Unannounced Primary Care Inspection

Name of establishment: **Ardmaine Care Home**

RQIA number: **1460**

Date of inspection: **9 October 2014**

Inspector's name: **Loretto Fegan**

Inspection number: **IN017208**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of establishment:	Ardmaine Care Home
Address:	Fullerton Road Newry BT 34 2 AY
Telephone number:	(028) 3026 2075
Email address:	ardmaine@fshc.co.uk
Registered organisation	Four Seasons Healthcare
Registered manager (Acting):	Mrs Anne Marie O'Loughlin
Person in charge of the home at the time of inspection:	Mrs Anne Marie O'Loughlin
Categories of care:	Nursing - I - 24 Nursing - DE - 33 Nursing - MP - 8
Number of registered places:	65
Number of patients accommodated on day of inspection:	44 Nursing - I - 19 Nursing - DE - 19 Nursing - MP - 6
Scale of charges (per week):	£581
Date and type of previous inspection:	14 October 2013 Secondary Unannounced Care Inspection
Date and time of inspection:	9 October 2014 09.00 - 18.50
Name of inspector:	Loretto Fegan

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/residents 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 the preliminary assessment of achievement by the Provider 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 notifiable events submitted to RQIA, in accordance with Regulation 30 of the Nursing Homes Regulations (NI) 2005, since the previous inspection.

- analysis of pre-inspection information submitted by the registered manager (Mrs A Begley).
- Discussion with Mrs Anne Marie O'Loughlin, acting manager and Ms P Graham, home manager from another FSHC facility who was in attendance during part of the inspection.
- Review of the returned quality improvement plan (QIP) from the previous care inspection conducted on 14 October 2013.
- Observation of care delivery and care practices.
- Discussion with staff on duty at the time of this inspection.
- Examination of records pertaining to the inspection focus.
- Consultation with patients individually and with others in groups.
- Tour of the premises.
- Evaluation and feedback.

5.0 Consultation process

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

Patients/Residents	13
Staff	4 (in addition to acting manager)
Relatives	5
Visiting professionals	0

Questionnaires were provided during the inspection, to patients, their representatives and staff to seek their views regarding the quality of the service.
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Issued to	**Number issued**	**Number returned**
Patients / residents	3	3 (completed with patients by inspector)
Relatives / representatives	3	3 (completed with relatives by inspector)
Staff	10	6

6.0 Inspection focus

The theme for the inspection year April 2014 – March 2015 is: 'Nursing Care'

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 regular reviewed. (Standard 5)

Under the 'Nursing Care' theme, inspection will focus on three areas of practice:

- management of wounds and pressure ulcers (Standard 11)
- management of nutritional needs of patients and weight loss (Standard 8 & 12)
- management of dehydration (Standard 12).

Only selected criteria from each of the four standards will be inspected across nine areas and incorporated into the Provider's Self-Assessment.

The inspector will also consider the management of patient's human rights during this inspection.

The inspection theme and focus for the 2014 – 2015 inspection year was outlined by RQIA at the annual Provider Roadshow in February 2014 and the self-assessment was made available on the RQIA website.

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

Ardmaine Care Home is situated in close proximity of Newry city and is owned and operated by Four Seasons Healthcare. The acting manager is Mrs Anne-Marie O'Loughlin.

The home is a two-storey building with a total of fifty one single and seven double bedrooms located over both floors. Communal lounges and dining rooms are also provided on both floors. In addition, the home has a hairdressing salon and a sun lounge and designated activity room are situated on the ground floor. Toilet, bathing and showering facilities are located throughout the home. Catering and laundry facilities, staff facilities and offices are also available on site.
The home has an enclosed courtyard area and car parking is to the front of the home.

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

Nursing care

I	old age not falling into any other category
DE	dementia care to a maximum of 33 patients accommodated within the dementia unit
MP(E)	mental disorder excluding learning disability or dementia over 65 years

8.0 Executive Summary

The unannounced inspection of Ardmaine Care Home was undertaken by Loretto Fegan on 9 October 2014 between 09.30 and 18.50 hours. The inspection was facilitated by Mrs Anne -Marie O'Loughlin, acting manager and Ms P Graham, a home manager from another Four Seasons Healthcare facility was also in attendance during the latter part of the inspection. Both Mrs O'Loughlin and Ms Graham were both available for verbal feedback at the conclusion of the inspection.

The theme for the 2014 – 15 inspection year is 'Nursing Care' (Standard 5) and the inspection focused on three areas of practice related to:

- management of wounds and pressure ulcers (Standard 11)
- management of nutritional needs of patients and weight loss (Standard 8 & 12)
- management of dehydration (Standard 12).

The inspector also considered the management of patient's human rights during this inspection. The requirements and recommendation made as a result of the previous inspection were also examined.

Prior to the inspection, the registered manager (Mrs A Begley) completed a self-assessment using the standard criteria outlined in the theme inspected. This self-assessment was received on 9 June 2014. The comments provided by the registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

Prior to the inspection taking place the inspector reviewed the completed self – assessment and other information submitted by Mrs A Begley, registered manager as part of the pre-inspection process (refer to section 11). The responses in the returned quality improvement plan (QIP) pertaining to the inspection undertaken on 14 October 2013 were also reviewed. The inspector also reviewed incidents submitted to RQIA from the home and followed up specific cases / issues as part of the inspection process.

In addition to observing care practices while undertaking a tour of the premises, the inspector undertook two periods of enhanced observation in the home. The inspector evidenced that the quality of interactions between staff and patients/ relatives at the time of the inspection demonstrated courtesy, respect and engagement with both patients and relatives.

