Unannounced Care Inspection

Name of Establishment:	**Drummaul House**
Establishment ID No:	**1411**
Date of Inspection:	**24 November 2014**
Inspector's Name:	**Bridget Dougan**
Inspection No:	**IN017069**

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

1.0 General Information

Name of Home:	Drummaul House
Address:	41 New Street Randalstown BT41 3AF
Telephone Number:	028 9447 3958
E mail Address:	mariabothwell@hutchinsonhomes.co.uk
Registered Organisation/ Registered Provider:	Hutchinson Homes Ltd Mrs Naomi Carey Mrs Janet Montgomery
Registered Manager:	Mrs Maria Bothwell
Person in Charge of the Home at the time of Inspection:	Mrs Maria Bothwell
Categories of Care:	RC-I, RC-MP(E), RC-PH(E), NH-I, NH-PH
Number of Registered Places:	43
Number of Patients Accommodated on Day of Inspection:	38
Scale of Charges (per week):	£461.00 - £581.00 plus £30 Top Up Fee
Date and type of previous inspection:	03 June 2013 Primary Unannounced
Date and time of inspection:	24 November 2014: 11.30am to 4pm
Name of Lead Inspector:	Bridget Dougan

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- Discussion with the registered manager
- Discussion with staff
- Discussion with patients individually and to others in groups
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- Review of a sample of care plans
- Observation during a tour of the premises
- Evaluation and feedback.

5.0 Consultation Process

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

Patients/Residents	**20**
Staff	**7**
Relatives	**2**
Visiting Professionals	**0**

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**6**	**6**
Relatives/Representatives	**2**	**2**
Staff	**7**	**7**

6.0 Inspection Focus

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

STANDARD 19 - CONTINENCE MANAGEMENT

Patients receive individual continence management and support.

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

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

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

7.0 Profile of Service

Drummaul House is situated in its own grounds in a quiet area on the edge of Randalstown.

The home is a two-storey building, which has been extensively developed and extended.

Facilities available include 37 single and three double bedrooms located on both floors.

Communal lounges and dining rooms are also provided and a hairdressing salon and visitors' room is located on the first floor.

Toilet, bathing and showering facilities are available throughout the home. Catering and laundry facilities are available on site.

Car parking is provided to the front of the home.

The home is registered to provide care for a maximum of 43 persons under the following care categories.

Nursing Care-

I	Old age not falling within any other category
PH	Physical Disability under 65 years

Residential Care

I	Old age not falling within any other category
PH (E)	Physical Disability over 65 years
MP (E)	Mental Health over 65 years.

8.0 Executive Summary

The unannounced secondary inspection of Drummaul House was undertaken by Bridget Dougan on 24 November 2014 between 11.30am and 4pm. The inspection was facilitated by Mrs Maria Bothwell, Registered Manager who was available for verbal feedback at the conclusion of the inspection.

During the course of the inspection, the inspector met with patients/residents, relatives and staff who commented positively on the care and services provided by the nursing home.

As a result of the previous inspection conducted on 3 June 2013 nil requirements and nil recommendations were issued.

Conclusion

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

The management of continence within the home was of a good standard and one recommendation has been made in respect of the development of a policy/procedure on stoma care. The inspector‘s overall assessment of the level of compliance in this area is recorded as ‘Substantially Compliant’.

The home's general environment was well maintained and patients/residents were observed to be treated with dignity and respect. Therefore, nil requirements and one recommendation have been made following this inspection. This is detailed throughout the report and in the quality improvement plan (QIP).

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

9.0 Follow-Up on Previous Issues – 03 June 2014

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
		No requirements were made as a result of this inspection.		

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
		No recommendations were made as a result of this inspection.		

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

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

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

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of three patients' care records evidenced that bladder and bowel continence assessments were undertaken for all patients. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. There was evidence in three patients care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. Review of three patient's/residents care records and discussion with patients/residents evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. The care plans reviewed addressed the patients/residents' assessed needs in regard to continence management. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Compliant

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. It is recommended that a policy and procedure on stoma care be put in place. 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
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not applicable	
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**

Inspection Findings:	
Discussion with the acting manager and review of training records confirmed that all relevant staff were trained and assessed as competent in continence care. Registered nurses received training in male and female catheterisation and had been deemed competent in this area. The inspector was informed that regular audits of the management of incontinence were included in care plan audits and the findings acted upon to enhance standards of care.	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/residents with dignity and respect. Good relationships were evident between patients/residents and staff.

