Unannounced Primary Inspection

Name of establishment: **Galgorm Care Home**

Establishment ID No: **1432**

Date of inspection: **13 June 2014**

Inspector's name: **Carmel McKeegan**

Inspection No: **IN017685**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of home:	Galgorm
Address:	90 Galgorm Road Ballymena BT42 1AA
Telephone number:	028 2565 1365
E mail address:	galgorm@fshc.co.uk
Registered organisation/ Registered provider / Responsible individual	Four Seasons Health Care Mr James McCall
Registered manager:	Mrs Lisa McDonald
Person in charge of the home at the time of inspection:	Mrs Lisa McDonald
Categories of care:	NH-I, NH-PH, NH-PH(E), NH-TI, RC-I, RC-PH(E), RC-PH
Number of registered places:	35
Number of patients / residents accommodated on day of inspection:	18 patients and 5 residents
Scale of charges (per week):	£581.00
Date and type of previous inspection:	Unannounced Primary Care Inspection 21 May 2013
Date and time of inspection:	13 June 2014 09.30 – 15.00
Name of inspector:	Carmel McKeegan

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 an unannounced primary care 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 inspection visit by the inspector.

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

- Analysis of pre-inspection information.
- Discussion with the registered manager.
- Observation of care delivery and care practices.
- Discussion with staff.
- Examination of records.
- Consultation with patients individually and with others in groups.
- 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	**5**
Staff	**5**
Relatives	**3**
Visiting Professionals	**0**

Questionnaires were provided, during the inspection, to patients/residents, their representatives and staff seeking their views regarding the service. Matters raised from the questionnaires were addressed by the inspector either during the course of this inspection or within the following week.

Issued To	**Number issued**	**Number returned**
Patients / Residents	**5**	**4**
Relatives / Representatives	**5**	**1**
Staff	**5**	**5**

6.0 Inspection Focus

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

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 registered persons and the inspector have rated the home's compliance level against each criterion of the standard 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		
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

Galgorm Care Home is situated on the Galgorm Road within close proximity to Ballymena town centre. It is one of a number of homes operated by Four Seasons Health Care Ltd. The current registered manager is Mrs Lisa McDonald.

Galgorm Care Home was first registered as a nursing home on 2 March 1992 and subsequently re-registered to allow social care residents to be accommodated. The home is a substantial two storey building which has been extensively developed and extended to accommodate thirty five persons.

There are four double and 27 single bedrooms. Access to the first floor is via a passenger lift and stairs.

There are adequate number of sitting/dining rooms and toilet, bathroom/shower facilities. These are appropriately located throughout the Home.

Catering and laundry services are provided by the Home. Car parking facilities are available within the grounds.

The home's RQIA 'Certificate of Registration' was appropriately displayed in the entrance hall of the home.

The home is registered to provide care for a maximum of 35 persons under the following categories of care:

<u>Nursing care</u>

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
PH(E)	physical disability other than sensory impairment over 65 years
TI	terminally ill

<u>Residential care</u>

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
PH(E)	physical disability other than sensory impairment over 65 years

8.0 Summary of Inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Galgorm Care Home. The inspection was undertaken by Carmel McKeegan on 13 June 2014 from 09.30 to 15.00.

The inspector was welcomed into the home by Mrs Lisa McDonald, registered manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Mrs McDonald 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. This self-assessment was received by the Authority in 28 May 2014. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector met with patients/residents, staff and relatives, who commented positively on the care and services provided by the nursing home. There were no concerns raised with the inspector.

The inspector observed care practices, examined a selection of records, issued patient, staff and representative questionnaires and carried out a general inspection of the nursing home environment as part of the inspection process.

The inspector also 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 was designed to help evaluate the type and quality of communication which takes place in the nursing home.

As a result of the previous inspection conducted on 21 May 2013, one requirement and two recommendations were issued.
These were reviewed during this inspection. The inspector evidenced that the requirement and both recommendations had been fully complied with. 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 were auditing processes in place to audit the standard of care and service provided for patients/residents in Galgorm Care Home.

Review of two patients' care records, who had been recently admitted to the nursing home revealed that patients' individual needs were not adequately established on the day of admission to the nursing home, several areas were identified for improvement and were discussed with the registered manager.

Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls risk assessment, Bristol stool chart and continence assessment should be completed on admission. It is recommended that specific validated assessment tools are undertaken on the day of admission. It is also recommended that all entries in care records are dated and signed.

Review of these patients' care records evidenced that a basic assessment of the patients' care needs was completed within 11 days of patient's admission to the home, however a comprehensive holistic assessment should be undertaken in order to accurately identify the patient's needs for which the home is required to meet. A recommendation is made in this regard.

Review of two patient's 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. Records also evidenced discussion with patients/residents and/or their representatives following changes to the plans of care. A care plan for one of the patients evidenced that discussion had taken place regarding the best interests of the patient. The registered manager stated that the home had recently introduced this aspect of care planing to safeguard patients' human rights and to be mindful of any potental deprivation of liberty for patients. This is good practice.

