



Announced Primary Inspection

Name of Establishment:	Milesian Manor
Establishment ID No:	1436
Date of Inspection:	13 May 2014
Inspector's Name:	Heather Moore
Inspection No:	16494

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

1.0 General Information

Name of Home:	Milesian Manor
Address:	9 Ballyheifer Road Magherafelt BT45 5DX
Telephone Number:	028 7963 1842
E mail Address:	milesian-manor@hotmail.co.uk
Registered Organisation/ Registered Provider:	Mr Patrick Forbes & Mr Seamus Higgins
Registered Manager:	Mrs Martha O'Kane
Person in Charge of the Home at the time of Inspection:	Mrs Martha O' Kane
Registered Categories of Care and number of places:	NH-I, NH-PH, NH-PH(E), RC-I 34
Number of Patients/ Residents Accommodated on Day of Inspection:	24 Patients 6 Residents (One patient in hospital on day of inspection)
Date and time of this inspection:	13 May 2014: 08.20 hours - 16.00 hours
Date and type of previous inspection:	11 June 2013 Primary Announced

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

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

4.0 Methods/Process

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

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

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

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

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

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

5.0 Consultation Process

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

Patients/Residents	Six individually and with others in groups
Staff	10
Relatives	3
Visiting Professionals	0

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

Issued To	Number issued	Number returned
Patients /Residents	6	6
Relatives / Representatives	3	3
Staff	10	9

6.0 Inspection Focus

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

The criteria from the following standards are included;

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

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

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

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

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

7.0 Profile of Service

Milesian Manor is situated on the outskirts of Magherafelt and occupies a spacious site surrounded by landscaped gardens.

The home comprises of two floors with bedroom accommodation on both floors. The first floor is accessible by stairs and a passenger lift.

A number of communal lounges are provided throughout the home. There are adequate car parking facilities.

The home provides care in the following categories of care:

NH-I, NH-PH, NH-PH (E), RC-I

Nursing care

I – Old age not falling into any other category

PH – Physical disability other than sensory impairment

Residential care

RC – Residential care

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

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (announced) to Milesian Manor. The inspection was undertaken by Heather Moore on Tuesday 13 May 2014 from 08.20 hours to 16.00 hours.

The inspector was welcomed into the home by Mrs Martha O’Kane, Registered Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to the registered manager at the conclusion of the inspection.

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

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

Questionnaires were issued to patients, staff and two relatives during the inspection one relative forwarded a questionnaire following the inspection.

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

These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool is designed to help evaluate the type and quality of communication which takes place in the nursing home.

As a result of the previous inspection conducted on 11 June 2013 one recommendation was issued. This recommendation was reviewed during this inspection. The inspector evidenced that the recommendation had been 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 was evidence to validate that patients' and residents' receive safe and effective care in Milesian Manor.

There was evidence of comprehensive and detailed assessment of patient needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patients' and residents' needs was evidenced to inform the care planning process. Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis as required.

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

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

The inspector evidenced that wound management in the home was well maintained. There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment. Care plans for the management of risks of pressure ulcers and wound care were maintained to a professional standard. A recommendation is made in regard to recording the type of pressure relieving equipment used on the patients care plans on pressure area care.

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

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

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

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

- **Management of Dehydration – Standard 12**

The inspector also examined the management of dehydration during the inspection. The home was evidenced to identify fluid requirements for patients and records were maintained of the fluid intake of those patients assessed at risk of dehydration. Patients were observed to be able to access fluids with ease throughout the inspection.

The inspector can confirm that based on the evidence reviewed, presented and observed; that the level of compliance with this standard was assessed as compliant.

Patients / residents/ their representatives and staff questionnaires.

Some comments received from patients/ residents and their representatives.

- “So far I have been very happy, content and I am well looked after.”
- “If I need anything all I have to do is to ask a member of staff and they will co-operate with me immediately.”
- “My visitors are always made welcome.”
- “The food is always good, we get a choice of food the cook comes to me if I don’t like what is on the menu and she will cook me something else.”
- “I am totally satisfied, I couldn’t complain about anything.”
- “The staff are always kind and helpful to me.”
- “It is homely and friendly.”

Some comments received from representatives comments.

- “Milesian Manor is a fine example of care for the elderly at the very best.”
- “I am very confident about the care that is being provided in Milesian Manor, any concerns or requests I have in relation to her care are discussed with me.”
- “I have nothing but praise for the manager and her team I cannot speak highly enough of the standard of care that was provided to my dying husband every one including the kitchen staff and cleaners were all so kind to me, I will never forget them.”