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

11.5 Patients/Residents and Relatives Comments

During the inspection the inspector spoke with 20 patients/residents individually and with the majority of others in smaller groups.

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

Some comments received from patients/residents and relatives:

- “Everything is great. The food couldn’t be better.”
- “I would like a jug of cold water on the table at meal times.”
- “The only concern I have is that my mother doesn’t want to go to activities and the activities therapist keeps asking her if she would like to attend.”
- “Staff treat me and my belongings with respect.”
- “The home is a happy and welcoming place.”

The issues raised by the one patient and one relative were discussed with the registered manager who agreed to address them.

11.6 Questionnaire Findings/Staff Comments

Review of a sample of staff duty rosters evidenced that the registered nursing and care staffing levels were found to be in line with the RQIA’s recommended minimum staffing guidelines for the number of patients/residents currently in the home. The inspector met with staff during the inspection and no concerns were expressed with regard to staffing at that time, however, review of completed questionnaires indicated some dissatisfaction with the current staffing levels. This was discussed with the registered manager following the inspection and it was agreed that staffing levels would be kept under review.

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

During the inspection the inspector spoke with seven staff. The inspector was able to speak to a number of these staff individually and in private. Seven staff completed questionnaires.

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

- “Drummaul House is a very well organised/run home.”
- “I feel that more staff could be put on through the day to allow more time to talk to residents.”
- “Drummal has high standards of care. Overall, I would suggest that the care rendered is top quality.”
- “A lovely home with good staff that care.”
- “The only time to talk with residents is when working with them or assisting with toileting which makes it difficult to listen or reassure them with their concerns.”

11.7 Environment

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

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed Mrs Maria Bothwell, Registered Manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

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

Enquiries relating to this report should be addressed to:

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The Regulation and Quality Improvement Authority
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Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.1 This information is recorded initally prior to admission to the home as a representative from the home will carry out an assessment to ensure we can meet the individuals needs of the patient. This assessment is based on Roper, Logan and Tierneys 12 activities of daily living. Information on assessments carried out by the occupational Therapist, physiotherapist, social worker and medical staff is also used to form part of this pre admission assessment. Other information is also obtained at that time such as medical history, allergies, next of kin, religion, a list of current medication and is there a need for any specialist equipment e.g. profiling bed or air mattress. We also assess for any	Compliant

infection risk using the GAIN assessment tool. Patients representatives are encouraged to be present if possible when this initial assessment is taking place. On admission to the home a nurse will carry out an initial assessment of all needs using the Roper, Logan and Tierney model of nursing. Following this the homes representative who carried out the assessment will make contact with the patients named worker and an admission date is agreed. The named worker will provide us with a detailed plan of care prior to the patient being admitted to the home. 5.2 On admission a named nurse is allocated to the patient and a holistic assessment of the patients needs are completed using the Roper, Logan and Tierney model of nursing. Other assesments that are carried out include the braden scale, moving and handling, falls risk assessment, continence assessment,community nutritional risk assessment, body mapping record, oral hygiene assessment, bedrail assessment and resusitation status amongst others. All of the above assessments are completed within 11 days of admission. 8.1 Nutritional screening is carried out on every patient on admission using the MUST tool and this is reassessed monthly or more frequent if indicated by the dietician or if the individuals needs change. 11.1 During the pre admission assessment a most recent Braden score is obtained where possible through laison with the multidiscliplinary team and information in relation to nutritional status, continence and pain are also obtained during this assessment. On admission to the home risk assessmens are carried out using the Braden scale, Malnutritional Scoring Tool, continence assessment and the abbey pain scale which is combined with the clinical judgement of the nurse who is carrig out the assessment.	

