charge and cook confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered mid-morning, afternoon and at supper times.

The inspectors observed that a choice of fluids to include fresh drinking water were available and refreshed regularly. Staff were observed offering patients fluids at regular intervals throughout the day.

Staff spoken with were knowledgeable regarding pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care.

On the day of the inspection, the inspectors observed the lunch meal. Observation confirmed that meals were served promptly and

assistance required by patients was delivered in a timely manner. The inspectors observed that there were two sittings for lunch. Those patients in the second sitting remained in a small day room adjacent to the dining room until the first group of patients had finished their meal. Discussion with staff and observations during the lunch time meal indicated a need for possible re-assessment of one patient's needs and further training for staff in the management of challenging behaviour. This was discussed with the registered manager by phone following this inspection.

One requirement and one recommendation have been made.

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

11.0 Additional Areas Examined

11.1 Documents 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.

During the inspection, the inspectors reviewed a sample of accidents / incidents recorded by the home. The inspectors requested that one event recorded should be referred to the local HSC Trust to be considered under the safeguarding procedure and reported to RQIA in accordance with legislation. Requirements are made in this regard.

11.2 Patients under guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) order 1986.

At the time of the inspection, and living in or using this service was sought as part of this inspection. During the inspection there were no patients in the home who were subject to a guardianship order.

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

The inspector discussed the Human Rights Act and the Human Rights Legislation with the nurse in charge. The inspector can confirm that copies of these documents were either available in the home or sourced at the time of the inspection.

11.4 Quality of interaction schedule (QUIS)

The inspectors undertook two periods of observation in the home which lasted for approximately 20 minutes each.

The inspectors observed the interactions between patients and staff during the serving of lunch in the dining room. The inspectors also observed care practices in the main sitting room following the lunch meal.

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	Mostly positive
Basic care interactions	
Neutral interactions	One neutral interaction
Negative interactions	

The inspectors evidenced that the quality of interactions between staff and patients was mostly positive with one neutral interaction observed during lunch.

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

11.5 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.

11.6 Patient Finance Questionnaire

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

11.7 NMC declaration

Prior to the inspection the 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 manager were registered with the NMC.

11.8 Staffing /Staff Comments

The inspectors examined duty rotas spanning a five week period. Review of duty rotas indicated that staffing arrangement fell below RQIA's recommended minimum staffing guidance for nursing homes. While the numbers of staff on duty were in keeping with RQIA staffing guidance, there was a deficit in the skill mix of registered nurses on duty between 0800 and 1400 hours on 11 out of 35 days. This was discussed with the registered manager following the inspection who confirmed that recruitment of registered nurses had taken place.

Ancillary staffing levels were also reviewed and following discussion with staff and review of duty rotas, there appeared to be a deficit of laundry staff on duty especially

at weekends. This was also discussed with the registered manager following the inspection and the inspector was informed that this has now been addressed.

One requirement has been made with regard to staffing.

The inspectors spoke with 12 staff members during the inspection process.

Examples of staff comments were as follows:

“I have had a good induction and plenty of training.”
“I have had behaviour management training, however I feel it would be better if it was focused on the challenging behaviour of actual patients in the home.”
“This is a lovely home to work in, I am happy here.”
“As patients have become more dependent, there is a need for more staff.”

Questionnaires were sent to the home for staff to seek their views regarding the service, however, at the time of writing this report none were returned to RQIA.

11.9 Patients’ Comments

The inspectors spoke to the majority of patients. Some patients were unable to verbalise their views on the quality of care and services provided. The inspectors observed that all patients appeared relaxed and content in their environment. A few comments received from those patients:

“I’m very happy here.”
“Staff are very good to me.”
“I enjoy the food.”

No relatives/patients representatives were present in the home during this inspection. Questionnaires were left for relatives who wished to provide feedback, however none were returned to RQIA.

11.10 Environment

The inspectors undertook an inspection of the home and viewed a number of patients bedrooms, communal facilities and toilet and bathroom areas.

