Unannounced Primary Inspection

Name of establishment:	**Ballyclare Nursing Home**
Establishment ID No:	**1442**
Date of inspection:	**30 September 2014**
Inspector's name:	**Bridget Dougan**
Inspection number:	**IN017097**

The Regulation And Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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1.0 General information

Name of establishment:	Ballyclare Nursing Home
Address:	107 Doagh Road Ballyclare Co. Antrim
Telephone number:	028 9334 0310
Email address:	ballyclare.nursinghome@btconnect.com
Registered organisation/ Registered provider / Responsible individual	Mrs Janet Montgomery Hutchinson Homes Ltd
Registered manager:	Mrs Harriet Dunsmore
Person in charge of the home at the time of inspection:	Sister Dorothy Burns
Categories of care:	Nursing - over pension age - max 31 places Residential - over pension age - max 3 places
Number of registered places:	34
Number of patients accommodated on day of inspection:	32
Scale of charges (per week):	Nursing - £510 Residential - £405
Date and type of previous inspection:	10 December 2013 Primary Unannounced
Date and time of inspection:	30 September 2014: 11.30am - 4.30pm
Name of inspector:	Bridget Dougan

2.0 Introduction

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

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

3.0 Purpose of the inspection

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

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

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

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

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

4.0 Methods/process

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

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

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

- Review of any notifiable events submitted to RQIA since the previous inspection
- analysis of pre-inspection information
- discussion with the nurse in charge

- observation of care delivery and care practices
- discussion with staff
- examination of records
- consultation with patients individually and with others in groups
- tour of the premises
- evaluation and feedback.

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

5.0 Consultation process

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

Patients	**10 individually and to others in small groups**
Staff	**6**
Relatives	**2**
Visiting Professionals	**0**

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

Issued to	**Number issued**	**Number returned**
Patients	**3**	**2**
Relatives / representatives	**0**	**0**
Staff	**6**	**6**

6.0 Inspection focus

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

Criteria from the following standards are included;

- management of nursing care – Standard 5
- management of wounds and pressure ulcers –Standard 11
- management of nutritional needs and weight Loss – Standard 8 and 12
- management of dehydration – Standard 12

An assessment on the progress of the issues raised during and since the previous inspection was also undertaken.
The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.

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

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

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

7.0 Profile of Service

Ballyclare Nursing Home was first registered in September 1989. It is a purpose built two storey home situated on the outskirts of Ballyclare town centre, convenient to all shops and amenities.

Bedroom accommodation is provided in single and double rooms. The first floor of the home is accessed by a passenger lift and stairs. There are a range of toilets, bathrooms and shower facilities, communal lounges and a large dining room.

The home shares a site with Clareview Private Nursing Home and car parking facilities are available.

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

Nursing Care

I	Old age not falling into any other category

Residential Care

I	Old age not falling into any other category
MP(E)	Persons with mental disorder excluding learning disability over pension age
PH(E)	Persons with physical disability over pension age

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

8.0 Summary of inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Ballyclare Nursing Home. The inspection was undertaken by Bridget Dougan on 30 September 2014 from 11.30 am to 4.30 pm.

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

The inspector was welcomed into the home by Sister Dorothy Burns who was the nurse in charge. Verbal feedback of the issues identified during the inspection was given to Sister Burns 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, relatives and staff to seek their opinions of the quality of care and service delivered. The inspector also, 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.

The inspector spent an extended period observing staff and patient 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 was designed to help evaluate the type and quality of communication which takes place in the nursing home.

As a result of the previous inspection conducted on 10 December 2013, five requirements and one recommendation were issued. These were reviewed during this inspection and the inspector evidenced that four requirements have been fully complied with; one requirement and one recommendation are moving towards compliance. Details can be viewed in the section immediately following this summary.

Standards inspected:

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

Standard 8: Nutritional needs of patients are met. (selected criteria)

Standard 11: Prevention and treatment of pressure ulcers. (selected criteria)

Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (selected criteria).

8.1 Inspection findings

8.1.1 Management of nursing care – Standard 5

The inspector can confirm that at the time of the inspection there was evidence to validate that patients received safe and effective care in Ballyclare Nursing Home.