The inspector was unable to confirm that pain assessments were consistently used for patients who required an active pain relief prescription. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 15 (2) that pain assessment is utilised for any patient prescribed regular or occasional analgesia, it is also required in accordance with regulation 16 (2) (b) that care plans on pain management are put in place for these patients, care plans should be reviewed to show that pain management is evaluated in a timely manner.

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

There was also evidence that the referring health and social care trust (HSCT) maintained appropriate reviews of the patient's satisfaction with the placement in the home, the quality of care delivered and the services provided.

- **Management of wounds and pressure ulcers – Standard 11 (selected criteria**

There was evidence of appropriate assessment of the risk of development of pressure ulcers.

Care plans for the management of risks of developing pressure ulcers were in place, however care plans need to be further developed to include the patient's Braden Scale pressure risk assessment outcome, follow up action based on the level of risk identified, the type of mattress required for the patient as identified by the Braden scale and also provide detail of pressure relieving equipment required for the patient when sitting out of bed.

Care plans must demonstrate that timely referral to tissue viability specialist nurses (TVN) for guidance and referral to the HSCT regarding the supply of pressure relieving equipment, if appropriate, has been undertaken.

Review of one patient's wound care records identified several areas for improvement in record keeping in relation to wound management. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 16 (2) (b) that wound management care plans provide clear guidance for practitioners to ensure that best practice is provided in order to promote healing and comfort for the patient.

It is required in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005, that that the incidence of a pressure ulcer, grade 2 and above is notified to RQIA.

As previously stated patients who required an active pain relief prescription should have a pain assessment undertaken and subsequently a pain management care plan implemented that is reviewed and evaluated as the patient's need predicts.

- **Management of nutritional needs and weight loss – Standard 8 and 12 (selected criteria)**

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

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

The inspector observed the serving of the lunch time meal and can confirm that patients were offered a choice of meal and that the meal service was well managed and supervised by the registered nurse in charge. It is recommended that the current three week menu planner is reviewed to include choices for snacks for all patients, including those patients on therapeutic diets.

Patients were observed to be assisted with dignity and respect throughout the meal.

- **Management of dehydration – Standard 12 (selected criteria)**

The inspector examined the management of dehydration during the inspection which evidenced that fluid requirement and intake details for patients were recorded and maintained for those patients assessed at risk of dehydration.

Review of a sample of fluid intake charts for three patients revealed that there was evidence that patients were offered fluids on a regular basis throughout the day and also during the night time period.

The fluid intake charts for patients recorded the total fluid intake for patients over 24 hours, an effective reconciliation of the total fluid intake against the fluid target was established, with a record of reconciliation of fluid intake in the daily progress notes.

Patients were observed to be able to access fluids with ease throughout the inspection. Staff were observed offering patients additional fluids throughout the inspection. Fresh drinking water/various cordials were available to patients in lounges, dining rooms and bedrooms.

The inspector can confirm that based on the evidence reviewed, presented and observed; that the level of compliance with the standards inspected was substantially compliant.

Patients' comments

During the inspection the inspector spoke with five patients individually and with a number in groups. In addition, on the day of inspection, four patients completed questionnaires.

The following are examples of patients' comments made to the inspector and recorded in the returned questionnaires.

"This is a great home. I'm very happy here. You'll not get rid of me. The care assistants have a very special calling to what they do with positive attitudes and caring"
"I sometime have trouble getting to the toilet as quickly as I'd like but I know the staff get to me as quickly as they can".
"I have a very sensitive stomach and staff have been very helpful finding foods I can eat. They recently had me try a hamburger, when I was about to give up meat – and I enjoyed it very much. They told me they'll make it for me more often, I can have to whenever I want".

"I would like more involved in discussing my care plan, kept up to date on my appointments like for my hearing aid and to see about the pain in my stomach. I joke all the time and sometimes I think people may not understand that I joke even when I have pain".
" It's a very good home, all the staff are lovely and very attentive".

Patient Representative/relatives' comments

During the inspection the inspector spoke with three patients/residents' relatives/visitors. In addition, on the day of inspection, one representative's/relative's competed and returned questionnaires.
The following are examples of relatives' comments during inspection and in questionnaires;

"The staff are very attentive, always take time to talk to the patients and have a bit of fun"
"This home is very homely, and welcoming when you visit, there is always some of the staff about to talk to"
"We have no complaints and are more than satisfied with the care and attention shown to all the residents".

Some comments received from staff:

"Staff are always positive and upbeat, which helps the overall atmosphere for residents visitors and staff tremendously".
"I am proud to be part of this home where everyone so clearly cares about the people here".

A number of additional areas were also examined.

- Records required to be held in the nursing home.
- Guardianship.
- 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 and visitors.
- Environment.