The home was comfortable and all areas were maintained to a high standard of hygiene. However, the décor of the lounge, dining room and corridors appeared tired and worn. A requirement made at the previous inspection has been stated for the second time.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms A. Colgan, Nurse in Charge at the conclusion of the inspection and with Mrs Geraldine Borelan, Registered Manager by telephone following the inspection 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**
5.1 Pre admission assessment is completed prior to admission. This enables the named nurse to draw up an agreed plan of care to meet the patients initial needs. This also assists staff in referring the patient to other professionals amd obtaining necessary equipment to meet their immediate care needs. Our pre admission assessment was afuited on 29.06.14. 5.2 Using the pre admission assessment and information received from the care management plan, resident and next of kin, a care plan is completed to meet the needs of the patient enabling them to settle into the Home with the patients care needs met. 8.1 Nutritional screening is completed in the pre admission assessment. On admission the malnutrition universal screening tool is completed.	Compliant

11.1 The Braden Scale is completed in the pre admission assessment. This includes nutritional, pain and continence. A further assessment is completed on admission to the Home.	

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**
5.3 Nursing intervention is obtained from patients, their representatives and care managers in the pre admission assessment form. This is ongoing from admission to the Home through to permanent placement reviews. Where necessary taking into account recommendations from other health professionals.	Compliant

11.2 After all assessments have been completed and input is required from other professional bodies the necessary referral arrangments are in place i.e. referral forms are completed and forwarded to the specialist services. If urgent advice or support is required this is stated on the referral form and followed up by phone. The date the form was sent was recorded on the referral form and daily statement. A copy of the referral form is maintained in the care plan. 11.3 Referral arrangements are inb place to obtain advice and support from tissue viability and other professional bodies. A treatment programme is drawn up to meet the individuals needs. 11.8 An appointment is arranged with the podiarty department and referral form completed. If the patient requires urgent referral this is stated at the time of referral. The date the referral has been sent and a copy of the referral form is maintained in the care plan. Any information and advice is recorded in the care plan and daily report. 8.3 A referral form is completed and sent to the Nutrition and Dietician Department. A copy of the completed referral form is sent to the G.P. for their information. If we require an urgent visit or adbice thssi is stated on the referral form and followed up by a phone call to inform the dietician. A copy of the referral form and the date is maintained within the care plan.	
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**
All assessments are ongoing. The named nurse will identify a date to reassess and evaluate risk assessments. Nursing interventions are reviewed on a three monthly basis or more frequently if required.	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**
5.5 Nursing interventions, activities and procedures are supported by research evidence are support by research evidence and best practice guidelines documents to evidence based practice and research available to staff on line. 11.4 A grading tool is used to screen patients. A treatment plan is implemented which include treatment prescribed by the relevant professional bodies. 8.4 Patient individual reccomendations from the department of Nutrition and Dieticians are maintained in care plans. Manor Healthcare company policy is available. Nutritional Guidelines and menu checklists for adults with a learning disability in residential and nursing homes. Nutritional guidelines and menu checklists for residential and nursing homes for older people are available with the Home.	Compliant

Section E

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

Criterion 5.6

- **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.**

Criterion 12.11

- **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.**

Criterion 12.12

- **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.**
  Where a patient is eating excessively, a similar record is kept.
  All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.6 Nursing records which include care plans, activities of living, nursing intervention, daily statement, daily reporting, yearly premanent care team reviews, medication prescription, weight recording charts and risk assessments. These are some of the records maintained in accordance to NMC. 12.11 A record is kept and maintained after each meal of the patients choice. A menu plan is displayed within the dinning area and catering department. 12.12 A daily food recording chart and fluid balance chart is recorded after each meal time for those patients suffering from a poor appetite. These charts are reviewed at the end of the day and a comment is made in the daily statement of the fluid intake and the condition of the patients appetite. A record is also maintained of the patients weight. This also includes the patient who would eat excessively. If concerns are noted regarding the patients intake of food or fluids the patient is referred to the relevant professional bodies. A record is maintained in the daily statement, care plan and daily report. Next of kin are kept informed of any changes. Reccomendations from the professional bodies are maintained. Staff are informed through the daily report and care plan.	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**
5.8Outcome of care delivered on a daily basis and recorded in daily report writing and care planning. An audit officer has been introduced to monitor the care delivered. This audit takes place on a monthly basis. Reviews by the permanent care placement team monitor the care delivered. Patient forum to seek feedback where possible from the patients. Relatives views are sought using invitations to social events within the Home and invitations to attend permanent care review meetings. Relatives questionnaires are alson sent annually to obtain relatives views on the care provided and overall view of the Home.	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**
5.8 Where possible patients will participate in multidisciplinary review meetings. On each occasion the care manager will meet with the patient and where possible will meet with the patients representative. 5.9 Minutes of all reviews are maintained within the patients care plan. A copy of the minutes are forwarded to the patients representative. Any changes to care planning are made as per the outcome of the review.	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**
12.1 Patients are provided with a nutritious and varied diet. Company policy, nutritional guidelines as mentioned in 8.4 are adhered to when planning menus. Advice for individual patients is provided by the dietician. Patient age is also taken into consideration when planning menus. 12.3 Patients are offered a choice of meals. Menu choice suits all ages. Patients choice of menu is collected by staff prior to the meal being served. However if the patient prefers something different then an alternative meal is provided as per patient choice. A choice of meal is also provided for patients receiving a pureed meal	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**
8.6 Nurses have attended training with an update in managing feeding techniques to be arranged. 12.5 Meals are served at appropriate intervals throughout the day in keeping with best practice guidelines. A choice of hot and cold drinks and a variety of snacks are available to meet patient choice and dietary requirements. Fresh drinking water is available at all times. 12.10 Staff are aware of the individual needs of patients. They are also aware of those residents requiring assistance, and	Compliant