Some comments received from staff;

- “Milesian Manor is a home in every sense of the word. It is friendly and a great place to work. The residents are all well looked after.”
- “The quality of care delivered in the home is excellent; we have a very friendly, caring, hardworking team who delivers individualised care under guidance of nurses.”
- “Good communication among all grades of staff.”
- “The nursing care here is excellent everyone does their best.”
- “This is a nice place to work, the training is very good.”
- “Yes I have been trained in wound management.”

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 visiting professionals
- Environment.

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

Conclusion

The inspector can confirm that at the time of inspection the delivery of care to patients 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.

One recommendation is made. This recommendation is addressed in the report and in the Quality Improvement plan (QIP)

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

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
		No requirements		

No	Minimum Standard Ref.	Recommendation	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	5.3	It is recommended that a pain assessment chart is incorporated in the identified patient's care record.	Inspection of three patients/residents care records confirmed that a pain assessment was incorporated in the identified patient's care record.	Compliant

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.

Nursing Home Regulations (Northern Ireland) 2005 : Regulations 12(1) and (4); 13(1); 15(1) and 19 (1) (a) schedule 3

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.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

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

Inspection Findings:

Policies and procedures relating to pre- admission and admission for planned and emergency admissions were 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.
 There was evidence to demonstrate that patients' and residents' individual needs were established on the day they were admitted to the nursing home, and effective procedures were in place to manage any identified risks.

The inspector reviewed three patients'/residents' care records which evidenced that at the time of each patient's /resident's admission to the home, a registered nurse carried out initial risk assessments and developed agreed plans of care to meet the patient's /resident's immediate care needs.

Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, pain and continence were also completed on admission.

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

Section B

Standard 5: 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.

The focus of inspection within Standard 5 will be based on three areas of practice or ‘themes’ as follows:

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

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.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1); 14(1); 15 and 16**Inspection Findings:**

The inspector observed that a named nurse system was operational in the home.

Review of three patients' /residents' care records and discussion with six patients/residents' individually and three patient's/resident's representatives evidenced that patients residents and/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.

In relation to wound care, the inspector examined one patient's care record.

Body mapping charts were completed for patients and residents on admission. These charts were reviewed and updated when any changes occurred to the patients' skin conditions. A recommendation is made that the pressure relieving equipment in place on the patient's bed and also when sitting out of bed is recorded in the patient's care plan.

There was evidence that patients' had pressure relieving devices in place, and the type of mattress in use was based on the outcome of the pressure risk assessment.

A daily repositioning and skin inspection chart was in place for patients with wounds and or at risk of pressure damage. A review of two repositioning charts revealed that patients' skin was inspected for evidence of change, patients were assessed at every positional change and a record of the findings was maintained.

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.

Wound observation charts outlined the dimensions of wounds and were completed each time dressings were changed. Entries were also made in wound care records each time the dressings were changed.

Care plans based on the outcome of a pain assessment was drawn up for patients.

Discussion with two registered nurses and review of three patients' care records confirmed that where a patient was assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention plan and treatment programme. Advice sought from the relevant healthcare professionals was recorded. Care records reflected advice provided by these professionals, and records reviewed

demonstrated that the advice provided was adhered to.

The registered manager 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 was knowledgeable regarding the referral process. Discussion with two registered nurses 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.

Review of the records of incidents revealed that the incidence of pressure ulcers, grade 2 and above was reported to the RQIA in accordance with Regulation 30 of the Nursing Home Regulations (Northern Ireland) 2005.

Patients' weights were recorded on admission and on at least a monthly basis or more often if required.

Patients' nutritional status was also reviewed on at least a monthly basis or more often if required.

Daily records were maintained regarding patients' daily food and fluid intake.

Policies and procedures were in place for staff on making referrals to the dietician. These include indicators of the action to be taken and by whom.

All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment.

Care records reviewed evidenced that patients were referred for dietetic assessment in a timely manner.

Observation of practice and discussion with patients and staff evidenced that the nutritional care plans were being implemented.

Review of staff training records revealed that registered nurses had received training in wound management on the 24 February 2014; care assistants had also received training in pressure area care and prevention on the 22 February 2014.

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

Section C

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

The focus of inspection within Standard 5 will be based on three areas of practice or ‘themes’ as follows:

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

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 Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16

Inspection Findings:

Review of three patients'/residents' care records revealed that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' and residents' needs.

Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care including wound management for each patient.

Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required.