There were no issues identified during review of the above areas. 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 this 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 were observed to be treated with dignity and respect.

Therefore, three requirements and three recommendations are made. These requirements and recommendations are detailed throughout the report and in the quality improvement plan (QIP).

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

The inspector would also like to thank the patients, relatives and staff who completed questionnaires.

9.0 Follow-up on the requirements and recommendations issued as a result of the previous inspection on 21 May 2013

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	27(4)	It is required that items of equipment are appropriately stored to ensure fire exits are maintained clear at all times.	Observations made on the day of the inspection confirmed that fire exits were not obstructed in any way. This requirement is assessed as compliant	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	25.2	It is recommended that patients/residents and their representatives are made aware of the availability of the report, if requested. For example, putting a notice on the relatives' notice board advising of the availability of the report.	A notice was displayed on the notice board which advised of the availability of RQIA inspection reports, the Annual Quality Report and the Monthly Monitoring Report in the home. This recommendation is assessed as compliant	Compliant
2	5.7	It is recommended that when care plans are no longer relevant to the patient's care needs that they are discontinued and archived.	Review of three patients/residents care records and discussion with the registered manager confirmed that discontinued care plans were removed and archived. This recommendation is assessed as compliant	Compliant

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

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

There have been three notifications to RQIA regarding safeguarding of vulnerable adults (SOVA) incidents since the previous inspection. The incidents are being managed in accordance with the regional adult protection policy by the safeguarding team within the Northern Health and Social Care Trust.

10.0 Inspection Findings

Section A

Standard 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**

Standard 5.2

- **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission**

Standard 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**

Standard 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.**

Inspection Findings:

Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

Review of two patients' care records, who had recently been admitted to the home, revealed that these patients' individual needs were not fully established on the day of admission to the nursing home, the following areas were identified.

Patient A (identity known to the registered manager)

- The patient's date of admission was not stated on the initial admission details, and this record was not signed or dated.
- The initial nursing needs assessment had not been completed.
- Specific validated risk assessments such as safe moving and handling, falls, nutritional, continence had not been completed on the

day of admission, assessments were seen to be completed 1 to 5 days post admission.

- The Malnutrition Universal Screening Tool (MUST) had not been completed at any point.
- Bedrail consent was signed and dated by the patient's relative at the time of admission, however the bedrail risk assessment was completed two days later.
- Pre-printed care plans were in place however the content did not provide specific individual detail to meet with person centred care planning, several care plans had not been signed or dated.
- There was no care plan for the safe management of bed rails for the patient.
- The management of pressure area care plan did not reflect the patient's Braden Scale risk assessment outcome which identified the patient to be at high risk. The care plan did not detail planned nursing interventions to manage and/or reduce the risk.

Patient B (identity known to the registered manager)

- The patient's date of admission was not stated on the initial admission details.
- The initial admission assessment was not signed or dated.
- Several specific validated risk assessment tools had not been completed on the day of admission.
- The management of pressure area care stated the type of mattress in place for the patient, but did not state the pressure relieving equipment required for the patient when sitting out of bed.

Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart and continence should be completed on admission. It is recommended that specific validated assessment tools are completed on the day of admission in order to establish the patient's current needs and base line observations. The specific risk assessments to be completed on the day of admission to the home are outlined in the Providers Guidance for Nursing Homes on RQIA web site.
It is also recommended that all entries in care records are dated and signed.

Review of these patients' care records evidenced that a basic assessment of the patients' care needs was completed within 11 days of patient's admission to the home, however a comprehensive holistic assessment must be undertaken in order to accurately identify the patient's needs for which the home is required to meet. A recommendation is made in this regard.

At the time of this inspection there were no patients/residents who had been admitted into the nursing home with an existing wound.

In discussion with the registered manager she demonstrated a good awareness of the patient who required wound management intervention for a wound and the number and progress of patients who were assessed as being at risk of weight loss and dehydration.

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

Section B

Standard 5.3
- **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.**

Standard 11.2
- **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.**

Standard 11.3
- **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.**

Standard 11.8
- **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration**

Standard 8.3
- **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.**

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

Review of two patient's 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. Records also evidenced discussion with patients/residents and/or their representatives following changes to the plans of care. A care plan for one of the patients evidenced that discussion had taken place regarding the best interests of the patient. The registered manager stated that the home had recently introduced this aspect of care planing to safeguard patients' human rights and to be mindful of any potental deprivation of liberty for patients. This is good practice.

The inspector observed that a pain assessment and care plan on pain management was undertaken 12 days post admission for Patient B, this should have been undertaken at the time of admission. However despite the presence of a wound/ pressure ulcers and an active pain relief prescription, this aspect of clinical assessment and care planning had not been implemented for Patient A. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 15 (2) that pain assessment is utilised for any patient prescribed regular or occasional analgesia, it is also required in accordance with regulation 16 (2) (b) that care plans on pain management are put in place for these patients, care plans should be reviewed to show that pain management is evaluated in a timely manner.