There was evidence of comprehensive and detailed assessment of patient needs from date of admission. A variety of risk assessments were also used to supplement the general assessment tool. The majority of assessments were found to be updated on a regular basis and as required. The assessment of patient need 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 for the majority of patients. There was evidence however that two patients assessments and care plans had not been updated on a regular basis.

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

COMPLIANCE LEVEL: Moving towards compliance

8.1.2 Management of wounds and pressure ulcers – Standard 11 (selected criteria)

The inspector evidenced that wound management in the home was generally well maintained.

There was evidence of appropriate assessment of the risk of development of pressure ulcers which demonstrated timely referral to tissue viability specialist nurses (TVN) for guidance and referral to the HSCT regarding the supply of pressure relieving equipment if appropriate.

Care plans for the management of risks of developing pressure ulcers and wound care were however not in place. There was no evidence of a policy and procedure for the prevention and treatment of pressure ulcers.

Discussion with staff and review of training records evidenced that training in relation to pressure area care and the prevention of pressure ulcers has not yet been provided for all relevant staff. A recommendation has been made in this regard. The nurse in charge confirmed that training had been arranged for registered nurses to receive tissue viability training in the management of wounds/pressure ulcers.

COMPLIANCE LEVEL: Moving towards compliance

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

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

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

The inspector also observed the serving of the lunch time meal and can confirm that patients were offered a choice of meal and that the meal service was well managed and supervised by registered nurses.

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

COMPLIANCE LEVEL: Compliant

8.1.4 Management of dehydration – Standard 12 (selected criteria)

The inspector examined the management of dehydration during the inspection which evidenced that intake details for patients were recorded and maintained for those patients assessed at risk of dehydration. It is recommended that fluid requirements are also recorded on care records for those patients assessed as being at risk of dehydration.

Patients were observed to be able to access fluids with ease throughout the inspection. Staff were observed offering patients additional fluids throughout the inspection. Fresh

drinking water/various cordials were available to patients in lounges, dining rooms and bedrooms.

COMPLIANCE LEVEL: Substantially compliant

8.3 Patient, representatives and staff questionnaires

Some comments received from patients:

- "Staff couldn't be better."
- "This is a home from home."

Some comments received from staff:

- "We have a great team. There is a great atmosphere in the home. Staff get on well and put residents needs first."
- "The work ethic in the home is of a very high standard and all staff give 100%. It would be great if we could just take a little more time with each resident."

8.4 A number of additional areas were also examined.

- records required to be held in the nursing home
- Human Rights Act 1998 and European Convention on Human Rights (ECHR)
- Patient and staff quality of interactions (QUIS)
- Complaints
- patient finance pre-inspection questionnaire
- NMC declaration
- staffing and staff comments
- environment.

The inspector can confirm that at the time of this inspection the delivery of care to patients was evidenced to be of a good standard. 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. However, areas for improvement were identified in relation to care records and staff training.

Therefore, one requirement and six recommendations are raised as a consequence of this inspection. One requirement and one recommendation have been stated for the second time. These requirements and recommendations are detailed throughout the report and in the quality improvement plan (QIP).

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

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

9.0 Follow-up on the requirements and recommendations issued as a result of the previous inspection on 20 June 2013.

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	13 (7)	The registered person shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff.	Discussion with the nurse in charge and observations during a general inspection of the internal environment of the home evidenced that this requirement had been	Compliant
2	18 (2) (c)	The registered person must ensure the issues pertaining to the maintenance and décor of the home identified during the inspection of 12 August 2013 have been addressed.	The inspector observed that an extensive refurbishment programme had been completed since the previous inspection.	Compliant
3	20 (1) (c)	The registered person shall having regard to the size of the nursing home, the statement of purpose and the number and needs of patients: – Ensure that at the persons employed by the registered person to work at the nursing home receive: Appraisal and supervision	Inspection of a sample of staff personnel records, discussion with the nurse in charge and review of documentation submitted by the registered manager following the inspection evidenced that this requirement had been met.	Compliant