The evaluation process included the effectiveness of any prescribed treatments, for example prescribed analgesia.

Discussion with the registered manager and review of governance documents evidenced that the quality of care records was 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.

<p>Provider's overall assessment of the nursing home's compliance level against the standard assessed</p>	<p>Compliant</p>
<p>Inspector's overall assessment of the nursing home's compliance level against the standard assessed</p>	<p>Compliant</p>

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.

The focus of inspection within Standard 5 will be based on three areas of practice or ‘themes’ as follows:

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

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

Inspection Findings:

The inspector examined four 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
- Nutritional risk assessment such as

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

- The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes for Older People
- The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care
- The European Pressure Ulcer Advisory Panel. (EPUAP)

Discussion with the registered manager and registered nurses confirmed that they had a good awareness of these guidelines. Review of three patients' care records evidenced that registered nurses implemented and applied this knowledge.

Discussion with the registered manager and review of governance documents evidenced that the quality of pressure ulcer/wound management was 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.

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. Two registered nurses and two care staff consulted could identify patients who required support with eating and drinking.

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 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.

The focus of inspection within Standard 5 will be based on three areas of practice or ‘themes’ as follows:

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

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.

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

Inspection Findings:

A policy and procedure relating to record 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 Home Minimum Standards (2008) and NMC professional guidance.

Registered nurses spoken with were aware of their accountability and responsibility regarding record keeping.

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'/residents' care records confirmed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient.

These statements reflected wound and nutritional management intervention for patients if required.

Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patient's status or to indicate communication with others concerning the patient.

Entries were noted to be dated, 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 which enabled the inspector to judge that the diet for each patient was satisfactory. For example, the record evidenced a choice at each mealtime.

The inspector reviewed the care records of two identified patients of being at risk of inadequate 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 regarding their dietary needs
- Where necessary a referral had been made to the dietician and or the speech and language therapist
- Care plans had been devised to manage needs and were reviewed regularly monthly or more often if deemed appropriate
- Care plans were reflective of recommendations made by specialist healthcare professionals.

Staff spoken with were knowledgeable regarding patients' and residents' nutritional needs.

Discussion with the registered manager and review of governance documents evidenced that the quality of record management was in keeping with DHSSPS minimum standards and NMC guidelines.

<p>Provider's overall assessment of the nursing home's compliance level against the standard assessed</p>	<p>Compliant</p>
<p>Inspector's overall assessment of the nursing home's compliance level against the standard assessed</p>	<p>Compliant</p>

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.

The focus of inspection within Standard 5 will be based on three areas of practice or ‘themes’ as follows:

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

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.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16

Inspection Findings:

Please refer to criterion examined in section E. In addition the review of patients’ care records evidenced that consultation with the patients and/or their representatives had taken place in relation to the planning of their care. This is in keeping with the DHSSPS minimum standards and the Human Rights Act 1998.

Provider’s overall assessment of the nursing home’s compliance level against the standard assessed	Compliant
Inspector’s overall assessment of the nursing home’s compliance level against the standard assessed	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.

The focus of inspection within Standard 5 will be based on three areas of practice or ‘themes’ as follows:

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

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.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)

Inspection Findings:

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 of the patients in the home had a care review undertaken through care management arrangements between 01 April 2013 and 31 March 2014.

The registered manager informed the inspector that care management reviews were held 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 patient or family. A member of nursing staff attends each review. A copy of the minutes of the most recent review was held in the patient's care record file.

The inspector viewed the minutes of four care management reviews which evidenced that, where appropriate patients, residents and their representatives had been invited to attend. Minutes of the review included the names of those who had attended an assessment of the

patients' and residents' needs and a record of issues discussed. Care plans were updated to reflect recommendations made at care management reviews where applicable.

<p>Provider's overall assessment of the nursing home's compliance level against the standard assessed</p>	<p>Compliant</p>
<p>Inspector's overall assessment of the nursing home's compliance level against the standard assessed</p>	<p>Compliant</p>

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 dietitians 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 Homes Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)

Inspection Findings:

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, residents, their representatives and staff in the home. The current menu planner was implemented on the 01 April 2014.

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/residents.

Staff spoken with were knowledgeable regarding the individual dietary needs of patients and residents to include their likes and dislikes. Discussion with staff including the cook and review of the record of the patient's /resident's meals confirmed that patients and residents 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.

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 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:
 - risks when patients are eating and drinking are managed
 - required assistance is provided
 - 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 Homes Regulations (Northern Ireland) 2005: Regulation/s 13 (1) and 20

Inspection Findings:

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 staff had attended training in dysphagia awareness.