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 On admission a named nurse is allocated to the patient and they have responsibility for planning nursing intervention to meet the identified needs of the patient. An individualised care plan is developed once all assessments	Compliant

have been carried out, this is then implemented and assessed on a monthly basis thereafter or as required. At various times following admission a review will be carried out with the patients named worker, a staff nurse or social care worker and relatives where all the identified needs are disussed and agreed upon. Recommendations from other members of the multidisciplinery team are always included in the care plan and maximum independence is promoted. 11.2 There are arrangements in place for staff to obtain advice and support from the tissue viability nurse when required.The staff can contact them via the telephone for immediate advice and guidence then follow up with a written referral on the tissue viability referral forms that are available in the home. Non urgent referrals are sent in writing by the registered nurse or social care worker. 11.3 When a patient is assessed "at risk" of developing pressure ulcers a documented prevention and treatment plan is devised and detailed within the careplan. This will be done in conjunction with other relevent health care professionals i.e. the GP, Tissue Viability Nurse and the Dietician. 11.8 Staff can make an immediate telephone referral to the Tissue Viability Nurse and gain advice and guidence in relation to current wound treatments that would be suitable. This would then be followed up by a written referral. Within the home we have a private podiatry service called 'fitter feet' which we can contact by telephone and have a visit within 24 hours if it was deemed an emergency, we can also avail of the health service podiatrist by making a telephone referral.We can also refer to the GP and dietician for their involvement in diagnosing and treating the patient if it was assessed as necessary. 8.3 If the patient has been assessed as high risk following nutritional screening using the MUST tool a referral is made to the dietician. This referral will be made verbally first followed by a written referral, and any treatment suggested will be implemented immediately. Within the referral the Dietician will also be informed if any other members of the multidisciplinary team that are involved e.g. the speech and language therapist may have recommended a soft mashed diet. The named nurse will update the care plan and the kitchen staff are verbally updated initially and then given a copy of the nutritional plan when it is sent to the home.	

Th new nutritional guidelines 2014 by the public health agency and menu checklist for nursing and residential homes are displayed on the notice board in the nurses station for care staff and a copy is in the kitchen for the catering staff. The speech and language therapist guidelines and the dysphagia diet and food texture descriptors (March 2012 - national patient Safety Agency) are also available at the nurses station for staff reference.	
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 Reassessment is carried out daily by day and night staff and recorded in the daily nursing progress notes. Identified reassessment dates are documented in the care plan evaluation which is every month or earlier as required. With wound care re assessment is carried out every time the wound is redressed (which can be every day,2days,3days) this will be specified within the individual care plan.	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 A list of common guidelines to support all nursiong interventions, activities and procedures are placed at the nurses station and include the Crest Guidelines in relation to prevention and management of pressure sores and the general principles of caring for patients with wounds amongst others. 11.4 The NPUAP (National Pressure Ulcer Advisory Panel 1989) tool is used as advocated by the Crest Guidelines and detailed within The Crest Guidelines for the prevention and management of pressure sores. An appropriate care plan will be devised and treatment plan implemented. 8.4 The nutritional guidelines and menu checklist booklet 2014 for nursing and residential homes is readily available for use within the home, one copy is kept at the nurses station and the other copy is in the kitchen.	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 are kept in accordance with the NMC guidelines and contain outcomes for each identified problem following the assessment carried out using the Roper, Logan and Tierney model of nursing. All our records are computerised and we have a policy in place called the DO's and Don't's of record keeping which was devised using the NMC record keeping guidence for nurses and midwives. The care plans are audited on a regular basis against this policy to ensure they are followed. 12.11Kitchen staff keep a record of all meals provided to each patient. More detailed information is recorded in food/fluid charts by the nursing staff for patients assessed as high risk. 12.12 If a patient chooses not to eat a meal the staff will report this to the nurse in charge who will document this in the	Compliant