4	27 (4) (b)	The registered person shall take adequate precautions against the risk of fire.	Observation of the environment at the time of this inspection and review of the completed Quality Improvement Plan for the previous inspection evidenced that this requirement has been met.	Compliant
5	16 (2) (b)	The registered person shall ensure that the patients risk assessments and care plans are kept under review	The inspector reviewed five patients care records and evidenced that two patients risk assessments and care plans had not been reviewed on a monthly basis or more frequently to take account of the changing needs of the patients.	Moving towards compliance

No	Minimum Standard Ref.	Recommendation	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	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.	Review of five patients care records evidenced that not all risk assessments and care plans were kept under review.	Moving towards compliance

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

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

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

10.0 Additional areas examined

10.1 Records required to be held in the nursing home

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

10.2 Patients under guardianship

There were no patients currently under guardianship resident at the time of inspection in the home.

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

The inspector discussed the Human Rights Act and Human Rights Legislation with the nurse in charge. A recommendation has been made for copies of these documents to be available in the home for staff to access. The nurse in charge confirmed that these documents will be discussed with staff during staff meetings and that staff will be made aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patients care and accompanying records.

10.4 Quality of interaction schedule (QUIS)

The inspector undertook one period of observation in the home which lasted for approximately 20 minutes.

The inspector observed the interactions between patient and staff during the serving of lunch in the dining room.

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

Positive interactions	All positive
Basic care interactions	0
Neutral interactions	0
Negative interactions	0

The inspector evidenced that the quality of interactions between staff and patients/residents was positive.

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

10.5 Complaints

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

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

10.6 Patient finance questionnaire

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

10.7 NMC declaration

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

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC. This was also evidenced by the inspector on the day of inspection.

10.8 Questionnaire findings

10.8.1 Staffing/staff comments

Discussion with a number of staff and review of a sample of staff duty rosters at the time of the inspection evidenced that while the registered nursing and care staffing levels were in line with RQIA's recommended minimum staffing guidelines, some staff had expressed a degree of dissatisfaction with staffing levels due to current sickness absence levels. This was discussed with the registered manager following the inspection. The registered manager informed the inspector that recruitment for additional staff was underway and this issue was being addressed.

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

- "We have a great team. There is a great atmosphere in the home. Staff get on well and put residents needs first."
- "The work ethic in the home is of a very high standard and all staff give 100%. It would be great if we could just take a little more time with each resident."
- "I feel we give good care in the home. All residents are treated with respect and dignity. However I feel that the home would benefit from more staff."
- "Staff work well within the home to provide the best care possible."

10.8.2 Patients' comments

During the inspection the inspector spoke with ten patients individually and with a number in groups. In addition, two patients completed questionnaires.

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

- "This home is excellent."
- "Staff are brilliant no matter what you ask them to do."
- "Staff couldn't be better."
- "This is a home from home."

10.8.3 Patient representative/relatives' comments

During the inspection the inspector spoke with two representatives/relatives who were complementary regarding the care and services provided.

10.9 Review of care records

The inspector examined a number of patient care records as part of the inspection process to validate the providers self-assessment. The inspector identified some areas for improvement in the management of care records as follows:

- assessments and care plans had not been updated on a regular basis for two out of the five care records reviewed
- care plans for the management of risk of developing pressure ulcers and wound care were not in place for two patients
- for those patients assessed at risk of dehydration, while fluid intake records had been recorded, it is recommended that target fluid requirements are also recorded on care records.

One requirement and three recommendations have been made with regard to care records. One requirement and one recommendation have been stated for the second time.

10.10 Staff training

Discussion with staff and review of training records evidenced that training in the management of wounds/pressure ulcers had been arranged for registered nurses. Training in relation to pressure area care and the prevention of pressure ulcers has not yet been provided for all relevant staff.

One recommendation has been made with regard to staff training.

10.11 Policies and procedures

The inspector was unable to evidence that a policy and procedure was in place to guide and inform staff in regard to the prevention and treatment of pressure ulcers. A recommendation has been made accordingly.