The registered manager informed the inspector that there was one patient (previously identified as Patient A), who required wound management for multiple wound/ulcers. Review of this patient's care records revealed the following;

- A body mapping chart was completed when skin changes were initially identified. This chart was reviewed and updated when any changes occurred to the patient's skin condition thereafter

- As previously stated the management of pressure area care plan did not reflect the patient's Braden Score risk assessment which identified the patient to be at high risk. The care plan did not detail planned nursing interventions to manage and/or reduce the risk.

- The care plan in place did not specify the pressure relieving equipment in place on the patient's bed and also when sitting out of bed.

- An initial wound assessment had been undertaken for each wound, however wounds/ulcers were not graded using an evidenced based classification system.

- One initial wound assessment record was not signed and contained detail of more than one wound. Ongoing wound assessment records were not clearly numbered to facilitate traceability for each individual wound.

The inspector discusses these recording deficits with the registered manager and a recommendation is made for improvement.

A wound care plan was in place for one wound which had been classified as a Grade 3 pressure ulcer, the ongoing wound assessment record had not been completed for 5 days prior to the inspection, a review date had not been provided, nor did the care plan did not state if a referral had been made to the Tissue Viability Nurse (TVN) or if a notification had been made to RQIA. The registered manager confirmed that a referral had been made to the TVN, however this clinical incident had not been not yet been notified to RQIA. It is required in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005, that that the incidence of a pressure ulcer, grade 2 and above is notified to RQIA.

The inspector was able to verify that daily repositioning and skin inspection charts were in place for the patient with the wound and also for patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these charts revealed that patients' skin condition was inspected for evidence of change at each positional change. There was also evidence that patients were repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention.

The registered manager and registered nurses on duty confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local healthcare Trust. Staff spoken with were knowledgeable regarding the referral process. Discussion with registered nurses on duty evidenced that they were knowledgeable of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient. The registered manager confirmed that she would liaise with the TVN as wound management link nurse for the home.

The patient's weight was recorded on admission and on at least a monthly basis or more often if required.

The patient's nutritional status was also reviewed on at least a monthly basis or more often if required.
Daily records were maintained regarding the patient's daily food and fluid intake.

Policies and procedures were in place for staff on making referrals to the dietician. These included indicators of the action to be taken and by whom. The registered nurse staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment.

Review of care records for one patient, who had been assessed as nutritionally compromised, evidenced that the patient was referred for a dietetic assessment in a timely manner. This patient was also referred to the speech and language therapist. The patient's care plan had been reviewed to address the dietician's and speech and language therapist's recommendations.

Discussion with the registered manager, registered nurses, care staff and review of the staff training matrix revealed that training has been provided in pressure area care and prevention, management of nutrition and the use of thickening agents for the elderly adult. The registered manager informed the inspector that arrangements were in place for further wound management training for the registered nursing staff.

Patients' moving and handling needs were assessed and addressed in their care plans. There was evidence that manual handling aids were used to minimise risk of friction. Staff consulted confirmed there was sufficient nursing equipment available to move and handle patients' appropriately.

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

Section C

Standard 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Homes Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**
Review of two patients' care records evidenced that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care. Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. Review of care records also evidenced that nutritional care plans for patients were reviewed monthly or more often as deemed appropriate. As previously stated in Section B, one patient's care records in relation to wound care indicated that the ongoing wound assessment record had not been completed for 5 days prior to the inspection. It is recommended that the daily evaluation process should include the effectiveness of any prescribed treatments, for example prescribed analgesia. Discussion with one registered nurse and review of governance documents evidenced that a number of care records were audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

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

Section D

Standard 5.5
- **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.**

Standard 11.4
- **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.**

Standard 8.4
- **There are up to date nutritional guidelines that are in use by staff on a daily basis.**

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

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

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

As previously stated in Section A, the Nutritional risk assessment such as Malnutrition Universal Screening Tool (MUST) had not been completed for one patient and a recommendation is already made to address this deficit.

The inspector confirmed the following research and guidance documents were available in the home;

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

Discussion with the registered manager and the registered nurse on duty confirmed that they had a good awareness of these guidelines.

Registered nurses and care staff were found to be knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care.

Discussion with the registered manager, registered nurses and review of governance documents indicated that the quality of pressure ulcer/wound management was audited each time dressings were changed and discussed at each hand over report. As previously stated a recommendation is made that wound management ongoing assessment records are kept up-to-date.

Five staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was available for staff reference.

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

Section E

Standard 5.6

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

Standard 12.11

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

Standard 12.12

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

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

The registered nurses spoken with were aware of their accountability and responsibility regarding record keeping. The inspector was able to evidence that care plans had been developed following consultation with the patient and/or representative, in keeping with the principles of the European Convention of Human Rights.