Patients including those who were unable to verbally express their views were observed to be well groomed, appropriately dressed and relaxed and comfortable in their surroundings.

Patients spoken with and the questionnaire responses confirmed that patients were very happy living in the home and felt well cared for. Relatives also indicated that they were content with the care their relatives were receiving.

Refer to section 11.0 for further details about patients/relatives.

The inspector can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a satisfactory standard and patients were observed to be treated by staff with dignity and respect.

Discussion with the acting manager and review of the nursing and care staff duty roster for week commencing 6 October 2014 evidenced that the registered nursing and care staffing levels were in accordance with RQIA's recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection. The acting manager informed the inspector that the home have advertised for a personal activities leader (30 hours per week) and housekeeper 38.5 hours per week as these posts are currently vacant.

During the inspection, the inspector spoke individually with four staff ; two registered nurses and two care staff and six staff completed questionnaires. Staff responses from both discussion and the returned questionnaires indicated that staff are generally well supported with induction and training commensurate with their roles and responsibilities. An issue raised by a staff member with regard to the induction process was discussed with the acting manager who agreed to follow this up with the staff member concerned.

All staff were satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and their individual wishes, however a few staff indicated that they did not have enough time to listen and talk to patients. Staff advised that they enjoyed working in the home; however one staff member whilst acknowledging in a returned questionnaire that "staff morale is good most days" also stated that there was "a divide between day and night staff". This was discussed with the acting manager who informed the inspector of the processes in place to support staff with any concerns.

With the exception of one bedroom which had a mal-odour, all other areas of the home inspected were maintained to an acceptable standard of hygiene and décor.

There were systems and processes in place to ensure the effective management of the standards inspected. However, areas for improvement were identified in relation to care records, notification of grade 2 and above pressure ulcers, training and audit of care records.

The inspector reviewed and validated the home's progress regarding the four requirements and one recommendation made at the last care inspection on 14 October 2013 and confirmed compliance outcomes as follows: two requirements and one recommendation had been fully complied with and two requirements were found to be substantially compliant.

Verbal feedback of the inspection outcomes was given to the acting manager throughout the inspection and to both Mrs O'Loughlin, acting manager and Ms P Graham, home manager from another FSHC facility at the conclusion of the inspection process.

Conclusion

As a result of this inspection, four requirements and four recommendations were made; two requirements are restated for a second time.

Details can be found under Section 10.0 in the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, relatives, Mrs O' Loughlin, acting manager, Ms P Graham, registered nurses and staff for their assistance and co-operation throughout the inspection process.

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

9.0 Follow-up on the requirements and recommendations issued as a result of the previous primary unannounced care inspection conducted on 14 October 2013

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
1	20 (1) (c) (i)	Ensure all staff receive mandatory training, this includes, safeguarding vulnerable adults, food hygiene, first aid and infection control. Registered nursing staff managing wound care should receive up to date training.	The inspector reviewed staff training records and confirmed with the acting manager that overall compliance with staff mandatory training was 81%. This included the following compliance rates: • safeguarding vulnerable adults 72% • food hygiene 72% • first aid 88% • infection control 81% The acting manager confirmed that two registered nurses have received a recent training update in managing wound care and they will act as leads with regard to wound care in the home. The acting manager informed the inspector that further wound management training has been organised for additional nurses to attend in November 2014. This requirement will be stated for the second time and compliance followed up during the next care inspection.	Substantially compliant

2	15	Ensure the following issues are addressed; • a full assessment of patients' needs should include nutritional and fluid intake/output management • ensure fluid balance charts contains all relevant information which includes the target amount of fluids alongside the action to take when the target is not met • ensure Malnutrition Universal Assessment Tool (MUST) is appropriately updated • where fluids are required to be thickened the consistency should be clearly written in the care plan	The inspector reviewed the care record of one patient who had a urinary catheter. The assessment process did not fully address nutritional and fluid intake/output management and the patient's fluid balance chart did not include the target amount of fluids or the action to take when the target is not met. A review of three care records evidenced that the Malnutrition Universal Assessment Tool (MUST) was appropriately updated. A review of two care records evidenced that where fluids were required to be thickened, the consistency was clearly written in the care plan. The non-compliant aspects of this requirement will be stated for the second time and compliance followed up during the next care inspection.	Substantially compliant

3	27	Ensure the following issues are addressed in relation to the environment; • the identified bedroom requires to have the floor covering replaced • doors are not to be wedged open • items should not be stored under stairwells • ensure clinical and general waste bins are appropriately provided	The floor covering on the twenty –two bedrooms viewed by the inspector was to a satisfactory standard. Fire doors observed by the inspector were not wedged open. The acting manager confirmed that all items stored under stairwells was removed following the inspection of 14 October 2013. Clinical and general waste bins were appropriately provided in the home.	Compliant

4	15	Ensure clarity is sought regarding the identified patient's diagnosis and ensure the care record is updated to reflect the required care. Care plans should be re-written when there are any changes to care	The acting manager confirmed that clarity was sought regarding the identified patient's diagnosis and that the care record was subsequently updated to reflect the required care. The inspector evidenced one care plan that was re-written to reflect changes to care.	Compliant

No	Minimum Standard Ref.	Recommendations	Action taken – as confirmed during this inspection	Inspector's validation of compliance
1	16.2	Ensure the induction period for care staff is spread over an appropriate period of time to ensure all information provided and is retained by the staff member.	The inspector spoke with one care staff member who confirmed that the induction period was undertaken in an unhurried pace, over a few months and confirmed this adequately facilitated consolidation of their learning. However, the induction records of this care staff member and that of a registered nurse who had also completed their induction period were not available for inspection. The staff members advised that the records remained with them to date. The acting manager confirmed that a record pertaining to a final statement of competency by the manager was outstanding. A separate recommendation has been made that a final statement of competency is signed off by the acting manager and retained on file.	Compliant

9.1 Follow up on any issues/concerns raised with RQIA since the previous inspection on 14 October 2013

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

RQIA have been notified by the home of an ongoing investigation in relation to a potential safeguarding of vulnerable adult (SOVA) issue. The SHSCT safeguarding team are managing the SOVA issue under the regional adult protection policy/procedures and the acting manager has agreed to keep RQIA updated regarding the outcome of the investigation.

