Unannounced Primary Inspection

Name of Establishment:	**Rylands**
Establishment ID No:	**1437**
Date of Inspection:	**02 June 2014**
Inspector's Name:	**Bridget Dougan**
Inspection No:	**17095**

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:	Rylands
Address:	11 Doagh Road Kells Ballymena BT42 3LZ
Telephone Number:	028 2589 2411
E mail Address:	rylndsprvt@aol.com
Registered Organisation/ Registered Provider:	Rylands Mr Trevor & Mrs Karen Duncan
Registered Manager:	Mrs Valerie Rutherford
Person in Charge of the Home at the time of Inspection:	Mrs Valerie Rutherford
Registered Categories of Care and number of places:	NH-I, NH-LD, NH-PH,NH-PH(E), RC-I, RC-MP(E), RC-PH(E) 59
Number of Patients Accommodated on Day of Inspection:	56 patients/residents
Date and time of this inspection:	02 June 2014: 11.30 – 17.00 hours
Date and type of previous inspection:	19 November 2013 Primary Unannounced

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

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

4.0 Methods/Process

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

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

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

- analysis of pre-inspection information
- discussion with the 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	**40**
Staff	**12**
Relatives	**2**
Visiting Professionals	**0**

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

Issued To	**Number issued**	**Number returned**
Patients	**4**	**3**
Relatives / Representatives	**4**	**2**
Staff	**6**	**5**

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

Rylands Private Nursing Home is a single storey, purpose built nursing home pleasantly located in the countryside between the village of Kells and the town of Ballymena. The home is situated on three acres of spacious grounds with a patio area and landscaped gardens. Ample car parking is available.

Bedroom accommodation is provided in single and double rooms and there is a range of communal lounges, dining area, toilets, and bathroom and shower facilities.

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

Residential Care (maximum 14 persons)

RC- I	Old age not falling into any other category
RC-MP (E)	Mental disorder excluding learning disability or dementia
RC-PH (E)	Physical disability other than sensory over 65 years

Nursing Care (maximum 45 persons)

NH- I	Old age not falling into any other category
NH-PH (E)	Physical disability other than sensory over 65 years
NH-PH	Physical disability other than sensory under 65 years
NH-LD	Learning disability (maximum 2 persons)

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

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (unannounced) to Rylands. The inspection was undertaken by Bridget Dougan on 02 June 2014 from 11.30 hours to 17.00 hours.

The inspector was welcomed into the home by Mrs Valerie Rutherford, 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 two 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/residents, staff and four relatives during the inspection.

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

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

As a result of the previous inspection conducted 19 November 2013, one requirement and two recommendations were issued. This requirement and recommendations were reviewed during this inspection. The inspector evidenced that the requirement and 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 was evidence to validate that patients/residents receive safe and effective care in Rylands Nursing Home.

The inspector inspected six patients/residents care records and 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 the patients/residents' needs was evidenced to inform the care planning process.

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

There was written evidence maintained in all the care records reviewed to indicate that discussions had taken place with patients/residents and their representatives in regard to planning and agreeing nursing interventions.

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

Compliance Level: Compliant

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

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

Compliance level: Compliant

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

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

Robust systems were evidenced with risk assessments and appropriate referrals to GP's, speech and language therapists and or dieticians being made as required. Inspection of staff training records revealed that staff as appropriate required a training update on Dysphagia. A recommendation is made in this regard.

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

Compliance level: Substantially Compliant

- **Management of Dehydration – Standard 12**

The inspector also examined the management of dehydration during the inspection. The home maintained fluid balance records for those patients/residents assessed at risk of dehydration. Patients were observed to be able to access fluids with ease throughout the inspection.

Compliance level: Compliant

Patients/residents / their representatives and staff questionnaires

Some comments received from patients/residents and their representatives:

"The quality of care I receive is good."

“My relative is treated with dignity and respect.”

Some comments received from staff:

“I am happy in my place of employment and see myself in this role for a long time.”

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/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.

Patients/residents were observed to be treated with dignity and respect.

One recommendation is made with regard to staff training.

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

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirement	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	15 (2)	The registered person shall ensure that the assessment of the patient's needs is kept under review and revised at any time when it is necessary to do so having regard to any change of circumstances.	The inspector reviewed six patients/residents care records and evidenced that this requirement had been met.	**Compliant**

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	5.3	The registered manager must ensure that repositioning charts have been accurately maintained and that the repositioning regimes prescribed in care plans are being adhered to.	Inspection of a sample of patients/residents repositioning charts evidenced that this recommendation has been met.	**Compliant**
2	5.6	The registered manager must ensure that 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.	The inspector reviewed six patients/residents care records and can confirm that this recommendation has been met.	**Compliant**

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

Since the previous care inspection on 19 November 2013, RQIA have received no notifications of safeguarding of vulnerable adult (SOVA) incidents in respect of Rylands Nursing Home.

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

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

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

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

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

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

Observation of care practices revealed that staff were respectful in their interactions with the patients/residents.

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. Complaints recorded since the previous inspection were investigated appropriately.

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/residents' 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 pro forma 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 pro forma indicated that all nurses, including the registered manager were registered with the NMC.

11.8 Staffing /Staff Comments

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

The inspector spoke to 12 staff members during the inspection process and reviewed five staff completed questionnaires.

Examples of staff comments were as follows:

“The home is well run and a bright and content place. Residents are happy as is their families.”
“I am happy in my place of employment and see myself in this role for a long time.”
“I enjoy my role as a care assistant and looking after the residents.”

11.9 Patients/Residents’ Comments

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

Examples of their comments were as follows:

“The quality of care I receive is good.”
“I am very happy and content here, but feel that the price charged is too much.”