A review of the training records confirmed that staff had received training on the importance of record keeping commensurate with their roles and responsibilities in the home.

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

Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patients' status or to indicate communication with other professionals/representatives concerning the patients.

Entries were noted to be timed and signed with the signature accompanied by the designation of the signatory.

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

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

- Daily records of food and fluid intake were being maintained.
- The nurse in charge had discussed with the patient/representative their dietary needs.
- Where necessary a referral had been made to the relevant specialist healthcare professional.
- A record was made of any discussion and action taken by the registered nurse.
- Care plans had been devised to manage the patient's nutritional needs and were reviewed on a monthly or more often basis.

Review of a sample of fluid balance charts for one identified patient revealed that there was evidence that the patient was offered fluids on a regular basis throughout the day and night time period.

Staff spoken with were evidenced to be knowledgeable regarding patients' nutritional needs

As previously stated in Section B, training has been provided in pressure area care and prevention, management of nutrition and the use of thickening agents for the elderly adult. The registered manager informed the inspector that arrangements were in place for further wound management training for the registered nursing staff.

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

Section F

Standard 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.**
Please refer to criterion examined in Section E. In addition the review of three patients' care records evidenced that consultation with the patient and/or their representative had taken place in relation to the planning of the patient's care. This is in keeping with the DHSSPS Minimum Standards and the Human Rights Act 1998.

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

Section G

Standard 5.8
- **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate**

Standard 5.9
- **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.**

Prior to the inspection a patients' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that all the patients in the home had been subject to a care review by the care management team of the referring HSC Trust between 1 April 2013 and 31 March 2014.

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

The inspector viewed the minutes of three care management care reviews which evidenced that, where appropriate patients and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended an updated assessment of the patient's needs and a record of issues discussed. Care plans were evidenced to be updated post care review to reflect recommendations made where applicable.

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

Section H

Standard 12.1
- **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.**
  Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.

Standard 12.3
- **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.**
  A choice is also offered to those on therapeutic or specific diets.

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

There was a three weekly menu planner in place. The registered manager informed the inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home. The current menu planner was dated to show the date of implementation.

The inspector discussed with the registered manager and a number of staff the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients.

Staff spoken with were knowledgeable regarding the individual dietary needs of patients to include their likes and dislikes. Discussion with staff and review of the record of the patient's meals confirmed that patients were offered choice prior to their meals.

Staff spoken with were knowledgeable regarding the indicators for onward referrals to the relevant professionals. e.g. speech and language therapist or dieticians.

As previously stated under Section D relevant guidance documents were in place.

Review of the menu planner and records of patients' choices and discussion with a number of patients, registered nurses and care staff it was revealed that choices were available at each meal time. The registered manager confirmed choices were also available to patients who were on therapeutic diets. A recommendation is made that the menu plan be reviewed to include choices for snacks for all patients including those on therapeutic diets.

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

Section I

Standard 8.6
• **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.**
Standard 12.5
• **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.**
Standard 12.10
• **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:**
  • **risks when patients are eating and drinking are managed**
  • **required assistance is provided**
  • **necessary aids and equipment are available for use.**
Standard 11.7
• **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.**

The inspector discussed the needs of the patients with the registered manager. It was determined that a number of patients had swallowing difficulties. Review of training records revealed that training in dysphagia awareness and the safe use of thickening agents was provided for all staff this year. The training matrix also indicated that all staff have completed First Aid Training which includes caring for the choking patient. Review of the three most recent Regulation 29 monitoring reports undertaken, confirmed that the regional manager reviews training provision and completion of training programmes on a monthly basis. Discussion with registered manager confirmed that meals were served at appropriate intervals throughout the day and in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes. The registered manager confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning afternoon and at supper times. The inspector observed that a choice of fluids to include fresh drinking water were available and refreshed regularly. Staff were observed

offering patients fluids at regular intervals throughout the day.

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Five staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was readily available for staff reference.

On the day of the inspection, the inspector observed the lunch meal. Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely manner.

Staff were observed preparing and seating the patients for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients with their meal and patients were offered a choice of fluids. The tables were well presented with condiments appropriate for the meal served.

Discussion with the registered nurses clearly evidenced their knowledge in the assessment, management and treatment of wounds. Review of the template used to undertake competency and capability assessments for the registered nurses revealed that pressure ulcer/wound care was addressed.

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

11.0 Additional Areas Examined

11.1 Records required to be held in the nursing home

Prior to the inspection a check list of records required to be held in the home under Regulation 19(2) Schedule 4 of The Nursing Homes Regulations (Northern Ireland) 2005 was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required records were maintained in the home and were available for inspection. The inspector reviewed the following records:

- the patient's guide
- sample of staff duty rosters
- record of complaints
- record of food and fluid provided for patients
- staff training matrix
- sample of incident/accident records

11.2 Patients/residents 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.

There were no patients/residents currently resident at the time of inspection in the home.