RQIA is satisfied that the acting manager has dealt with SOVA issue in the appropriate manner and in accordance with regional guidelines and legislative requirements.

10.0 Inspection findings

Section A – On admission a registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Standard criterion 5.1, 5.2, 8.1 and 11.1 examined.
Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre - admission, planned and emergency admissions. The inspector reviewed the care records of two patients who were admitted to the home within recent months. This evidenced that patients' individual needs were established on the day of admission to the nursing home, through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks. Specific assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), and falls were also completed on admission. Continence and bowel assessments were also completed as part of the admission process. Review of two patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 11 days of the patient's admission to the home. In discussion with the acting manager, she demonstrated a good awareness of the patients who required wound management and the number and progress of patients who were assessed as being at risk of weight loss and dehydration.

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

Section B –A registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Care records evidence involvement of the patient and /or their representative and that care planning and delivery reflect the recommendation from relevant health professionals. Referrals to healthcare professionals are made as required and in a timely manner. Standard criterion 5.3, 11.2, 11.3, 11.8 and 8.3 examined.

The inspector observed that a named nurse and key worker system was operational in the home. The acting manager informed the inspector that the roles and responsibilities of named nurses and key workers is included in the updated version of the service user guide due to be issued shortly.

Review of three patients' care records and discussion with patients and relatives evidenced that patients or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Records also evidenced discussion with patients and/or their representatives following changes to the plans of care.

The acting manager informed the inspector that there were two patients in the home who required wound management for a wound. Review of these patients' care records evidenced the following:

- A body mapping chart was updated when any changes occurred to the patients' skin condition.

- A care plan was in place in respect of the prevention and management of pressure ulcers which specified the pressure relieving equipment in place on the patient's bed and also when sitting out of bed with regard to one patient, however this required further development in respect of the other patient. A requirement made in relation to care planning issues has incorporated this deficit.

- Although the type of mattress in use for one identified patient had pressure relieving properties, this was not based on the outcome of the pressure ulcer risk assessment/clinical judgement of the patient's condition. This was rectified on the day of inspection and reflected in the care plan. A requirement made in relation to care planning issues has incorporated this deficit.

- The acting manager advised that a daily repositioning and skin inspection chart was in place for patients with wounds/patients who were assessed as being at risk of developing pressure ulcers. However, review of one patient's repositioning chart identified that on occasions the re-positioning chart did not reflect consistent intervals of re-positioning taking place as would be indicated as best practice. The frequency of repositioning should be stated in the patient's care plan in accordance with best practice and the patient's assessed needs and this frequency should be reflected on the re-positioning chart records. A requirement made in relation to care planning issues has incorporated this deficit.

The acting manager and registered nurses confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local healthcare Trust. Staff spoken with were knowledgeable regarding the referral process. Discussion with two registered nurses evidenced that they were knowledgeable of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

The inspector cross referenced the incidence of pressure ulcers, grade 2 and above, with notifications submitted to RQIA. A notification was submitted to RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005 in relation to one patient, however this requires to be completed with regard to another patient**.** A requirement is made in this regard.

A sample of four care records evidenced that the patients' weights were recorded on admission and on at least a monthly basis or more often if required.

A sample of four care records evidenced that the patients' nutritional status was also reviewed on at least a monthly basis or more often if required.

Review of wound care in two patients' care plans evidenced that the dressing regime was recorded appropriately.

Review of care records for two patients evidenced that the patients were referred for a speech and language therapist assessment in a timely manner and the patients' care plans included the speech and language therapist's recommendations.

Discussion with the acting manager, registered nurses, care staff and review of the returned staff questionnaires indicated that there is ongoing training in wound management, pressure area care/prevention of pressure ulcers and in relation to the management of nutrition. A recommendation is made that all staff are continued to be supported with training in these areas commensurate with their roles and responsibilities until 100% compliance is achieved:

Patients' moving and handling needs were in the main assessed and addressed in their care records. However, a moving and handling re-assessment should be completed in respect of one patient who requires frequent repositioning while seated and the outcome should be reflected in the care plan. Discussion took place with the acting manager regarding this patient's seating which had a lap strap in place and it was agreed that a referral would be made to the occupational therapist to re-assess the suitability of the chair for the patient/discuss specific moving and handling requirements with regard to this patient. There were no records available to demonstrate that monitoring arrangements were in place to evidence the frequency the lap belt was released while the patient was seated in this chair. Another patient should have the mobility aid they use included in the care plan as identified in the assessment process. A requirement made in relation to care planning issues has incorporated these care planning deficits.

There was evidence that manual handling aids were used to minimise risk of friction. However, one member of care staff consulted informed the inspector that there were an insufficient number of hoists available. This was discussed with the acting manager who provided an assurance to the inspector that there were a sufficient number of hoists available to ensure patient care was delivered in a timely and person centred way.

The acting manager and registered nurses informed the inspector that pressure ulcers were graded using an evidenced based classification system.