11. 10 Relatives’ Comments

The inspector spoke to two relatives and these relatives completed questionnaires.

An example of the relatives’ comments is:

“My relative is treated with dignity and respect.”

11.11 Environment

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

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

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Valerie Rutherford, 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:

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

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**
At the time of admission a nurse carries out a nursing needs assessment based on the Roper Logan & Tierney activities of daily living. All information received prior to admission ie Pre Admission, Trust Careplans, OT, Physio and Medical Assessments are also used to draw up a plan of care to meet the residents immediate nursing needs. All careplans are completed within 11 days following admission. These are based on the residents needs which are devised following completion of validated assessment tools ie Braden, Community Nutritional Risk scoring Tool, Moving and Handling, Bedrail Balance Tool, Falls risk Assessment,	Compliant

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

meet identified nursing needs with the resident and their representative. The careplan promotes independence and rehabilitation and reflects any advice and recommendations given by relevant health professionals. There are referral arrangements in place to obtain advice and support for relevant healthcare professionals eg Tissue Viability Nurse, Speech and Language Therapists, Dieticians and Podiatrists. If a patient is assessed as 'at risk' of a pressure ulcer a careplan is in place for the prevention of pressure ulcer and comfort of the resident. This has been discussed with relevant healtcare professionals.	
Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Re-assessment is an ongoing process that is carried out on a daily basis and at identified times as recorded in nursing careplans. Progress Notes are completed at least twice a day by day and night staff or more frequent if required. Wound careplans are evaluated each time a wound is redressed and any antibiotic careplan is evaluated at agreed time intervals. All other careplans are evaluated monthly or following advice or recommendations from other healthcare professionals.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All nursing interventions and procedures are supported by research evidence and guidelines defined by professional guidelines. A validated pressure ulcer grading tool - (EPUAP) is used to assess the grades of wounds. A plan of care and treatment is implemented depending on the condition of the wound. Advice is sought from the Tissue Viability Nurse as appropriate. The Nutritional Guidelines and menu checklist for Residential and Nursing Home (2014) is available to all staff for consultation and advice.	Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All nursing interventions are maintained in accordance with the NMC Guidelines. Nursing interventions, activities and procedures are recorded and action taken as necessary ensuring careplans are reviewed and updated as required. Allied Health Professionals, patients and their representatives are informed of any changes in accordance with the standards. All records demonstrate current care provided and any changes in patients condition. A diet and fluid chart is kept for each nursing resident. This is detailed to allow any person inspecting it to judge whether the diet for each resident is satisfactory. It is also recorded on the diet and fluid chart if any resident is unable to or refuses to eat a meal. This information is then relayed to the nurse in charge and as appropriate will make a referral to the relevant healthcare professionals. The Residents Representative and GP are also informed and a record kept of action taken.	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care delivered is monitored and recorded on a daily basis by day and night staff in the daily progress notes. In addition to this antibiotic and wound careplans are evaluated at agreed time intervals. Residents or their representatives are involved in the careplanning process and expected outcomes.	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**
Residents and their Representatives are encouraged to participate in all aspects of reviewing their outcomes of care. They are encouraged and facilitated to attend and participate in all review meetings arranged by their Care Manager. All reviews are minuted and any changes to the nursing careplan are implemented. Residents or their Representatives are involved in the careplanning process as appropriate.	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**
All Residents are provided with a Nutritious and varied diet which meets their individual needs and preferences. The kitchen is kept informed of all guidance provided by dieticians and speech and language therapists. The kitchen also has a copy of the Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes (2014). The menu offers the resident a choice of meals. The Chef establishes what the resident wants for the meal. If the Resident does not want what is on the menu, the Chef will then discuss this with them and cook them whatever they want from his supplies. Residents who are on a therapeutic diet are also offered a choice as appropriate.	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nurses ensure that all recommendations and advice given by speech and language therapists are adhered to. The recent Dysphagia Diet Food Texture Descriptors (2012) guidelines are available within the home. The nurse accompanies the speech and language therapist when she is assessing the resident and gleans knowledge from her on the skills necessary in managing feeding techniques for residents who have swallowing difficulties. Training has also been organised for all staff to update them in their knowledge and professional development of assisting residents with their dietary intake who have swallowing difficulties. Meals are provided at conventional times. There are tea trolleys that offer hot and cold drinks and snacks for the	Moving towards compli

residents. Fresh drinking water and juices are available throughout the day for the residents. All staff are aware of each residents needs regarding eating and drinking. Staff are aware if the the resident is on a specialised diet and if they require assistance with diet and fluids. There is adequate staff available during mealtimes. This helps to ensure that Residents are assisted as necessary and that any risks to residents are managed. The kitchen ensures that all necessary aids and equipment is available eg specialised drinking vessels and plate guards. Staff are aware of the EPUAP guidelines which are available in the home. They also use their own clinical judgement in wound assessments and wound care products and dressings. The staff will also seek advice from the TVN as appropriate and make referrals for home visits as appropriate. Training is also being arranged for all staff to update them in their knowledge and professional development in woundcare via the TVN.	

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	**COMPLIANCE LEVEL**
	Moving towards compliance

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

Rylands

02 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 Mrs Valerie Rutherford 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	8.6	The registered manager must ensure that all relevant staff receive update training in the management of dysphagia. **Reference: Section 8.0**	One	Training has been arranged for all staff in the management of dysphagia.	Within one month from date of this report

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	V Rutherford
Name of Responsible Person / Identified Responsible Person Approving Qip	

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

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Bridget Dougan	22 August 2014
Further information requested from provider			