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

The inspector discussed the Human Rights Act and Human Rights Legislation with the registered manager and one of the registered nurses. The inspector can confirm that copies of these documents were available in the home.

The registered manager and registered nurse demonstrated an awareness of the details outlined in these documents.

The registered manager informed the inspector that these documents will be discussed with staff during staff meetings and that staff will be made aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patients care and accompanying records.

The inspector also discussed the Deprivation of Liberty Safeguards (DOLs) with the registered manager and registered nurses including the recording of best interest decisions on behalf of patients. A copy of DOLS was also available in the home**.**

11.4 Quality of interaction schedule (QUIS)

The inspector undertook two periods of observation in the home which lasted for approximately 15 – 20 minutes each.

The inspector observed the lunch meal being served in the dining room and also observed care practices in the main sitting room following the lunch meal.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area being observed.

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

The inspector observed staff preparing for and serving the mid-day meal. Observation confirmed that meals were served promptly and assistance required by patients was provided in a timely manner.

Staff were observed preparing and seating patients for their meal in a caring, sensitive and unhurried manner. Staff were seen to speak directly to each patient, making eye contact and actively communicating with each person. Care staff were also noted assisting patients with their meals, staff sat down beside the patient they were assisting and were fully engaged in the activity of providing the patient's meal, offering encouragement and prompting as appropriate.

Following lunch patients/residents were respectfully offered assistance to move to whatever area of the home they preferred. Some patients/residents chose the main communal lounge and others chose to go to their own bedrooms or sit at the main reception area.

The activity therapist was observed to attend to patients on a one to one basis throughout the morning informing patients/residents of the planned activity for that afternoon. Patients/residents were observed to respond positively to the gentle and individual attention being offered by the activity therapist.

The inspector evidenced that the quality of interactions between staff and patients was positive. Staff were polite and courteous when speaking with patients, conversation was relaxed and respectful.

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

11.5 Complaints

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being pro-actively managed.

The inspector reviewed the complaints records. This review evidenced that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought.

The registered manager informed the inspector that lessons learnt from investigations were acted upon.

11.6 Patient finance questionnaire

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

11.7 NMC declaration

Prior to the inspection the registered 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 registered manager, were appropriately registered with the NMC. This was also evidenced by the inspector on the day of inspection.

11.8 Questionnaire findings

Staffing/Staff Comments

Discussion with the registered manager and a number of staff and review of a sample of staff duty rosters evidenced that the registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients currently in the home. An activity therapist is employed to provide additional hours for the provision of activities to patients/residents, this is commendable practice.

The ancillary staffing levels were found to be satisfactory, the home was organised, clean and tidy throughout.

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

During the inspection the inspector spoke to five staff. The inspector was able to speak to a number of these staff individually. On the day of inspection four staff completed questionnaires, a review of which indicated that staff were 'very satisfied ' or 'satisfied' in relation to their induction, training provision and with the general standard of care provided in the home. The following are examples of staff comments during the inspection and in questionnaires;

"Staff are always positive and upbeat, which helps the overall atmosphere for residents visitors and staff tremendously".

"I am proud to be part of this home where everyone so clearly cares about the people here".

Patients' comments

During the inspection the inspector spoke with five patients individually and with a number in groups. In addition, on the day of inspection, four patients completed questionnaires.

The following are examples of patients' comments made to the inspector and recorded in the returned questionnaires.

"This is a great home. I'm very happy here. You'll not get rid of me. The care assistants have a very special calling to what they do with positive attitudes and caring"
"I sometime have trouble getting to the toilet as quickly as I'd like but I know the staff get to me as quickly as they can".
"I have a very sensitive stomach and staff have been very helpful finding foods I can eat. They recently had me try a hamburger, when I was about to give up meat – and I enjoyed it very much. They told me they'll make it for me more often, I can have to whenever I want".
"I would like more involved in discussing my care plan, kept up to date on my appointments like for my hearing aid and to see about the pain in my stomach. I joke all the time and sometimes I think people may not understand that I joke even when I have pain".
" It's a very good home, all the staff are lovely and very attentive".

Patient Representative/relatives' comments

During the inspection the inspector spoke with three patients/residents' relatives/visitors. In addition, on the day of inspection, one representative's/relative's competed and returned questionnaires.
The following are examples of relatives' comments during inspection and in questionnaires;

"The staff are very attentive, always take time to talk to the patients and have a bit of fun"
"This home is very homely, and welcoming when you visit, there is always some of the staff about to talk to"
" We have no complaints and are more than satisfied with the care and attention shown to all the residents".

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Lisa Donaldson, 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.