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

Section C - Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans. Standard criteria 5.4 examined.
Review of four patients' care records evidenced that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care including wound care for each patient. Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. Review of two patients' care records in relation to wound care indicated that these care records were reviewed each time the dressing was changed. Review of care records also evidenced that nutritional care plans for patients were reviewed monthly or more often as deemed appropriate. Discussion took place with the acting manager regarding governance arrangements in place relating to audit of nursing records. While the inspector acknowledges that some audit activity in this regard has taken place in recent months, it is recommended that this process is further developed to ensure that the record audit sample size is proportionate to the number of patients accommodated in the home and that re-audit evidences that action is taken to address any deficits or areas for improvement identified through the audit process.

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

Section D – All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. Standard criterion 5.5, 8.4 and 11.4 examined.

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

- Braden pressure risk assessment tool.
- Nutritional risk assessment such as Malnutrition Universal Screening Tool (MUST).

The home uses the company (FSHC) documentation to support the assessment, care planning and evaluation process. This includes an admission assessment (incorporating a record of the patients' preferences) and a needs assessment to include 16 areas of potential need. A process for care planning and evaluating care is also in place.

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

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

Discussion with the acting manager and one registered nurse on duty confirmed that they had a good awareness of these guidelines. One registered nurse appeared unsure regarding awareness of some of these research and guidance documents, this was discussed with the acting manager who agreed to follow this up and provide further support through the induction process with the staff member concerned. A recommendation made in relation to induction will incorporate this issue.

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

Section E – Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients. Standard criterion 5.6, 12.11 and 12.12 examined.

A policy relating to nursing records management was available in the home. A cursory review of this policy evidenced that it reflected/referenced legislative requirements and other professional guidance including NMC guidance. However, a recommendation is made that the policy is localised to reflect/reference the relevant parts of The Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Nursing Homes Minimum Standards (2008). Outdated references such as UKCC should be removed.

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

The acting manager advised that e-learning training on record keeping is available for staff to undertake and informed the inspector that this is an optional training opportunity for care staff. It was not possible to review the percentage of staff trained in this regard on the home's computer system on the day of inspection. The acting manager confirmed that training is ongoing for all staff in relation to the newly developed FSHC documentation relating to patient care. It is recommended that all staff are continued to be supported with training in relation to record keeping commensurate with their roles and responsibilities in the home.

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

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

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

The inspector reviewed a record of the meals provided for patients and cross referenced this with a sample of cooking temperature records. Records were maintained in sufficient detail to enable the inspector to judge that the diet was satisfactory.

The inspector reviewed the care records of two patients identified of being at risk of inadequate or excessive food and fluid intake. This review confirmed that a care plan had been devised for both patients to manage their nutritional needs and was reviewed on a monthly or more often basis. The care plan reflected the relevant multi-professional advice. A daily record of food and fluid intake was being

maintained in respect of these patients.

Staff spoken with were knowledgeable regarding patients' nutritional needs.

The acting manager informed the inspector that staff have received training in the management of dysphagia within the past year as part of supervision, and that arrangements were in place for ongoing training in nutrition and dysphagia for all staff. A recommendation has been made that all staff undertake ongoing training in nutrition and the management of dysphagia.

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

Section F – 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. Standard criteria 5.7 examined.
Please refer to criterion examined in Section E. In addition, the review of three patients' care records evidenced that consultation with the patient and/or their representative had taken place in relation to the planning of the patients' care. Evidence of a partnership approach to patient care planning was ascertained by the inspector through discussion with patients and relatives. This is in keeping with the DHSSPS Minimum Standards and the Human Rights Act 1998.

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

Section G – The management and involvement of patients and/or their representatives in review of care. Standard criterion 5.8 and 5.9 examined.
Prior to the inspection, a patients' care review questionnaire was forwarded to the home for completion by staff. The acting manager confirmed that all patients in the home had a care review by the care management team of the referring HSC Trust during the past year. The home manager informed the inspector that patients' care reviews are held approximately eight weeks post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff preferably the patient's named nurse attends each care review. The inspector requested the minutes of two patients' care reviews, however she was informed by the acting manager that while these took place a few months previously, the minutes were not yet made available to the home. While acknowledging that this was beyond the control of the home, it was agreed with the acting manager that she would follow this up with the relevant Trust. The inspector evidenced from discussion with a patient, the acting manager and review of a specific aspect of the patient's care record that the patient was fully involved in the care management discussion and the care plan was updated in response to the outcome of the meeting which is commendable.

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

Section H – Management of nutrition including menu choice for all patients. Standard criterion 12.1 and 12.3 examined.
A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. There was a three weekly menu planner in place, and from review of the menu planner and record of food temperatures and from discussion with a number of patients, registered nurses and care staff, it was evident that choices were available at each meal time, including patients who were on therapeutic diets. The inspector discussed the systems in place to identify and record the dietary needs and preferences of individual patients with the acting manager and a number of staff. Staff spoken with were knowledgeable regarding the individual dietary needs of patients, including their likes and dislikes. Discussion with staff and patients and observation on the day of inspection confirmed that patients were offered choice prior to their meals. Registered nurses spoken with were knowledgeable regarding the indicators for onward referrals to the relevant professionals. e.g. speech and language therapist or dieticians. As previously stated under Section D, relevant guidance documents pertaining to nutrition were in place. As previously stated under Section E, the inspector reviewed the care records of two patients identified of being at risk of inadequate or excessive food and fluid intake. This review confirmed that a care plan had been devised for both patients to manage their nutritional needs and was reviewed on a monthly or more often basis. The care plan reflected the relevant multi-professional advice. A daily record of food and fluid intake was being maintained in respect of these patients. As previously stated under Section D, relevant guidance documents were in place.