Review of patients' care records that had been assessed by a speech and language therapist confirmed that their care plans had been reviewed to include the speech and language therapist's recommendations.

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. Two registered nurses and two care staff consulted could identify patients who required support with eating and drinking. .

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 manager, registered nurses, care staff and review of the staff training records revealed that these staff were trained in nutrition and dysphagia on the 28 March 2013 further training is planned for the 26 June 2014.

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.

<p>Provider's overall assessment of the nursing home's compliance level against the standard assessed</p>	<p>Compliant</p>
<p>Inspector's overall assessment of the nursing home's compliance level against the standard assessed</p>	<p>Compliant</p>

11.0 Additional Areas Examined

11.1 Documents required to be held in the Nursing Home

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

- The home's statement of purpose
- The patient's guide
- Sample of reports of unannounced visits to the home under regulation 29
- Sample of staff duty rosters
- Record of complaints
- Sample of incident/accidents
- Record of food provided for patients
- Statement of the procedure to be followed in the event of a fire
- Sample of the minutes of patients/relatives and staff meetings.

11.2 Patients under guardianship

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

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

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

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

11.4 Quality of interaction schedule (QUIS)

The inspector undertook a number of periods of observation in the home which lasted approximately 30 minutes each. The inspector observed the lunch meal being served in the dining room and the interactions between two care staff comforting a recently bereaved relative.

The observation tool used to record these observations was the Quality of Interaction Schedule (QUIS). This tool uses a simple coding system to record interactions between staff, patients, residents and visitors.

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

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

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

Observation of care practices, and communication with relatives revealed that staff were respectful and dignified in their interactions with the patients, residents, and relatives.

Overall the periods of observations were positive.

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.

11.6 Patient Finance Questionnaire

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

11.7 NMC declaration

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

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

11.8 Staffing /Staff Comments

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

The inspector spoke to 10 staff members during the inspection process and eight staff completed questionnaires.

Examples of staff comments were for as follows:

- "Milesian Manor is a home in every sense of the word. It is friendly and a great place to work. The residents are all well looked after."
- "The quality of care delivered in the home is excellent; we have a very friendly, caring, hardworking team who delivers individualised care under guidance of nurses."
- "Good communication among all grades of staff."

- “The nursing care here is excellent everyone does their best.”
- “This is a nice place to work, the training is very good.”
- “Yes I have been trained in wound management.”

11.9 Patients’ Residents’ Comments/Representatives Comments

The inspector spoke to six patients individually and with others in groups. Six patients completed questionnaires.

Examples of their comments were as follows:

- “So far I have been very happy, content and I am well looked after.”
- “If I need anything all I have to do is to ask a member of staff and they will co-operate with me immediately.”
- “My visitors are always made welcome.”
- “The food is always good, we get a choice of food the cook comes to me if I don’t like what is on the menu and she will cook me something else.”
- “I am totally satisfied, I couldn’t complain about anything.”
- “The staff are always kind and helpful to me.”
- “It is homely and friendly.”

11.10 Relatives’ Comments

The inspector spoke to three relatives and these relatives completed a questionnaire.

An example of the relatives comments are as follows.

- “Milesian Manor is a fine example of care for the elderly at the very best.”
- “I am very confident about the care that is being provided in Milesian Manor, any concerns or requests I have in relation to her care are discussed with me.”
- “I have nothing but praise for the manager and her team I cannot speak highly enough of the standard of care that was provided to my dying husband every one including the kitchen staff and cleaners were all so kind to me, I will never forget them.”

11.11 Environment

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

The premises presented as warm, clean and comfortable with a friendly and relaxed ambience.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Martha O'Kane, 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:

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



Quality Improvement Plan

Announced Primary Inspection

Milesian Manor

13 May 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 Martha O’Kane, Registered Manager either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
		No requirements were made as a result of this inspection.			

Recommendations

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

No.	Minimum Standard Reference	Recommendation	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.3	<p>It is recommended that the pressure relieving equipment in use on patients' beds and when sitting out of bed be addressed in patients' care plans on pressure area care and prevention.</p> <p>Ref Section B</p>	One	This is now being done.	From the date of this inspection

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

Name of Registered Manager Completing Qip	Martha O'Kane
Name of Responsible Person / Identified Responsible Person Approving Qip	Mr Patsy Forbes/Mr Seamus Higgins

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Heather Moore	26 June 2014
Further information requested from provider			