special aids, to make meal times an enjoyable experience. Meals are served promptly with all staff in the dinning area, to give assistance, choice and an explabation of the meal. Choices of condiments and fluids are also available and servced by staff. 11.7 Two registered nursing staff have received training in the managemnt of wound care.	

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.

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Primary Inspection

Queenscourt

24 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 Ms A Colgan, Nurse in Charge and with Mrs Geraldine Borelan, 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	27 (2) (b) (d)	The registered person shall, having regard to the number and needs of the patients, ensure that- The premises to be used as the nursing home are of sound construction and kept in a good state of repair externally and internally. **Reference: Follow up on previous issues**	Two	New floor in corridor has replaced worn tired carpet. New chairs purchased for dinning Room. Selected bedrooms repainted. On going external Maintenance to grounds and building	Within three months from date of this inspection
2	15 (2) (a)	The registered person shall ensure that the assessment of the patient's needs is kept under review. Risk assessments should be reviewed and updated at least monthly or more frequently in response to changes in the patient's condition. **Reference: Section B**	One	Risk assessments are now reviewed Monthly. Care Plan audits are carried out Monthly or more frequent if necessary as part of the Regulation 29 Provider Visit Report.	From the date of this inspection
3	16 (2) (b)	The registered person shall ensure that the patient's care plan is kept under review. Care plans should be reviewed and updated at least monthly or more frequently in response to changes in the patient's condition.	One	Care plans are reviewed Monthly and more frequently to include Short Term problems.	From the date of this inspection

		Reference: Section B			
4	13 (1) (a)	The registered person shall ensure that the nursing home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. The registered manager should ensure that the needs of the identified patient have been re-assessed and an appropriate care plan has been implemented to meet these needs. **Reference: Section I**	One	This has been put in place, areas have been reassessed and care plan re written.	From the 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	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	20.4	The registered manager should ensure there is an identified first aider on duty for each shift. **Reference: Follow up on previous issues**	Two	Five Nursing staff successfully completed First Aid Training in Oct/Nov 2014. Remaining staff to complete Training in Feb/March 2015. Identified First Aider written on the notice board in office	From the date of this inspection
2	11.3	The registered manager should ensure that, for those patients identified as being at risk of developing a pressure ulcer, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant professionals. The following areas should also be addressed: • assessments and care plans for management of pain are in place for patients assessed as having a wound/pressure ulcer and for all patients in receipt of prescribed analgesia • repositioning charts should be in place for patients identified as being at risk of developing a pressure ulcer and should evidence that patients' skin condition was inspected at each positional change • wound observation charts are maintained for all patients with	One	Repositioning and skin condition observation charts are in place for three identified at Risk residents. Wound observation charts, including Body Map charts and comments are recorded on each resident when wounds are redressed. The wound assessment chart includes all stated in the recommendations plus skin Care, cleanser and dressing Each resident has	From the date of this inspection