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

Section I – Knowledge and skills of staff employed by the nursing home in relation to the management of nutrition, weight loss, dehydration, pressure area care and wounds. Standard criterion 8.6, 11.7, 12.5 and 12.10 examined.

The inspector reviewed the care records of two patients identified of being at risk of inadequate or excessive food and fluid intake or who had swallowing difficulties. This review confirmed that a care plan had been devised for both patients to manage their nutritional needs and was reviewed on a monthly or more often basis. The care plan reflected the relevant multi-professional advice. A daily record of food and fluid intake was being maintained in respect of these patients.

Discussion with acting manager confirmed that meals were served at appropriate intervals throughout the day. The acting manager confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning, afternoon and at supper times.

The inspector observed that a choice of fluids to include fresh drinking water were available and refreshed regularly. Staff were observed offering patients fluids at regular intervals throughout the day.

Staff spoken with were knowledgeable regarding pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. While the acting manager did not have overall compliance rates for staff undertaking dysphagia training, Mrs O'Loughlin confirmed that care assistants had received dysphagia awareness training within the past year through supervision. The acting manager confirmed that 88% of staff had completed their first aid training which includes care in the event of choking.

The inspector observed the serving of the lunch meal. Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely and appropriate manner. Staff were observed preparing and seating the patients for their meal in a caring, sensitive and unhurried manner. Staff were also observed assisting patients with their meal and patients were offered a choice of fluids. The tables were well presented with condiments appropriate for the meal served.

One registered nurse confirmed they had received recent training in the assessment, management and treatment of wounds. The acting manager advised that there was ongoing training planned for wound care and pressure area care. Care staff spoken with by the inspector were aware of the importance of timely reposition changes in the prevention of pressure ulcers. The acting manager confirmed that 41% of staff (care assistants and all registered nurses) have completed the e-learning Pressure Ulcer Prevention training. While this is not considered a mandatory training module for the FSHC company, a recommendation is made that all staff undertake this or similar training.

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

11.0 Additional areas examined

11.1 Records required to be held in the nursing home

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

11.2 Patients/residents under Guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) Order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection.

The acting manager confirmed that there were no patients accommodated at the time of inspection in the home who were subject to guardianship arrangements.

11.3 Quality of Interaction Schedule (QUIS)

In addition to observing care practices while undertaking an observational tour of the premises, the inspector undertook two periods of enhanced observation in the home which lasted for forty minutes observing care practices and staff interactions with patients prior to and while the lunch meal was being served in the dining room and also interaction between staff and patients and also staff and relatives in a lounge.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area. A description of the coding categories of the Quality of Interaction Tool is appended to this report.

Total number of observations	27
Positive interactions	27
Basic care interactions	
Neutral interactions	
Negative interactions	

The inspector evidenced that the quality of interactions between staff and patients at the time of the inspection demonstrated courtesy, respect and engagement with the patients and relatives.

11.4 Complaints

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

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 discussed the management of complaints with the acting manager and reviewed the complaint record. This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements within recent months, however complaints received in the earlier part of 2014 were not all clearly recorded in accordance with legislative requirements. It was unclear what one complaint related to and on three occasions there was no evidence that the persons who made the complaints were informed of the investigative process, outcome and action (if any) that was taken. A requirement is made in this regard.

11.5 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 and clarification on the day of inspection in relation to records pertaining to patients' personal furniture indicated that patients' monies were being managed in accordance with legislation and best practice guidance.

11.6 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.

11.7 Questionnaire findings

11.7.1 Staffing levels and staff comments

Discussion with the acting manager and review of the nursing and care staff duty roster for week commencing 6 October 2014 evidenced that the registered nursing and care staffing levels were in accordance with RQIA's recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection.

The acting manager informed the inspector that the home is currently using agency staff to cover annual and sick leave and that that every effort is made to ensure continuity of patient care by having the same staff where possible. Mrs O' Loughlin

also informed the inspector that the home have advertised for a personal activities leader (30 hours per week) and housekeeper 38.5 hours per week as these posts are currently vacant.

During the inspection, the inspector spoke individually with four staff; two registered nurses and two care staff and six staff completed questionnaires. Staff responses from both discussion and the returned questionnaires indicated that staff received an induction and completed a range of training commensurate with their roles and responsibilities. An issue raised by a staff member with regard to the induction process was discussed with the acting manager who agreed to follow this up with the staff member concerned.

All staff were satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and their individual wishes, however a few staff indicated that they did not have enough time to listen and talk to patients. Staff advised that they enjoyed working in the home; however one staff member whilst acknowledging in a returned questionnaire that "staff morale is good most days" also stated that there was "a divide between day and night staff". This was discussed with the acting manager who informed the inspector that day and night staff are invited to attend staff meetings and that she operates an open door policy to listen to and address any staff concerns and that to date no significant issues were raised in this regard.

11.7.2 Patients/residents and relatives comments

During the inspection, the inspector spoke with thirteen patients individually and three of these patients provided responses to the questionnaire, which the inspector completed on their behalf.

Patient spoken with and the questionnaire responses confirmed that patients were treated with dignity and respect, that staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home.

Patients' comments included:

- "the food is particularly good"
- "I feel 100% safe in this home"
- "staff are very courteous and very caring"
- "good range of activities, I like the pottery on Wednesdays"

One patient informed the inspector that sometimes cutlery or crockery is missing from the dining room table in the ground floor and that it can cause embarrassment asking to have it replaced. This was discussed with the acting manager who agreed to monitor the situation.

Those patients who were unable to verbally express their views were observed to be well groomed, appropriately dressed and relaxed and comfortable in their surroundings.