11.0 Quality improvement plan

The details of the quality improvement plan appended to this report were discussed with Sister Dorothy Burns, Nurse in Charge at the time of the inspection and with Mrs Harriet Dunsmore, Registered Manager following the inspection, 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
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Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All residents coming into the Nursing Home have a pre assessment from which an agreed plan of care is drawn up. . A comprehensive holistic assessment of the resident's needs is completed. All residents has nutritional screening carried out using CNRST tool. We use a the Braden Score tool for pressure ulcer risk assessment. for pre assessment and on admission	Substantially compliant

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

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**
Computerised nurse record system currently being installed. We are working towards meeting Criterion 5.4	Moving towards compliance

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**
Criterion 5.5 we believe we meet this criteria Criterion 11.4 we use the Braden tool Criterion 8.4 We have and use up to date nutritional guidelines	Substantially compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
We aim to meet criterion 5.6 more completely following the introduction of the computerised record system We keep a record of all meals provided to meet criterion 12.11 We meet criterion 12.12	Moving towards compliance

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**
We are working towards this criterion and hope to have it fully implemented following the installation of the computerised record system	Moving towards compliance

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**
Criterion 5.8 criterion 5.9 we meet these areas but wish to develop more robust records	Substantially compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
We meet these criteria	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**
All staff have up to date skills as required in criterion 8.6 Meals are provided as required in criterion 12.5 Criterion 12.10 we meet this criteria 11.7 Staff have the expertise and skill in wound management.	Compliant

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

Ballyclare Nursing Home

30 September 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 Sister Dorothy Burns, Nurse in Charge at the time of the inspection and with Mrs Harriet Dunsmore, 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	Requirement	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	16 (2) (b)	The registered person shall ensure that the patients risk assessments and care plans are kept under review. **Reference: Follow up on previous issues**	Two	Each Member of staff have received a memo concerning these issues. Regular audits will be carried out	From date of last inspection

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.6	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. **Reference: Follow up on previous issues**	Two	All staff have been made aware by individual memos about this issue. Audits will be carried out to ensure compliance.	From date of last inspection
2	5.5	The registered manager should ensure that copies of the following documents are available in the home for staff to access: • Human Rights Act 1998 • European Convention on Human Rights • (ECHR) DHSSPS • Deprivation of Liberty Safeguards (DOLS) The content of these documents should be discussed with staff during staff meetings and staff should be aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patient care and accompanying records. **Reference: Section 10.3**	One	We have these documents and will be discussing these with staff at staff meetings The staff are aware that the documents are available to access	Within one week from date of this inspection

3	11.3	The registered manager should ensure that where a patient has been assessed as being 'at risk' of developing a pressure ulcer, a care plan is in place to manage the prevention plan and treatment programme. **Reference: Section 11.0**	One	Staff have been made aware of this Audits are in place to ensure compliance by staff	From the date of this inspection
4	11	The registered manager should ensure there is a policy and procedure for the prevention and treatment of pressure ulcers available in the home for staff to reference. **Reference: Section 13.0**	One	We have a policy and procedure for the prevention and treatment of pressure ulcers available for staff to reference	Within two weeks from the date of this inspection
5	28.4	The registered manager should ensure that training in relation to pressure area care and the prevention of pressure ulcers is provided for all relevant staff **Reference: Section 12.0**	One	Tissue Viability nurse specialist is providing training in Ballyclare on Tuesday 9th Dec '14. Several staff have already completed training	Within two months from date of this inspection
6	8.3	A recommendation has been made to ensure that, for those patients identified as being at risk of inadequate or excessive food and fluid intake: • a fluid intake target over 24 hours is recorded in the relevant care plan and on fluid balance charts • an effective reconciliation of the total fluid intake against the fluid target established • action to be taken if targets were not	One	We have taken measures to ensure that all of these recommendations are put into practice. Audits are in progress.	From the date of this inspection

		being achieved. **Reference: Section 11.0**			

The registered provider / manager is required to detail the action taken, or to be taken, in response to the issue(s) raised in the Quality Improvement Plan. The Quality Improvement Plan is then to be signed below by the registered provider and registered manager and returned to:

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

Signed: _____ **Signed:** H. Dunsmore

Name: J. Montgomery **Name:** HARRIET DUNSMORE
Registered Provider **Registered Manager**

Date 17.12.2014. **Date** 17/12/14

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

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Bridget Dougan	06 January 2015
Further information requested from provider			