		pressure ulcers/wounds. The assessment recorded after each dressing renewal should include the dimensions of the wound, descriptions of the wound base, exudate, odour and the appearance of surrounding skin • appropriate pressure relieving equipment should be in place for patients identified as being at risk of developing a pressure ulcer . **Reference: Section B**		an individual chart. Pressure relieving equipment such as Airflow Mattresses, Cushions, hand splints are in place for those residents at Risk. Input from physio and O/T is also adhered to. The abbey Pain scale for Measurement of Pain in people with dementia is recorded before and after Pain relief is administered	
3	5.1	The registered manager should ensure that body mapping charts are completed for all patients on admission and reviewed and updated when any changes occur to the patient's skin condition. **Reference: Section B**	One	A body Map was completed for our last admission on 26th Sept '14 and signed by 2 staff. Body Mapping is included in all wound observation charts or patients with changing skin conditions.	From the date of this inspection
4	8.3	A recommendation has been made to ensure that, for those patients identified as being at risk of inadequate or excessive food and fluid intake: • a fluid intake target over 24 hours is recorded in the relevant care plan and on fluid balance charts • an effective reconciliation of the total fluid intake against the fluid target established • action to be taken if targets were not	One	All identified patients Fluid intake is recorded on fluid Balance Charts. It is recorded in the care Plan by the N.I.C. Fluid Target for each Individual is calculated and recorded on F.B.C. If the target has not been Met, the action is recorded in the	From the date of this inspection

		being achieved. **Reference: Sections B and E**		Nursing Intervention/ Action Plan of the Patients Care Plan.	
5	11.7	It is recommended that: • all registered nurses undertake wound care training and their competency is assessed to ensure training has been embedded into practice • all care staff complete training in relation to pressure area care and the prevention of pressure ulcers and their competency is assessed to ensure training has been embedded into practice. **Reference: Section B**	One	Wound Training was due to take place on 14th + 19th Nov. 2014 These dates were Rescheduled by the trainer to 16th Dec. 2014 with a further date to be arranged. This training includes Nursing and Care staff.	Within six weeks from receipt of this QIP
6	25.11	The registered manager should ensure that an action plan has been developed to address any deficits or areas for improvement identified through the regular monthly audits of care records. **Reference: Section C**	One	Monthly audits of Care plan include Details of Action Taken for Improvement with an overview that identifies all the needs and abilities of residents	From the date of this inspection
7	8.1	It is recommended that the Malnutrition Universal Screening Tool (MUST) is used as the tool for the assessment of patients nutritional risk assessments. **Reference: Section D**	One	MUST has replaced The Community Nutrional Risk Scoring Tool in patients Care Records.	From the date of this inspection

8	5.5	It is recommended that the following research and guidance documents should be made available in the home for staff to access: • DHSSPS 'Promoting Good Nutrition' A Strategy for good nutritional care in adults in all care settings in Northern Ireland 2011-16 • The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes • The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care • The European Pressure Ulcer Advisory Panel (EPUAP). **Reference: Section D**	One	The recommended research and guidance documents are available for staff information	Within two weeks from the date of this inspection
9	12.1	The registered manager should ensure that catering staff receive written confirmation of the guidance provided by dieticians and other professionals for those patients on therapeutic or special diets. **Reference: Section D**	One	A file has been developed for Catering Staff Information. This file includes information from S.A.L.T, dept. of Nutrition and dietetics. File last updated 10th Dec 2014.	From the date of this inspection
10	28.4	It is recommended that update training on the importance of record keeping is provided for staff commensurate with their roles and responsibilities in the home.	One	Record Keeping and Care Plan Training was completed on 10th Nov. 2014	Within six weeks from receipt of this QIP

		Reference: Section E			
11	10.6	The registered manager should ensure that all relevant staff have training in responding to patients behaviour. Team reviews of all behaviour management interventions should be held to provide learning and practice development. **Reference: Section I**	One	All staff have up to date Behaviour Management Training with Last Training session completed on 8th Oct. 2014. Team Reviews on behaviour management interventions are discussed after issues occur	Within six weeks from receipt of this QIP
12	11.3	The registered manager should ensure that repositioning charts are in place for those patients identified as being at risk of developing a pressure ulcer. Repositioning charts should evidence that patients' skin condition was inspected at each positional change. **Reference: Section B**	One	Repositioning charts are in place for three residents identified this includes details of position change and skin condition observation.	From the date of this inspection

The registered provider / manager is required to detail the action taken, or to be taken, in response to the issue(s) raised in the Quality Improvement Plan. The Quality Improvement Plan is then to be signed below by the registered provider and registered manager and returned to:

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

Signed: _____ **Signed:** Geraldine Borelan

Name: Eoghain King **Name:** Geraldine Borelan
Registered Provider **Registered Manager**

Date 15th Dec 2014 **Date** 15th December 2014

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

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			