individual patient records. The member of staff will in the first instance offer the patient an alternative meal at that time . If the patient is on a Food/fluid chart this will be completed. When a patient is eating excess food a record will also be kept to moniter the intake. Any concerns in relation to patients dietry needs will be referred to the relevent professionals and a copy of this referral will be kept in the patient notes and any actions/recommendations will be docunentated.	
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**
5.7 Care delivered is monitered and recorded in the daily progress notes of each patient on a daily basis which is held on the computerised epicare system. The outcomes are evaluated at agreed times and documented in the evaluation sheet of the careplan. patients and their representatives are kept up to date of any changes in care by staff speaking with the patient and making telephone contact with the representative as soon as possible. Formal reviews are carried out in conjunction with the trust staff. The homes staff invite representatives to meet with them at agreed times to discuss the patients careplan.	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 appropriate and able patients are encouraged and facilated to attend formal multidisciplinery review meetings carried out by the local HSC trusts. Patients and their representative are spoken to prior to the review commencing to ascertain if this is suitable and appropriate for that individual patient. If the patient is not in attendance during the review they are always consulted at the end if this is possible. During the review the patient is offered the chance to comment on all aspects of the care delivered and the outcomes of them. 5.9 The results of all reviews are immediately recorded in the patients care records and the nursing careplans are updated accordingly. These results will be agreed with patients and their representatives during the review and prior to any changes being implemented. The home recieves a documented copy of the review carried out by the trust staff and this is kept with the patients notes. Patients and their representatives are kept informed of progress being made and any change to the nursing care plan by the staff nurses on a daily basis.	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 which is tailored to meet individual dietry needs and preferences. the "nutritional guidelines and menu checklist for nursing and residential homes for older people(2014)" is used as part of the planning menu process. The menu is rotated over a three week basis. On admission the cook will speak with the patient and or their representative to establish the individuals likes and dislikes. This information is documentated and left available for all staffs use. All the meals are homecooked this includes traybakes/cakes atc provided for afternoon teas. All patients are offered a choice of meal on a daily basis. Guide lines are available for all care staff on individual patients needs as provided by the dieticians and a copy is given to the kitchen staff also. 12.3 There is an alternative menu available if the patient does not like the option available at that specific meal time. There is also a choice available for patients on specific diets e.g.diabetic or soft diets.	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 Training on Dysphasia,Nutrition and Hydration has been carried out in May/June 2014 for all care and catering staff which included the thickening of fluids as per the nutilis guidelines and the Dysphagia Diet food texture descriptions as per the National Patient Safety Agency. The outcomes of assessments carried out by the speech and language therapist are documented in the staff communication book and are also placed on the notice board in the nurses station for all staff to read, then these are placed in their notes and care plans are updated if required. Kitchen staff are also given a copy of the outcome of the	Compliant

assessment to read and sign. 12.5 Breakfast is served form 9.30 - 10.30 am, juice is offered at 11am, lunch is served between 12.30 - 1.30pm, tea and biscuits/traybakes are provided at 3pm, dinner is served at 5pm then evening tea with snacks is served at 7pm. Jugs of water or juice depending on the patients choice is provided within all day rooms and patient bedrooms if they spend time within their bedroom area. 12.10 Within each patients careplans dietry requirements are documented. All care staff have a daily report with up to date information about all patients needs to include their dietry requirements. A list of individual diet consistencies and fluid type is displayed in each dining room and readily available for all staff to see. The kitchen staff are provided with a copy of the record sheet detailing diet consistencies as recommended by the speech and language therapist. Adequate staffing is available at mealtimes to give assistance to those who require it. A table with guidelines on the use of fluid thickener is placed in both dining rooms for all staff to refer to. Specific aids and utensils are available for individual patients as required. 11.7 There are regular opportunities available for nurses to attend training sessions in relation to wound assessment and care to develop their expertise and skills in wound management to include carrying out a wound assessment and applying wound care products and dressings.	

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

Appendix 2

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

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

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

References

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

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

Quality Improvement Plan

Secondary Unannounced Care Inspection

Drummaul House

24 November 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 Mrs Maria Bothwell, 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
		No requirements were made as a result of this inspection.			

Recommendations

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

No.	Minimum Standard Reference	Recommendation	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	19.2	It is recommended that a policy and procedure on stoma care be put in place. **Reference: Section 10: Criterion 19.2**	One	A policy and procedure on stoma care has been developed and available for all staff to refer to.	Within two weeks from date of inspection

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Maria Bothwell
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Janet Montgomery

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Bridget Dougan	14 January 2015
Further information requested from provider			