Unannounced Primary Inspection

Name of Establishment:	**Ashwood House**
Establishment ID No:	**1413**
Date of Inspection:	**07 August 2014**
Inspector's Name:	**Bridget Dougan**
Inspection No:	**17111**

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:	Ashwood House
Address:	2/10 Ashgrove Road Glengormley BT36 6LJ
Telephone Number:	(028) 90837270
E mail Address:	admin@ashwoodpnh.co.uk
Registered Organisation/ Registered Provider:	Mrs Mary Patricia Pollock
Registered Manager:	Mrs Ann Marie Morris
Person in Charge of the Home at the time of Inspection:	Mrs Elizabeth Jones, deputy manager
Registered Categories of Care and number of places:	NH-I, RC-I, RC-MP(E) 36
Number of Patients/Residents Accommodated on Day of Inspection:	35 patients/residents
Date and time of this inspection:	07 August 2014: 12.00 – 16.00 hours
Date and type of previous inspection:	06 February 2014 Unannounced Secondary

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

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

4.0 Methods/Process

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

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

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

- analysis of pre-inspection information
- discussion with the deputy manager
- examination of records

- consultation with stakeholders
- tour of the premises
- evaluation and feedback.

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

5.0 Consultation Process

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

Patients	**20**
Staff	**8**
Relatives	**0**
Visiting Professionals	**0**

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

Issued To	**Number issued**	**Number returned**
Patients	**4**	**4**
Relatives / Representatives	**0**	**0**
Staff	**8**	**8**

6.0 Inspection Focus

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

The criteria from the following standards are included;

- Management of Nursing Care – Standard 5
- Management of Wounds and Pressure Ulcers –Standard 11
- Management of Nutritional Needs and Weight Loss – Standard 8 and 12
- Management of Dehydration – Standard 12

An assessment on the progress of the issues raised during and since the previous inspection was also undertaken.

The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.

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

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

7.0 Profile of Service

Ashwood House Private Nursing Home is a thirty-six bed purpose built, two-storey nursing home, situated in a residential area on the outskirts of Glengormley.

The home is convenient to local shops, library and churches and is on a bus route.

Bedroom accommodation is provided in double and single rooms, some with en-suite facilities and there are a range of communal lounges and dining areas, toilets and bathrooms and shower facilities.

The first floor is accessed by the stairs and a passenger lift.

The home has ample car parking spaces and a nicely appointed garden.

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

Nursing Care	(Maximum 33 patients)
I	Old age not falling into any other category
Residential Care	(Maximum 3 residents)
I	Old age not falling into any other category
MP(E)	Mental disorder excluding learning disability or dementia - over 65 years

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) accurately reflected the categories of care and was appropriately displayed in a prominent position of the home.

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (unannounced) to Ashwood House. The inspection was undertaken by Bridget Dougan on 07 August 2014 from 12.00 hours to 16.00 hours.

The inspector was welcomed into the home by Mrs Elizabeth Jones, deputy manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to the deputy manager at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix 1.

During the course of the inspection, the inspector met with patients/residents, staff and one relative. The inspector observed care practices, examined a selection of records and carried out a general inspection of the nursing home environment as part of the inspection process.

Questionnaires were issued to patients/residents, staff and one relative during the inspection.

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

These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool is designed to help evaluate the type and quality of communication which takes place in the nursing home. A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix 2.

As a result of the previous inspection conducted on 06 February 2014, one requirement and three recommendations were issued. This requirement and the recommendations were reviewed during this inspection. The inspector evidenced that the recommendations had been fully complied with, however the requirement was moving towards compliance. Details can be viewed in the section immediately following this summary.

Standards inspected:

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

Standard 8: Nutritional needs of patients are met. (Selected criteria)
Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)
Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria)

Inspection Findings:

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

The inspector can confirm that at the time of the inspection there was evidence to validate that patients/residents receive safe and effective care in Ashwood House.

The inspector inspected three patients/residents care records and there was evidence of comprehensive and detailed assessments of patient/resident needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of the patients'/residents' needs was evidenced to inform the care planning process.

Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis plus as required.

Inspection of three patients/residents care records confirmed that written evidence was maintained to indicate that discussions had taken place with patients/residents, and their representatives in regard to planning and agreeing nursing interventions.

There was also evidence that the referring HSC Trust maintained appropriate reviews of the patients'/residents' satisfaction with the placement in the home and the quality of care delivered.

Compliance Level: Compliant

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

The inspector evidenced that wound management in the home was well maintained. There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment. Care plans for the management of risks of pressure ulcers and wound care were maintained to a professional standard.

Inspection of staff training records evidenced that staff as appropriate required a training update on the prevention of pressure ulcers. A recommendation is made in this regard.

Compliance level: Substantially Compliant

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

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

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

The inspector also observed the serving of the lunch meal and can confirm that the patients/residents were offered a choice of meal and that the meal service was well delivered. Patients/residents were observed to be assisted with dignity and respect throughout the meal.

Compliance level: Compliant

- **Management of Dehydration – Standard 12**

The inspector also examined the management of dehydration during the inspection. The home maintained fluid balance charts for those patients/residents assessed at risk of dehydration. The patient's daily fluid intake was also recorded in the daily evaluation of care and treatment records.

Compliance level: Compliant

Patients/their representatives and staff questionnaires

Some comments received from patients and their representatives:

"I'm very happy here"
"staff are very good to me"
"I enjoy the food"

Some comments received from staff:

"this is a very nice home and I enjoy coming to work"
"I feel that because most staff have worked here for a long periods and that the home is family run, that the care delivered is very good"
"this is a well run home in my opinion. Relatives and visitors always comment on how homely it is and there is always a good atmosphere here".
"I am very happy with the care provided in this home. When I am not here to get information, it is related to other members of my family"

A number of additional areas were also examined

- records required to be held in the nursing home
- Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)
- patient and staff quality of interactions (QUIS)
- complaints
- patient finance pre-inspection questionnaire
- NMC declaration
- staffing and staff comments
- comments from representatives/relatives
- environment.

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

Conclusion

The inspector can confirm that at the time of inspection the delivery of care to patients/residents was evidenced to be of a good standard. There were processes in place to ensure the effective management of the themes inspected.

The home's general environment was well maintained and patients/residents were observed to be treated with dignity and respect. However areas for improvement were identified in relation to staff training and the maintenance of the Regulation 29 reports in the home for inspection.

Therefore, one requirement made at the previous inspection has now been stated for the second time and one recommendation has been made for the first time as a result of this inspection. The requirement and recommendation are detailed throughout the report and in the quality improvement plan (QIP).

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

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

No	Regulation Ref.	Requirement	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1.	29 (5)	The registered provider should ensure that Regulation 29 reports are available in the nursing home for inspection and also for patients and their representatives. **Ref Follow up on previous issues**	The inspector reviewed the Regulation 29 reports for the months January, February, March and April 2014. However the reports for the months May, June and July 2014 were not available in the nursing home for inspection. This requirement will therefore be stated for the second time	**Moving towards compliance**

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 Regulation 29 reports include the following: • An action plan with a time scale responding to the Quality Improvement Plan of any inspection undertaken. **Ref Follow up on previous issues**	Review of four Regulation 29 reports evidenced that this recommendation had been met.	**Compliant**
2.	20.3	The policy documentation in respect of resuscitation should be reviewed and updated to provide; Clear and up-to-date guidance for staff in the management of resuscitation in keeping with best practice guidelines. Clear distinction between advanced care planning and a DNR directive. The frequency of review of the DNR directive should be clearly recorded and in keeping with the Resuscitation Council (UK) guidelines. **Ref Criterion 20.3**	The inspector can confirm that this recommendation had been met.	**Compliant**

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
3.	5.3	It is recommended that where a nursing assessment is made to monitor a patient's daily fluid intake, then the patient's daily (24hour) fluid intake should be recorded in their daily progress record in order to evidence that this area of care is being properly monitored and validated by the registered nurse. **Ref Section 6.5**	Inspection of three patients/residents care records evidenced that this recommendation had been met.	**Compliant**

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

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

Since the previous care inspection on 06 February 2014, RQIA have received no notifications of safeguarding of vulnerable adult (SOVA) incidents or complaints in respect of Ashwood House.

