The Regulation and Quality Improvement Authority

Unannounced Secondary Care Inspection

Name of Establishment:	**Tamlaght Nursing Home**
RQIA Number:	**1400**
Date of Inspection:	**9 January 2015**
Inspector's Name:	**Norma Munn**
Inspection ID:	**20126**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Tamlaght Nursing Home
Address:	34 Larne Road Carrickfergus BT38 7DY
Telephone Number:	028 9336 6194
Email Address:	laura@tamlaghtnursinghome.com
Registered Organisation/ Registered Provider:	Tamlaght Private Nursing Home Limited
Registered Manager:	Mrs Fiona Maree Gray (Registration pending)
Person in Charge of the Home at the Time of Inspection:	Mrs Fiona Maree Gray
Categories of Care:	RC-I, NH-I
Number of Registered Places:	45
Number of Patients Accommodated on Day of Inspection:	40
Scale of Charges (per week):	£596.00
Date and Type of Previous Inspection:	25 March 2014 Primary unannounced inspection
Date and Time of Inspection:	9 January 2015 10:50 – 17:05 hours
Name of Inspector:	Norma Munn

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- Discussion with the home manager
- discussion with staff
- discussion with patients individually and to others in groups
- consultation with relatives
- review of a sample of staff duty rotas
- review of records pertaining to regulation 29 visits
- review of competency and capability assessments
- review of a sample of policies and procedures
- 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	16 individually and to others in groups
Staff	7
Relatives	2
Visiting Professionals	0

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

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

6.0 Inspection Focus

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

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

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

Standard 19 - Continence Management

Patients receive individual continence management and support.

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

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

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

7.0 Profile of Service

Tamlaght Nursing Home is a substantial two-storey dwelling which has been adapted and extended to create a 45 bedded nursing home. It is situated on a main bus route close to all facilities in the town of Carrickfergus and occupies a large corner site on the main Carrickfergus to Larne road.

In July 2013 the ownership of the home changed to Ms Laura Wheeler who is the responsible individual. Mrs Fiona Gray is the current manager of the home and has applied for registration with RQIA.

Bedroom accommodation is provided in both single and double bedrooms (41 single and two double). The first floor of the home is accessed by a passenger lift and stairs.

There is a range of toilet, bath and shower facilities, communal lounges and a large dining room. The home's gardens have been landscaped and provide a pleasant outlook for patients in the home.

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

Nursing care

I old age not falling into any other category

Residential care

I old age not falling into any other category up to a maximum of two residents

The home is also approved to provide care on a day basis only to 4 persons.

8.0 Executive Summary

This unannounced inspection of Tamlaght Nursing Home was undertaken by inspector Norma Munn on 9 January 2015 between 10 50 and 17 05 hours. The inspection was facilitated by Mrs Fiona Gray, home manager who was available throughout the inspection and was joined by Mr Trevor Gage, external consultant. Verbal feedback was provided to Mrs Gray and Mr Gage at the conclusion of the inspection. .

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection of 25 March 2014.

As a result of the previous inspection four requirements and three recommendations were issued. These were reviewed during this inspection and the inspector evidenced that three requirements were fully compliant and one requirement in relation to care records was assessed as not compliant and has been stated for a second time. All three recommendations have been fully complied with. Details can be viewed in the section immediately following this summary.

The inspector reviewed assessments and care plans in regard to the management of continence in the home. Review of patients' care records evidenced that patients and/or their representatives were informed of changes to patients need and/or condition and the action taken. Areas for improvement were identified with the care records and two recommendations have been made.

Nursing staff spoken with on the day of the inspection were knowledgeable regarding the management of urinary catheters and the frequency with which the catheters within the home required to be changed. Discussion with staff confirmed that staff had been trained and assessed as competent in urinary catheterisation.

From a review of the available evidence, discussion with relevant staff and observation, the inspector can confirm that the level of compliance with the standard inspected is substantially compliant.

Additional Areas Examined

Care Practices
Staffing
Patients and Relatives Comments
Staff Comments
Environment

Details regarding the inspection findings for these areas are available in the main body of the report. Areas for improvement were identified in relation to care practices, infection control and the environment. Requirements have been made.

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 and patients were observed to be treated by staff with dignity and respect. Good relationships were evident between staff and patients. Patients were well groomed, appropriately dressed and appeared comfortable in their surroundings. Those patients who were unable to verbally express their views were also observed to be well groomed, appropriately dressed in clean matching attire and were relaxed and comfortable in their surroundings.