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:

Carmel McKeegan
The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Prior to admission to the home, the Home Manager or a designated representative from the home carries out a pre admission assessment. Information gleaned from the resident/representative (where possible), the care records and information from the Care Management Team informs this assessment. Risk assessments such as the Braden Tool are carried out, if possible, at this stage. Following a review of all information a decision is made in regard to the home's ability to meet the needs of the resident. If the admission is an emergency admission and a pre admission is not possible in the resident's current location then - a pre admission assessment is completed over the telephone with	Compliant

written comprehensive, multidisciplinary information regarding the resident being faxed or left into the home. Only when the Manager is satisfied that the home can meet the residents needs will the admission take place. On admission to the home an identified nurse completes initial assessments using a patient centred approach. The nurse communicates with the resident and/or representative, refers to the pre admission assessment and to information received from the care management team to assist her/him in this process. There are two documents completed within twelve hours of admission - an Admission Assessment which includes photography consent, record of personal effects and a record of 'My Preferences' and a Needs Assessment which includes 16 areas of need - the additional comments section within each of the 16 sections includes additional necessary information that is required to formulate a person centred plan of care for the Resident. In addidtion to these two documents, the nurse completes risk assessments immedidiately on admission. These include a skin assessment using the Braden Tool, a body map, an initial wound assessment (if required), a moving and handling assessment, a falls risk assessment, bed rail assessment, a pain assessment and nutritional assessments including the MUST tool, FSHC nutritional and oral assessment. Other risk assessments that are completed within seven days of admission are a continence assessment and a bowel assessment, Following discussion with the resident/representative, and using the nurse's clinical judgement, a plan of care is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations. This can be evidenced in the care plan and consent forms. The Home Manager and Regional Manager will complete audits on a regular basis to quality assure this process	

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**
A named nurse completes a comprehensive and holistic assessment of the resident's care needs using the assessment tools as cited in section A, within 7 days of admission. The named nurse devises care plans to meet identified needs and in consultation with the resident/representative. The care plans demonstrate the promotion of	Compliant

maximum independence and focuses on what the resident can do for themselves as well as what assistance is required. Any recommendations made by other members of the mutidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable. Registered nurses in the home are fully aware of the process of referral to a TVN when necessary. There are referral forms held in a designated file in the nurse's office, the Tissue Viability Nurse's details are also held in this file - name, address and telephone no. Once the form has been sent it is then followed up by a telephone call to the TVN where advice can be given prior to their visit. Referrals are also made via this process in relation to residents who have lower limb or foot ulceration to either the TVN or a podiatrist. If necessary, a further referral is made to a vascular surgeon by the G.P, TVN or podiatrist. Where a resident is assessed as being 'at risk' of developing pressure ulcers, a Pressure Ulcer Management and Treatment plan is commenced. A care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. The care plan will give due consideration to advice received from other multidisciplinary members. The treatment plan is agreed with the resident/representative, Care Management and relevant members of the MDT. The Regional Manager is informed via a monthly report and during the Reg 29 visit. The Registered Nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Dietician referral forms are held within the home. These forms can be completed by staff in the home and posted directly to the dietician for referral. The dietician is also available over the telephone for advice until she is able to visit the resident. All advice, treatment or recommendations are recorded on the MDT form with a subsequent care plan being compiled or current care plan being updated to reflect the advice and recommendations. The care plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in the home and other members of the MDT are kept informed of any changes.	

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**
The Needs Assessment, risk assessments and care plans are reviewed and evaluated at a minimum of once a month or more often if there is a change in the resident's condition. The plan of care dictates the frequency of review and re assessment, with the agreed time interval recorded on the plan of care. The resident is assessed on an ongoing daily basis with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the Home Manager's attention. The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.	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**
The home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to. The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading sysytem. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime or if the condition of the pressure ulcer changes. There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', ' PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in	Compliant

relation to nutritional care, diabetic care, care of subcuteanous fluids and care of percutaneous endoscopic gastrostomy (PEG)..	

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**
Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are comtemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines - Record keeping:Guidance for nurses and midwives. Records of the meals provided for each resident at each mealtime are recorded on a daily menu choice form. The Catering Manager also keeps records of the food served and include any specialist dietary needs. Residents who are assessed as being 'at risk' of malnutrition, dehyration or eating excessively have all their food and fluids recorded in detail on a daily basis using a FSHC food record booklet or fluid record booklet. These charts are	Compliant

recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. The nurse utilises the information contained in these charts in their daily evaluation. Any deficits are identified with appropriate action being taken and with referrals made to the relevant MDT member as necessary. Any changes to the resident's plan of care is discussed with them and/or their representative. Care records are audited on a regular basis by the Manager with an action plan compiled to address any deficits or areas for improvement - this is discussed during supervision sessions with each nurse as necessary.	