The inspector spoke with five relatives during the inspection, three of these relatives provided responses to the questionnaire which the inspector completed on their behalf. Relatives' responses indicated that they were content with the care their relatives were receiving.

11.8 Record keeping

In accordance with Regulation 19 (2) Schedule 4, a number of records are required to be kept in a nursing home. Prior to this inspection the registered manager (Mrs A Begley) completed and returned a declaration to confirm that these documents were available in the home. The returned declaration for Schedule 4 documents confirmed that all documents listed were available in the home. The inspector sampled a number to confirm this as follows:

- duty roster record
- record of complaints
- record of accidents/ incidents
- record of food provided
- record of training
- record of visitors to the home

Review of specific aspects of seven patient care records evidenced that generally a good standard of record keeping was maintained. However, care plans/care records should be reviewed in relation to the following:

- the prevention of pressure ulcers
- type of pressure relieving equipment is based on the outcome of a validated pressure ulcer risk assessment and clinical judgement
- The frequency of re-positioning patients should be recorded in care plans in accordance with assessed need and this should be accurately reflected on repositioning chart records.
- patients mobility aids should be included in the care plan
- Re-assess one identified patient's moving and handling needs (while seated) in conjunction with the occupational therapist.
- Ensure a record is maintained of monitoring arrangements in place for the use of lap straps.

A requirement was made in relation to the above care planning/record keeping issues.

11.9 General Environment

The inspector undertook an observational tour of the internal environment of the home. This included viewing communal lounges, the dining room, twenty-two bedrooms and toilet/bathroom facilities. With the exception of one bedroom which had a mal-odour, all other areas of the home were maintained to an acceptable standard of hygiene and décor. A requirement is made to address the malodour in the identified bedroom.

12.0 Quality Improvement Plan

The details of the quality improvement plan appended to this report were discussed with Mrs Anne Marie O'Loughlin, acting 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:

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

_____ _____

Loretto Fegan Date
Inspector / Quality Reviewer (Bank)

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Prior to admission to the home, the Home Manager or a designated member of Nursing Staff from the Home carries out a Pre-Admission Assessment. During the Pre-admission assessment information is obtained from the resident / representative where appropriate. In addition Care Records and information / assessments from the Care Management Team forms this assessment. Following a review of all information a decision is made is regard to the home's ability to meet the needs of the residents. If the admission is an Emergency Admission and a Pre-admission is not possible the comprehensive Multi-disciplinary information regarding the resident is faxed or left into the Home. Nursing Staff are also required to complete a Pre-Admission Assessment over the telephone. Admissions only take place when the Manager is satisifed the home care meet the residents needs.	Substantially compliant

On admission to the home an identified nurse completes Initial Assessments by referring to the Pre-Admission Assessment, Information received from the Care Management Team and through discussion with the resident / representative. The Nurse is advised to ensure Nursing Care is planned and agreed with the resident. The FSHC Documentation completed on initial admission include: 1) An Admission Assessmen, which includes photography consenet, record of personal effects and a record of 'My Preferences'; 2) A Needs Assessment which includes 16 areas of need, each area of need has an additional comments section for providing additional information which enables nursing staff to formulate a Person Centred Care Plans for the resident. Person Centred Care Plans are further facilitated by the completion of Risk Assessments, including: Braden Assessment; An Initial Wound Assessment (if required); A Moving and Handling Assessment; A Fall Risk Assessment; A Bed Rail Assessment and Nutritional Assessments - including the MUST tool and FSHC Nutritional and Oral Assessments. A Programme of Care File Audits is in place and is following by the Home Manager / Deputy Manager on a monthly basis. In addition the Regional Manager completes further Audits of Documentation to qualtiy assure this process.	

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care received within the Home is based on a holistic assessment of individual care needs using the assessment tools as cited in Section A. The Named Nurse devises Care Plans to meet the identified needs; demonstrating the promotion of Independence while ensuring the Care Plan Goals are realistic and achievable for the individual. Where input has been provided by other members of the Multi-disciplinary team the Named Nurse ensures their guidance / advice is included in the Care Plan.	Substantially compliant

Nursing Staff ensure the Referral Process is followed when the expertise of a Tissue Viability Nurse is required. Nursing Staff complete and send a Referral Form through to the Tissue Viability Nurse; in addition the staff would make a phone call to the Tissue Viability Nurse to obtain advice prior to their visit to ensure treatment is not delayed. The same process is followed when a resident requires a referral to the Tissue Viability Nurse of a Podiatrist for treatment of lower limb or foot ulceration. Where a resident is assessed as "at risk" of developing pressure ulcers a Pressure Ulcer Management and Treament Plan is commenced. An Individualised Care Plan is formulated to include skin care; frequency of repositioning, mattress type and setting. The Care Plan will also reflect the advice received from other members of the Multi-disciplinary team and be agreed with the resident / representative. Nursing Staff use the MUST tool to determine nutritional requirements of the individual; the Score from this assessment along with the clinical judgement of the nursing staff determines when a referral to the Dietician is required. A Referral form is completed and forwarded to the Dietician; while awaiting a domiciallary visit the Dietician can also be contacted via the telephone for advice. Advice / recommendations obtained are documentated on the Multidicsiplinary Team form and used when formulating the Care Plan.	