As a result of this inspection four requirements and two recommendations have been made. One requirement made following the previous inspection was assessed as not compliant and has been stated for a second time.

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

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	13 (8)	It is required that a written nursing care plan is in place as to how the patient's needs are to be met. The care plan for patient B (identity known to the registered manager) should be further developed as follows; • a care plan regarding the planned nursing care to manage periods of behaviour challenging for staff should be developed in consultation with the patient/representative. • a pain assessment tool suited to the needs of the patient should be in place • a care plan regarding oral care and oral pain management should be implemented.	Discussion with the home manager and staff confirmed that the identified patient was no longer residing in the home.	Compliant
2.	16 (1)	The registered person shall make suitable arrangements to ensure that the nursing home is conducted in a manner which respects the privacy and dignity of patients.	Observation of the environment evidenced that a privacy curtain is now in place.	Compliant

3.	16 (2) (b)	It is required that where a patient has more than one wound, a separate initial wound assessment , ongoing assessment record and care plan stating the prescribed treatment and management regime is maintained for each wound. A wound care plan should evidence the decision making process when a registered nurse changes any prescribed wound treatment regime.	On the day of the inspection there were no patients residing in the home with more than one wound. Discussion with the registered nurses confirmed that they were knowledgeable regarding the recording of wound assessments and care plans.	Compliant
4.	16 (2) (b)	It is required that a procedure is established to evidence that patient's individual care plans are reviewed and evaluated on at least a monthly basis.	Review of three patients' care plans evidenced that care plans were not reviewed or evaluated monthly. Discussion with staff and the home manager confirmed that there is no procedure in place to review and evaluate care plans. This requirement has not been complied with and has been stated for a second time.	Not compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	25.12	It is recommended that the record of interviews with patients and relatives, contained within the Regulation 29 report are anonymised. Regulation 29 reports should also provide detail in the following areas. • a record of their opinion as to the standard of nursing provided in the home at the time of their visit • evidence that where deficits were identified an action plan is developed to address the deficits • evidence that previous action plans issued had been reviewed to ensure deficits previously identified were addressed or improved	Review of records of recent regulation 29 visits evidenced that this recommendation has been addressed.	Compliant
2.	16.3	It is recommended that the nurse in charge of the home competency assessments are further developed to include staff awareness of their role in dealing with and responding to allegations of suspected abuse.	Review of competency and capability assessments evidenced that this recommendation has been addressed.	Compliant

3.	25.20	It is recommended that the whistle blowing policy is further developed to include the contact details of internal and external sources to whom staff report concerns about poor practice.	Review of the whistle blowing policy evidenced that this recommendation has been addressed.	Compliant

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

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

Since the previous inspection on 25 March 2014, RQIA have been notified by the home manager of an ongoing investigation in relation to a potential or alleged safeguarding of vulnerable adults (SOVA) issue.

Following discussion with the home manager RQIA were satisfied that SOVA issues were dealt with in the appropriate manner and in accordance with regional guidelines and legislative requirements.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of three patients' care records evidenced that bladder and bowel continence assessments were undertaken as part of the assessment process within the home. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. One patient had continence needs identified through the assessment process however not all care plans to direct the care were fully completed. A recommendation has been made to ensure that care plans are fully completed for each individual assessed need In one patient's care record reviewed a care plan was in place for the management of a urine infection dated June 2014. Discussion with staff confirmed that this care plan was no longer required. A recommendation has been made to ensure that care plans for the management of urinary infections are discontinued when no longer required. . There was evidence in three patients' care records that bladder and bowel assessments were reviewed and updated on a monthly basis or more often. However, discussion with staff and a review of three patients' care records evidenced that continence care plans had not been reviewed or updated on a monthly basis or more often as deemed appropriate. It is required that a procedure is established to evidence that patient's individual care plans are reviewed and evaluated on at least a monthly basis. As discussed in section 9.0 this requirement has been stated for a second time Review of patients' care records evidenced that patients and/or their representatives were informed of changes to patient need and/or condition and the action taken.	Substantially compliant

Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	

STANDARD 19 - CONTINENCE MANAGEMENT **Patients receive individual continence management and support**	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place; • continence management / incontinence management • catheter care However, the policies and procedures relating to continence management should be reviewed and updated in keeping with best practice guidance. A recommendation has been made. 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.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not assessed.	Not assessed
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 staff confirmed that they were trained and assessed as competent in continence care. Identified nurses in the home were deemed competent in male and female catheterisation and the management of stoma appliances. The registered nurses informed the inspector that the continence link nurse in the Trust is available for guidance and support if needed.	Compliant

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.