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 delivered is monitored and recorded on a daily basis on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan of care or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their represenatatives are involved in the evaluation process.	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**
Care Management Reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the resident's file. Any recommendations made are actioned by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals.	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 follows FSHC policy and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs on admission and review on an ongoing basis. The care plan reflects type of diet, any special dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if necessary. The home has a 3 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives - residents meetings, one to one meetings and food questionnaires. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied. Copies of instructions and recommendations from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs.	Compliant

Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything from the daily menu an alternative meal of their choice is provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room, with the 3 week menu displayed in a menu display folder and on the wall outside the kitchen.	

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**
Registered nurses have received training on dysphagia and enteral feeding techiques (PEG) on10/9/13. Further training on dysphagia and feeding techiques is arranged for all care and kitchen staff on 29/4/14, 13/6/14 and 11/9/14. The Speech and Language therapist and dietician also give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document -	Compliant

'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for feeding, equipment to use and assistance required. The kitchen receive a copy of the SALT's recommendations and this is kept on file for reference by the kitchen. Special diets are displayed on a white board in the fridge room. Meals are served at the following times:- Breakfast - 9am-10.30am Morning tea - 11am Lunch - 12.40pm-12.50pm Afternoon tea - 3pm Evening tea - 4.50pm Supper - 7.30pm-8pm There are variations to the above if a resident requests to have their meals outside of these times. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. There are foods available outside of these times for those resident's who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedrooms, these are replenished on a regular basis. Any matters concerning a resident's eating and drinking are detailed on each individual care plan - including for eg. likes and dislikes, type of diet, consistency of fluid, any special equipment required and if assistance is required. A diet notification form is completed for each resident with a copy given to the kitchen and one held in the care file. Meals are not served unless a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Appropriate aids such as plate guards and specialised cutlery are available as necessary and as indicated in the plan of care. Each nurse has completed an education e-learning module on pressure area care. The home has a link nurse who has received enhanced training, to provide support and education to other nurses within the home on an ad hoc basis. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the home have a competency assessment completed. Competency assessments have a quality assurance element built into the process.	

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

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Primary Inspection

Galgorm

13 June 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 Lisa Donaldson, registered manager, either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	16 (2) (b)	The registered person shall ensure that – (b) The patient's plan is kept under review. • Management of pressure area care plans should include the patient's Braden Scale risk status and detail planned nursing interventions to manage or reduce the risk as identified, the patient's required pressure relieving equipment when in bed and sitting out of bed, as appropriate. • Wound management care plan should clearly state the frequency of dressing change. • Wound assessment should include an evidence based classification system. • The effectiveness of analgesia should be regularly evaluated and recorded. **Ref; Section A and C**	One	Staff have been informed that care plans for pressure area care should be more detailed to include Braden Score, planned repositioning and the name of the pressure relieving equipment being used with each individual. Staff were reminded to ensure wound assessment and corresponding documentation should be completed in full detail with no areas left blank. Any resident receiving analgesia should have a care plan in place with its effectiveness reviewed and recorded.	From the date of this inspection
2.	15 (2)	The registered person shall ensure that the assessment of the patient's needs is (a) kept under review; and (b) revised at any time when it is necessary	One	Staff were reminded that any resident receiving analgesia should have a care plan and pain assessment completed in a timely manner with	From the date of this inspection

		to do so having regard to any change of circumstances and in any case not less than annually. • pain assessments must be utilised for any patient prescribed regular or occasional analgesia **Ref; Section B and C**		efffectiveness of the analgesia monitored and recorded.	
3.	30 (1) (d)	The registered person should notify RQIA of the incidence of a pressure ulcer, grade 2 and above. **Ref; Section B**	One	Staff are advised that pressure ulcer grade 2 and above need to be reported under Regulation 30.	From the date of this inspection

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	5.1	Specific validated assessment tools should completed on the day of admission in order to establish the patient's current needs and base line observations. The specific risk assessments to be completed on the day of admission to the home are outlined in the Providers Guidance for Nursing Homes on RQIA web site. **Ref: Section A**	One	All trained staff have received clinical supervision on completing the validated assessment tools on the day of admission.	From the date of this inspection
2.	5.2	A comprehensive holistic assessment must be undertaken and completed within 11 days of admission in order to accurately identify the patient's needs for which the home is required to meet. **Ref: Section A**	One	All trained staff have received clinical supervision on completing a comprehensive holistic assessment within the 11 days.	From the date of this inspection
3.	12.13	The menu plan should be reviewed to include choices for snacks for all patients, those patients on therapeutic diets. **Ref: Section H**	One	Menu plan has been reprinted to now include the snack choices available for residents on a therapeutic diet.	31 August 2014

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 and return to nursing.team@rqia.org.uk

Name of Registered Manager Completing Qip	Lisa McDonald
Name of Responsible Person / Identified Responsible Person Approving Qip	J Watson Jim McCall DIRECTOR OF OPERATIONS 5/9/14

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				Inspector	Date
		Yes	No		
A.	Quality Improvement Plan response assessed by inspector as acceptable	yes		Carmel McKeegan	**09/09/14**
B.	Further information requested from provider				