Unannounced Primary Care Inspection

Name of establishment:	**Donaghcloney**
RQIA number:	**1467**
Date of inspection:	**1 October 2014**
Inspector's name:	**Loretto Fegan**
Inspection number:	**IN017170**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of establishment:	Donaghcloney Care Home
Address:	1 Monree Road Donaghcloney Craigavon BT66 7HA
Telephone number:	(028) 3888 2343
Email address:	donaghcloney@fshc.co.uk
Registered organisation/ Registered provider / Responsible individual	Four Seasons Health Care Ltd Mr James McCall
Home Manager (Registration pending):	Ms Tracey Palmer
Person in charge of the home at the time of inspection:	Ms Tracey Palmer
Categories of care:	NH - I
Number of registered places:	45
Number of patients accommodated on day of inspection:	24
Scale of charges (per week):	£581.00
Date and type of previous inspection:	23 April 2013 Announced primary Inspection
Date and time of inspection:	1 October 2014 10.15 – 19.00 hours
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 any 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 on 15 April 2014 by the then acting home manager
- discussion with the home manager and regional manager
- review of the returned quality improvement plan (QIP) from the previous care inspection conducted on 23 April 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
- observational tour of the premises
- evaluation and feedback.

5.0 Consultation process

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

Patients	**14**
Staff	**4 (in addition to home manager and regional manager)**
Relatives	**2**
Visiting professionals	**0**

Questionnaires were distributed, 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	**9**	**9**
Relatives / representatives	**2**	**1**
Staff	**8**	**7**

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 patients' 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

Donaghcloney Nursing Home is situated in the village of Donaghcloney and is owned and operated by Four Seasons Health Care Ltd. Ms T Palmer is the current home manager.

The facility comprises two buildings, Donaghcloney House, a listed building, and Monree Lodge, a purpose built unit. On 17 December 2010, Donaghcloney House closed and patients were transferred to Monree Lodge.

Monree Lodge is a two storey facility which comprises of 15 single and seven double bedrooms. Accommodation for patients is provided on both floors of the home and access to the first floor is via a passenger lift and stairs.

There are three sitting rooms, a foyer area, dining room and toilet / bathroom facilities. The main kitchen is adjacent to Monree Lodge and there is staff accommodation and offices. A separate external laundry facility is positioned to the rear of Donaghcloney House.

The home is registered to provide care for a maximum of 45 persons under the following categories of care:

<u>Nursing care</u>

I old age not falling into any other category

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) was reviewed and was appropriately displayed in the foyer of the home.

8.0 Executive summary

The unannounced inspection of Donaghcloney Care Home was undertaken by Loretto Fegan on 1 October 2014 between the hours of 10.15 and 19.00 hours. The inspection was facilitated by the home manager, Ms Tracey Palmer. The regional manager, Ms Heather Murray and the home manager 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 recommendations made as a result of the previous inspection were also examined.

Prior to the inspection, Ms M Lee Leuterio, the then acting home manager, completed a self-assessment using the standard criteria outlined in the theme inspected. This self-assessment was received by RQIA on 15 April 2014. The comments provided by the acting home 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 the acting 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 23 April 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 a period of enhanced observation in the home. 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.

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.

Patient spoken with and the questionnaire responses confirmed that patients were generally happy living in the home and felt well cared for.

However, a number of issues were raised by patients through the patient questionnaires, identifying aspects of their care needs which they considered could be improved. These were shared with the home manager who agreed to further explore the issues with the patients generally and monitor the identified care practices, taking appropriate action if required. A recommendation was made in this regard.

One patient raised concerns regarding aspects of their care with the inspector. Following the inspection the concerns were referred by the home manager to the Southern Health and Social Care Trust (SHSCT) safeguarding team who are managing the potential Safeguarding Vulnerable Adult (SOVA) concern under the regional adult protection policy/procedures.

The inspector spoke with two relatives during the inspection and one relative questionnaire was returned at the end of the inspection. Relatives' responses indicated that they were content with the care their relatives were receiving.

One person who wished to remain anonymous informed the inspector that it was unusual to see patients in the sitting room in the afternoon (as on the day of inspection) as patients are usually left unattended in the dining room after the activities end at 14.30 hours. The inspector subsequently spoke with two care assistants, one registered nurse and the home manager individually and asked them to describe the usual routine in the afternoon for patients. All staff responses concurred that a few patients (naming the patients) request to remain in the dining room after the activities end at 14.30 hours and that the other patients are transferred to the sitting room or room of their choice. **(**Refer to section 11.0 for further details about patients).

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 home manager and review of the nursing and care staff duty roster for week commencing 29 September 2014 evidenced that the registered nursing and care staffing levels were in accordance with the RQIA's recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection.

The home manager informed the inspector that the home is currently using agency care staff to cover sick leave and is awaiting four additional recently recruited part-time care staff to take up post.

During the inspection, the inspector spoke individually with four staff; two registered nurses and two care staff. Seven staff completed questionnaires. Staff responses in discussion and in the returned questionnaires generally were positive regarding the standard of care provided to patients, however several staff indicated that they did not have enough time to listen and talk to patients. Staff raised concern regarding staffing levels, staff duties and staff morale. The inspector discussed the issues raised by staff at length with the home manager and the regional manager who were aware of the issues and provided evidence that the issues raised were either being addressed or evidence provided clarity regarding some of the other issues raised (refer to detail in section 11.7.1).

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 and ongoing training.

The inspector reviewed and validated the home's progress regarding the three requirements and four recommendations made at the last inspection on 23 April 2014 and confirmed compliance outcomes as follows: one requirement and one

recommendation had been fully complied with; two requirements and two recommendations were found to be substantially compliant. A further recommendation was not verified on the day of inspection and will be followed up during the next care inspection.