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**
Each resident is assessed on an on-going basis with any changes to care needs documentated in the daily progress notes and care plan evaluation forms. In addition these changes are reflected in the 24 hour shift report for the Home Manager's attention. All Risk Assessments / Care Plans are reviewed and evaluated a minimum of once a month or indeed more often when required when a resident experiences a change in condition / care need. Nursing staff ensure each Care Plan dictates the frequency of review.	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**
Up-to-date resources / guidelines are available for Nursing Staff to ensure the Nursing Care Provided is supported by research evidence. The resources / guidelines are from: NICE; GAIN; RCN; NIPEC; HSSPS; PHA and RQIA. Nursing Staff use the EPUAP grading system to screen residents who have skin damage. An Initial Wound Assessment is completed and a Care Plan is implemented which will include the grade of pressure ulcer, dressing regime, how to clean the wound; frequency of repositioning; mattress type and time-scale for review. On each subsequent dressing change an On-going Wound Assessment is completed and the Care Plan Evaluation is updated. When required the Care Plan is updated to reflect changes in the Dressing Regime. Up-to-date Nutritional Guidelines are avaible for staff information including: "Promoting Good Nutrtition"; RCN - "Nutrition Now"; PHA 2014 - "Nutritional Guidelines and Menu Checklists for Residential and Nursing Homes; and NICE Guidelines - "Nutrition support in Adults". To futher suppport their practice Nursing Staff refer to FSHC Policies and Procedures in relation to Nutritional Care and Diabetic Care. If required FSHC Policies are also available on Care of Subcuteanous Fluids and Care of Percutaneous Endoscopic Gastrostomy.	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**
Nursing Staff have access to FSHC Policies and Procedures in relation to Record Keeping; in addition all Nursing Staff have been provided with personal copies of the NMC Guidelines - Record Keeping: Guidance for Nurses and Midwives. Contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out for each individual resident to include outcomes. All record keeping is in accordance with the NMC Guidelines. Daily Menu Choice forms are completed for each resident and retained to enable a review of the meals provided. A FSHC Food Record Booklet and /or a Fluid Booklet is completed for all those residents deemed to be "at risk" of malnutrition; dehydration; eating excessively. These Bookelts are completed over a 24 hour period and the fluid intake totalled every 24 hours.	Moving towards compliance

Nursing staff use the information recorded in these booklets to identify any deficits with a residents dietary / fluid intake to ensure appropriate action is take with referrals to the relevant professionals as required. When action is taken Nursing Staff ensure the relevant Care Plan / Evaluation is updated. As previously stated a programme for the auditing of Care Files is in place by the Home Manager / Deputy Manager; an Action Plan is compiled during this process to address any deficits or areas for improvement.	

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 to each resident is monitored and recorded within the daily progress notes - with one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the Nursing Care Plan or as required should the needs of the resident change / if there are recommendations made by other membes of the Multi-Disciplinary Team. Nursing Care is planned and agreed with the resident / representative and they are involved in the evaluation process.	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**
The Trust are responsible for organising Care Management Reviews and inviting the resident / representative to attend. In addition a member of the Home's Nursing Staff will attend the reviews. Care Management Reviews usually take place 8 weeks following a new admission to the home; and then annually thereafter. A resident / representative / member of the nursing staff can request additonal reviews to discuss changing needs or the dissatisfaction of care. Minutes of all Care Reviews are held in the residents file. Should the Care Review highlight any recommendations / changes to care being provided the Named Nurse ensurs the Care Plans are up-dated to reflect these changes.	Substantially compliant

Section H

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

Criterion 12.1

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

Criterion 12.3

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

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

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
The Home follows FSHC Policy and Procedure in relation to Nutrition and follows best practice as cited in Section D. Each resident's dietary needs are assessed on admission and a Care Plan formulated which is reviewed monthly or more often if required. The content of the Care Plan reflects the following: type of diet; any special dietary needs; personal preferences; specialised equipment if required; if the resident is independent or level of assistance required; and any recommendations / advice made by the Dietician and / or the Speech and Language Therapist. The Home has a 3 week menu which is reviewed approximately 6 monthly taking into account seasonal foods and the outcome of food questionnaires completed by the residents and representatives where required. The 2014 PHA Document entitled: "Nutritional Guidelines and Menu Checklist for residential and nursing homes" is used to ensure a nutritious and balanced diet is provided. A diet notification form is completed and updated as requried for each resident; a copy of which is made available to the kitchen to ensure the catering staff are aware of all residents specific dietary needs. Residents are offered a choice at each meal time; if the residents does not want anything on the meal the catering staff liase with the resident to ensure they receive and alternative. Daily menus are on display in each dining room, with the 3 week menu	Substantially compliant

displayed outside each dining area and the main kitchen.	

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing staff refer to the FSHC Policy on "The Management of the Risk of Choking" and up to date guidance to support their practice and clinical judgement. The Guidance includes: the NICE Guidelines - "Nutrition and Support in Adults" and NPSA document "Dysphagia Diet Food Texture Descriptors". Training is scheduled for May on Dysphagia for all staff. In addition the Speech and Language Therapist will provide advice and guidance during visits to the home.	Moving towards compliance

As previously stated all recommendations made by the Speech and Language Therapist are incorporated into individual care plans - to include diet type; consistency of fluids; position for feeding; assistance required. The Kitchen also receive a copy of the SALT recommendations and individual Diet Notification Forms - these are kept on file for reference by the kitchen. Meals are provided at conventional times for Breakfast; Lunch and Evening Tea with additional customary intervals for morning / afternoon tea and supper time. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. Cold drinks, including fresh drinking water are available at all times in the lounges and bedrooms; these are replenished on a regular basis. Individual Care Plans are available for all staff information regarding 'eating and drinking' including: likes and dislikes; type of diet; consistency of fluid; assistance required. As stated before a Diet Notification Form is completed for each resident with a copy given to the kitchen and a copy kept on file. A member of staff is present in the dining room throughout the dining process. Residents who require supervision, or a level of assistance are give individual attention and are assited at a pace suitable to them. Nursing staff are required to complete an E-Learning Module on Pressure Area Care; in addition Nursing staff within the home are also required to complete a Wound Competency Assessment.	