10.0 Additional Areas Examined

10.1 Documents required to be held in the Nursing Home

Prior to the inspection a checklist of documents required to be held in the home under regulation 19(2) schedule 4 of The Nursing Homes Regulations (Northern Ireland) was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required documents were maintained in the home and were available for inspection. The inspector reviewed the following records:

- The home's statement of purpose
- The patient's guide
- Sample of reports of unannounced visits to the home under regulation 29
- Sample of staff duty rosters
- Record of complaints
- Sample of incident/accidents
- Record of food provided for patients

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10.2 Patients under guardianship

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

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

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

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

10.4 Quality of interaction schedule (QUIS)

The inspector undertook a number of periods of observation in the home which lasted approximately 30 minutes each.

The inspector observed the patients' lunch meal which was served in the dining room. The inspector also observed a small number of patients having their lunch meal in their bedrooms.

The observation tool used to record these observations uses a simple coding system to record interactions between staff, patients and visitors.

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix 2.

The staff were observed seating the patients/residents in preparation for their lunch in an unhurried manner.

The staff explained to the patients/residents their menu choice and provided adequate support and supervision.

Observation of care practices during these periods of observation revealed that staff were respectful in their interactions with the patients.

Overall the periods of observations were positive.

10.5 Complaints

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. Five complaints were recorded since the previous inspection and were investigated appropriately.

10.6 Patient Finance Questionnaire

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

10.7 NMC declaration

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

The evidence provided in the returned proforma indicated that all nurses, including the manager were registered with the NMC.

11.8 Staffing /Staff Comments

On the day of inspection the inspector examined staff duty rosters for three weeks. Inspection confirmed that registered nurses and care staff staffing levels for day and night duty were in accordance with the RQIA's recommended minimum staffing guidelines.

The inspector spoke with eight staff members during the inspection process and eight staff also completed questionnaires.

Examples of staff comments were as follows:

“this is a very nice home and I enjoy coming to work”
“I feel that because most staff have worked here for a long periods and that the home is family run, that the care delivered is very good”
“this is a well run home in my opinion. Relatives and visitors always comment on how homely it is and there is always a good atmosphere here”.

10.9 Patients’ Comments

The inspector spoke to 20 patients/residents individually and with others in groups. Four patients/residents completed questionnaires.

Examples of patients/residents comments were as follows:

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

10.10 Relatives’ Comments

The inspector spoke with one relative and this relative also completed a questionnaire.

The following is an example of the relative’s comments:

“I am very happy with the care provided in this home. When I am not here to get information, it is related to other members of my family”

10.11 Environment

The inspector undertook an inspection of the home and viewed a number of patients/residents’ bedrooms, communal facilities and toilet and bathroom areas

The home was clean, warm and comfortable. The ambience in the home was relaxed and friendly.

11.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Elizabeth Jones, deputy manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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

25 September 2014

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Bridget Dougan
Inspector/Quality Reviewer