On the day of the inspection patients were attending the hairdresser within the conservatory area of the home. The hairdresser was using the conservatory as a hairdressing salon. The inspector was concerned that this area of the home did not feel warm. Relatives who were visiting commented to the inspector that the conservatory felt cold. The inspector did not observe any means of heating in the conservatory and recorded the room temperature on the wall thermometer to be less than 16 degrees Celsius. Due to the low temperature of the conservatory the inspector immediately requested the patients be relocated to a warm area of the home. This practice of seating patients in this cold environment was unacceptable. A requirement has been made.

11.2 Staffing

Duty rotas for weeks commencing 22 December 2014 and 29 December 2014 were reviewed and evidenced that staffing numbers were in keeping with RQIA's recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection.

11.3 Patients and relatives views.

During the inspection the inspector spoke with sixteen patients individually and with the majority of others in smaller groups. Patients spoken with confirmed that they 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.

Two relatives spoken with commented positively regarding the attitude of staff and the care their loved ones received. They confirmed that the staff in the home kept them informed of any changes to their relatives' condition and consulted with relevant healthcare professionals in a timely way.

Five completed questionnaire from patients and one from a relative were received by the inspector during the inspection.

As discussed in section 11.1 visiting relatives commented that the conservatory in the home felt cold. This issue was discussed with the home manager. There were no other issues or concerns raised with the inspector during this inspection.

11.4 Questionnaire Findings/Staff Comments

During the inspection the inspector spoke with seven staff and received six completed questionnaires during the inspection. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

No issues or concerns were raised by staff during this inspection.

11.5 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a high standard of hygiene.

The inspector observed fire doors in the conservatory and store room wedged/propped open when not in use. The practice of wedging/propping open fire doors must cease and a requirement has been made.

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

- Hoists, slide sheets and slings and were stored in bathrooms/shower rooms
- an area of flooring in the ground floor corridor had an uneven surface and was identified as a potential trip hazard for patients

Requirements have been made.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Fiona Gray, home manager and Mr Trevor Gage, external consultant, as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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BT1 3BT

Norma Munn

Norma Munn
Inspector/Quality Reviewer

4/2/15.

Date

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 A pre-admission assessment is done prior to admission to provide a base line and to enable the named nurse to draw up an agreed plan of care to meet the resident's individual needs. This also assists staff to make appropriate onward referrals to other professionals. 5.2 The home uses Roper, Logan and Teirney to complete a comprehensive, holistic assessment and other validated assessment tools such as MUST and Braden. The resident and their family are also consulted. 8.1 Initial nutritional screening is carried out during the pre-admission assessment. On admission MUST is completed. 11.1 Braden is used to assess the resident's level of risk in relation to pressure ulcers.	Compliant

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
5.3 Each resident has a named nurse who liases with the resident, their family and other health professionals to ensure identified needs are met. 11.2 Where input is required from other professionals, there is a referral process which is followed. Forms are completed and if input is urgent this is highlighted on the referral form and is followed up with a phone call. 11.3 There are referral arrangements in place to obtain advice and support from Tissue Viability and other professional bodies. All care plans are individualised. 11.8 When appropriate, a referral is made to the podiatrist. A refferal form is completed and a copy kept on file and where necessary the request can be marked as urgent. 8.3 As required by the individual resident, a referral may be made to the dietician and associated others such as speech and language, they will assess the residents needs and prescribe an individualised plan of care which will then be followed.	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**
5.4 All assessments are ongoing. The named nurse will identify a date to re-assess and evaluate risk assessments. Nursing interventions are reviewed monthly 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 All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. 11.4 A validated pressure ulcer grading tool is used to screen residents and an appropriate treatment plan put in place to include input from other professionals. 8.4 The resident's individual recommendations from Nutrition and Dieticians are maintained in the resident's care plan. Nutritional Guidelines and menu checklists for residential and nursing homes for older people are available within 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 Contemporaneous nursing records are kept in accordance with NMC guidelines for records and record keeping. These include all nursing interventions, activities and procedures carried out and their outcomes for the resident. 12.11 A record of the menu offered at each meal and what the resident has taken is maintained. 12.12 A daily food chart is recorde which reflects the residents choices on that day. A fluid balance chart is also maintained for those residents whose appetite or fluid intake is causing concern. These charts are reviewed by nurses at the end of the day and an entry made in the progress notes. Where concerns arise a referral is made to the relevant professionals. A record of all referrals is maintained in the Care Plan. Families and care managers are informed of any concerns and a holistic approach put in place to address the concerns.	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**
5.8 The daily report includes outcomes of care delivered on a daily basis. The care plans are reviewed monthly by the named nurse. Care Managers monitor the ongoing care provided by the home to their individual residents and work with us to constantly improve the residents experience. Relatives are encouraged to participate in the life of the Home, to attend care reviews and are asked to complete an annual review questionaire.	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 it is possible and appropriate, the resident is invited to participate in multidisciplinary review meetings. The Care Manager will seek for their and their families input into the process. 5.9 The outcome of care reviews are kept in the residents care plan. Any changes desired or issues raised are addressed and implemented as appropriate following 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 Residents are provided with a nutritious and varied diet which takes into account the national guidelines and individual dietary needs. Input from other professionals is also implemented. 12.3 Choice is offered at each meal time, at point of delivery to the resident, and individual likes and dislikes are catered for. Residents on a modified consitancy diet are also given choice.	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 appropriate knowledge of and skills in managing feeding techniques for residents who have swallowing difficulties. Training has been provided. 12.5 Meals are served at appropriate intervals throughout the day in keeoing with best practice guidelines. Hot and cold drinks are available at any time, and snacks are always available. Fresh drinking water is also available at all times. 12.10 Staff are aware of each individuals needs in respect of diet, consistency, assistance needed and any special aids required. Staff are assigned appropriately to ensure a pleasant dining experience. 11.7 Staff Nurses have the expertise necessary to ensure that wounds are assessed and appropriate products prescribed for use. Nurses have been trained by a Tissue Viability nurse. They also know when it is appropriate to ask assistance/input from other professionals.	Compliant