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.

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The Regulation and Quality Improvement Authority

Quality Improvement Plan

Primary Unannounced Care Inspection

Ardmaine Care Home

9 October 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Anne-Marie O'Loughlin, acting manager either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	20 (1) (c) (i)	Ensure all staff receive mandatory training, this includes, safeguarding vulnerable adults, food hygiene, first aid and infection control. Registered nursing staff managing wound care should receive up to date training. Ref – Follow-up on previous issue section 9.0	Two	Currently there is an ongoing programme for all staff to undertake face to face training on safeguarding of vulnerable adults and first aid. Staff nurses to attend wound care training provided by training department. Acting manager to continue to assist staff with completion of E learning to meet 100% compliance for mandatory training.	From the date of the previous inspection
2	15	Ensure the following issues are addressed; • a full assessment of patients' needs should include nutritional and fluid intake/output management • ensure fluid balance charts contains all relevant information which includes the target amount of fluids alongside the action to take when the target is not met Ref – Follow-up on previous issue section 9.0	Two	As a home we have revisited the use of fluid balance charts and when they are appropiate. Supervisions commenced with all staff regarding the completion of fluid charts and supporting documentation so relevant information and actions required is evident.	From the date of the previous inspection
3	16 (2) (b)	The registered person must ensure that care plans / care records are kept under review in relation to the following:	One	Acting Manager completing reveiws on documenation on any resident with pressure	From date of inspection

		• the prevention of pressure ulcers • type of pressure relieving equipment is based on the outcome of a validated pressure ulcer risk assessment and clinical judgement • the frequency of re-positioning patients should be recorded in care plans in accordance with assessed need and this should be accurately reflected on repositioning chart records • patients mobility aids should be included in the care plan • re-assess one identified patient's moving and handling needs (while seated) in conjunction with the occupational therapist • ensure a record is maintained of monitoring arrangements in place for the use of lap straps Ref- Section10.0 (B) & 11.8		damage to ensure correct steps have been taken. Staff complete braden on admission for all patients and reveiwed monthly there after or sooner if a signifcant change in condition and the use of pressure relieving equipment to be ascertained following this. Repositioning charts reveiwed and frequency of repositioning corresponding in care plans and repositioning charts. Mobility careplans reveiwed and mobility aids evident in careplan and handling profile. Identified patients moving and handling needs re-assessed and a specialist chair to be supplied by the Trust as per assessment from Occupational Therapist. Residents who require the use of lap belts have records maintained in accordance with Fours Seasons Health Care policies and procedures and completed on a daily basis.	

4	30 (1) (d)	The registered person must ensure that notification is submitted to RQIA of the occurrence of all pressure ulcers grade 2 or above Ref- Section10.0 (B)	One	Acting manager to complete notifications for any occurance of pressure damage within required timescales.	From date of inspection
5	24 (3) & (4)	The registered person must ensure that any complaint made is fully recorded and the person who made the complaint is informed of the investigative process, outcome and action (if any) that is to be taken Ref- Section 11.4	One	Acting Manager to continue to complete any complaints sbmitted following Four Seasons Health Care procedures and within appropriate time scales.	From the date of inspection

6	18 (2) (j)	The registered person must ensure that the offensive odour is addressed in the identified bedroom Ref- Section 11.4	One	New flooring approved for identified room.	From the date of 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	27	It is recommended that the policy relating to nursing records management is updated to reflect only current guidance (not UKCC) and be localised to reflect/reference The Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Nursing Homes Minimum Standards (2008). **Ref- Section 10.0 (E)**	One	Policies currently being reveiwed by Senior Management in Four Seasons Health Care.	By 30 November 2014
2	28	It is recommended that all staff are continued to be supported with training commensurate with their roles and responsibilities in relation to the following until 100% compliance is achieved: • Record keeping • Skin care and prevention and management of pressure ulcers • Wound care (registered nurses) • Management of nutrition • Management of dysphagia **Ref- Section 10.0 (B, E & I)**	One	Staff are to complete all mandatory E-Learning to achieve 100% compliance. Supervision sessions arranged with staff members who are not reaching full compliance to give support with any identified need. Training Department assisting with this.	From date of inspection and ongoing

3	25.11	It is recommended that audit of nursing records is further developed to ensure the sample size is proportionate to the number of patients accommodated in the home and that re-audit evidences that action is taken to address any deficits or areas for improvement identified through the audit process.. **Ref - Section 10.0 (C)**	One	Acting manager auditing care files in accordance with minimum standards to ensure quantity audited is compliant with reccommended target for amount of patients accommodated within the home. Procedures in place to re-audit records and actions put inplace for nursing staff to address issues that arise.	From date of inspection
4	28.1	It is recommended that the following identified issues pertaining to induction of staff are addressed: • A final statement of competency is signed off by the acting manager and retained on file. • Any identified issues raised by staff / identified through the inspection regarding induction are followed up by the acting manager **Ref- Section 9.0 , 10.0 (D) and 11.7.1**	One	Inductions ongoing for any new staff and final statement of compentency to be completed. Issue discussed with staff member and supervision completed with staff nurse in induction procedures.	From date of inspection

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

NAME OF REGISTERED MANAGER COMPLETING QIP	A M O'LOUGHLIN
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall DIRECTOR OF OPERATIONS 26.11.14

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	yes	Donna Rogan	3/12/14
Further information requested from provider			