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**
The home uses a computerised Caresys Pre Admission Assessment tool which is used by the qualified nurse/manager or deputy to carry out the assessment. Any assessments received from Care Management team are signed and dated; these will be incorporated into the residents final care plan. Nutritional screening, moving and handling, pressure risk assessment, dehydration risk assessment, dietary preferences, falls risk assessment, continence assessment are all carried out.	Substantially 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**
There is a named nurse identified for each individual patient. Referrals to other members of the multidisciplinary team are straight forward and familiar to all the nursing team. Any resident assessed at risk of developing pressure sores have a care plan in-situ for prevention and treatment of same. Nurse Manager and a fellow nurse attended RCN course on Treatment and Management of Pressure Sores. This information was then relayed to remaining nursing staff. Awaiting date for further training from Northern Area Tissue Viability Team.	Substantially 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**
Re-assessment is an ongoing process through the daily statements and the ongoing monthly evaluation and reassessments evident with monthly audits of care plans. Time intervals are as agreed or when changes occur	Substantially compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All nursing intervention, activities & procedures are based on National Standards, guidelines etc. All nursing staff are aware of the use of NICE Guidelines and NI wound Care Formulary to identify wound type and best practice Treatment	Substantially 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**
Contemporaneous records are kept in accordance with the NMC guidelines. All meals eaten and fluids taken by residents are recorded daily. Residents at risk of dehydration are on a daily fluid balance chart. New menu currently being devised by Head Cook, to give residents choices as reflected in recent annual and food survey.	Substantially 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**
The outcome of care is evaluated and recorded on a daily basis as well as at regular intervals or when deemed necessary using the appropriate benchmarks, the resident, relative and their representatives along with the multi-disciplinary professionals will also have input from the pre- admission assessment of prospective resident onwards.	Substantially 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**
Annual reviews take place, to which all family members are invited, any action plans as a result of same are put in progress	Substantially 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**
The home's residents are provided with a nutritious and varied diet with individual choice. The food eaten is recorded by the home's staff. The home's kitchen Head Cook is currently undergoing a review of the menu which will have input from local dietician and other professionals.	Substantially compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Staff attended training on Feeding residents with speech and swallow difficulties this year. All RGNs attended in house training regarding preventing treating pressure sores, awaiting further training from Northern Tissue Viability Team	Substantially compliant

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

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Primary Inspection

Ashwood House Nursing Home

07 August 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Elizabeth Jones, deputy manager either during or after the inspection visit.

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

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

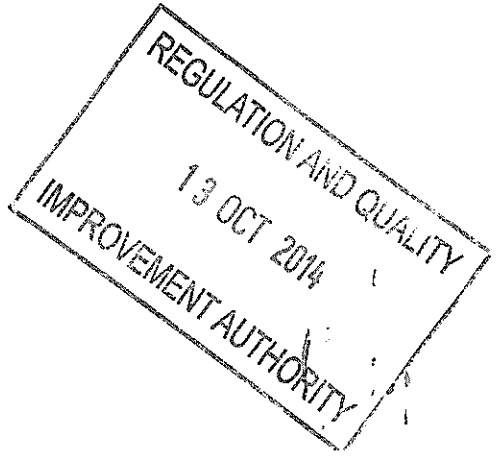
It is the responsibility of the registered provider/manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	29 (5)	The registered provider should ensure that Regulation 29 reports are available in the nursing home for inspection and also for patients and their representatives. **Ref: Follow up on previous issues**	Two	This has been achieved. Now available	From date of this inspection

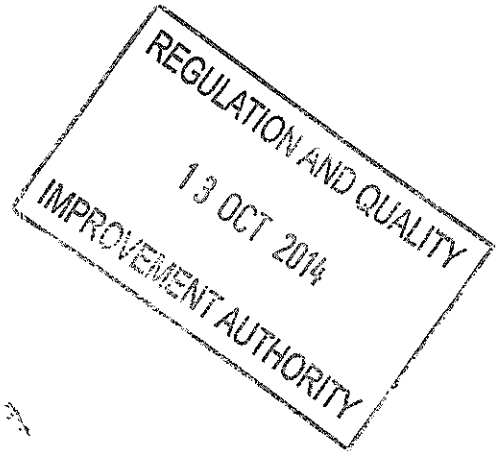


Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	28.4	The registered manager should ensure that all staff receives update training in the prevention of pressure ulcers, appropriate to their roles and responsibilities in the home. **Ref: Section 8.0**	One	Training delivered by Tissue Viability Northern Trust has been arranged for 24/10/14	Within one month from receipt of this QIP

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	ANNE-MARIE MORRIS
Name of Responsible Person / Identified Responsible Person Approving Qip	TREVOR CAGE

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

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Bridget Dougan	24 October 2014
Further information requested from provider			