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 Care Inspection

Tamlaght

9 January 2015

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 Fiona Gray, home manager and Mr Trevor Gage, external consultant 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.	16 (2) (b)	It is required that a procedure is established to evidence that patient's individual care plans are reviewed and evaluated on at least a monthly basis **Ref: Section 9.0 and 10.0, criterion 19.1**	Two	A new process has been established and a new Named Nurse list to assign and induct new staff into the process. A computerised system is being installed in April 2015	Ongoing
2.	13 (1) (a) and (b)	The registered person must review the delivery of care to ensure that all areas of the home where patients have access are adequately heated **Ref: Section 11.1**	One	The conservatory is no longer being used during the winter months.	By 6 February 2015
3.	27 (4)	The registered person must ensure that the practice of wedging/propping open fire doors must cease. **Ref: Section 11.5**	One	All staff have been reminded that fire doors are never to be wedged open. Signs in place to that effect.	By 6 February 2015
4.	14 (2) (a)	The registered person must ensure that • the identified area of flooring in the corridor is replaced or replaced **Ref: Section 11.5**	One	The area of floor which had an uneven surface has been made good in the corridor.	By 6 February 2015

5	13 (7)	The registered person must ensure that hoists, slide sheets and slings are not stored in the bathroom/shower room **Ref: Section 11.5**	One	All bathrooms are free of clutter	By 6 February 2015

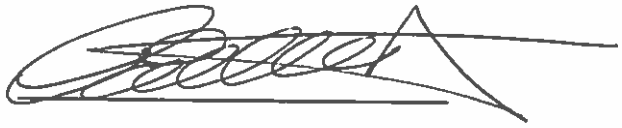
Recommendations

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.	19.1	The registered person must ensure that • Care plans are fully completed for each individual assessed need. • care plans for the management of urinary infections are discontinued when no longer required **Ref: Section 10.0, criterion 19.1**	One	We are doing ongoing work on the care plans in preperation for the new computerised system being installed in April 2015.	By 6 February 2015
2.	26.2	The registered person must ensure that policies and procedures in relation to continence management are reviewed in keeping with best practice guidance **Ref: Section 10.0, criterion 19.2**	One	Up-to-date guidelines on best practice are available in the home.	By 6 February 2015

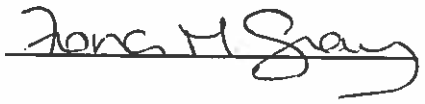
The registered provider / manager is required to detail the action taken, or to be taken, in response to the issue(s) raised in the Quality Improvement Plan. The Quality Improvement Plan is then to be signed below by the registered provider and registered manager and returned to:

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

SIGNED: 

NAME: LAURA WHEELER
Registered Provider

DATE 3/3/2015

SIGNED: 

NAME: FIONA GRAY
Registered Manager

DATE 03.03.15

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Norma Lynn.	10/3/15.
Further information requested from provider	Yes.	Norma Lynn.	4/3/15