Verbal feedback of the inspection outcomes was given to the home manager throughout the inspection and post inspection. The regional manager was present during the latter part of the inspection and also received feedback.

Conclusion

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

Details can be found under Section 10.0 and 11.0 in the report and in the quality improvement plan (QIP).

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

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

9.0 Follow-up on the requirements and recommendations issued as a result of the previous primary announced care inspection conducted on 23 April 2013

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
1	Regulation 19(1)(a) Schedule 3, 2(k)	The registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence prescribed care.	Specific aspects of care records pertaining to four patients were reviewed during the inspection. In the main, the records evidenced that contemporaneous notes were maintained of nursing care provided to patients. However two repositioning charts examined had on occasions, intervals of up to 7 hours between recording repositioning. While a rationale was provided by the home manager in relation to one of these patients, this was not reflected in the care plan. Another record examined also revealed incomplete recording of the daily food and fluids taken by the patient. This requirement will be stated for the second time and compliance followed up during the next care inspection.	Substantially compliant

2	Regulation 12(1)(a)	The registered person shall ensure that the treatment and other services provided reflect current best practice. RQIA must be notified of pressure ulcers, graded two or above.	The inspector examined the record of accident/ incidents in the home and cross referenced this with notifications made to RQIA. Notification was received by RQIA in relation to pressure ulcers grade 2 or above in respect of one patient, however not in relation to another patient. This requirement will be stated for the second time and compliance followed up during the next care inspection.	Substantially compliant
3	Regulation 18(2)(j)	It is required that malodours are eliminated and systems introduced to keep the home free from offensive odours.	The inspector viewed communal areas and seventeen bedrooms in the home, all were found to be free from offensive odours.	Compliant

No	Minimum Standard Ref.	Recommendations	Action taken – as confirmed during this inspection	Inspector's validation of compliance
1	16.2	It is recommended that induction records are further developed to include a general awareness of the correct use of restraint.	The induction records of two care assistants who took up employment in the home during the past year were examined. While these records did not specify that a general awareness regarding the correct use of restraint had taken place, the home manager confirmed that the use of restraint is included in both the safeguarding of vulnerable adults and the deprivation of liberty training which both staff had undertaken within the first 3 months of their employment. The regional manager advised that a new induction programme is now in place for all new staff and will include a general awareness of the correct use of restraint in a timely manner. This recommendation will be stated for the second time and compliance followed up during the next care inspection.	Substantially compliant

2	10.7	It is recommended that alarms mats are managed as a form of restraint.	The home manager confirmed that there were no alarm mats in use within the home, therefore this recommendation was not validated on this occasion. This recommendation will be followed up during the next care inspection.	Not validated on this occasions
3	5.1	It is recommended that all patients have a baseline pain assessment completed and an ongoing pain assessment where indicated.	Two patients' records were examined in this regard. While both patients had a care plan in place to address pain management, only one had a baseline / or ongoing pain assessment completed. This recommendation will be stated for the second time and compliance followed up during the next care inspection.	Substantially compliant
4	5.3	It is recommended that: • body maps are updated to reflect when wounds are healed • that care plans are in place for all patients who are assessed as at risk of developing pressure ulcers • the frequency with which dressing require to be renewed should be included in t care plan.	Review of a sample of specific aspects of care records evidenced that • body maps are updated to reflect wound healing / wound progress • care plans were in place for patients assessed as at risk of developing pressure ulcers • the frequency with which wound dressings require to be renewed was included in the care plan.	Compliant

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

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.

Since the previous inspection on 23 April 2013, RQIA have been notified by the home of an ongoing investigation in relation to a potential or alleged safeguarding of vulnerable adults (SOVA) issue. The SHSCT safeguarding team are managing the SOVA issues under the regional adult protection policy/procedures.

RQIA is satisfied that the home manager has dealt with SOVA issues 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 three patients' care records which 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 three patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 11 days of the patient's admission or readmission to the home. There was evidence of a re-assessment taking place for one of these patients who was residing in the home for more than one year. In discussion with the home manager, she demonstrated a good awareness of the patients who required wound management intervention for a wound and the number and progress of patients who were assessed as being at risk of weight loss and dehydration.

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

Section B – A registered nurse 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 home 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, discussion with patients /relatives and review of the responses received from the patient / relative questionaires evidenced that in the main either patients or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions and that changes to the plans of care were discussed with the patient and /or their representatives. However, from four of the returned patient questionaires and discussion with two of the patients there was evidence that a partnership approach to care planning / care delivery could be further enhanced. This was discussed with the home manager who agreed to address the issue. A recommendation has been made that the home manager further explores issues raised by patients during the inspection and monitors associated care practices, taking any required action in this regard.

Patients' care records evidenced that a re-assessment process was in place to identify patients at risk of developing pressure ulcers and care plans were also in place to address the prevention and management of pressure ulcers. However, as identified in section 9.0, two repositioning charts examined had on occasions intervals of up to 7 hours between recording repositioning. While a rationale was provided by the home manager in relation to one of these patients, this was not reflected in the care plan. A requirement has been restated in this regard. There was also incomplete recording of the daily food and fluids taken by one patient. According to records another patient's fluid intake target was not been met on four out of seven successive days and the care plan did not include the action to be taken when the fluid intake target was not achieved. A requirement made in relation to care planning issues has incorporated these deficits.

The home manager informed the inspector that there were three patients in the home who required wound care treatment. Review of two of these patient's care records evidenced the following:

- A body mapping chart was reviewed and updated when changes occurred to the patient's skin condition
- A care plan was in place which specified the pressure relieving equipment in place.

Discussion with the home manager and two registered nurses confirmed that where a patient was assessed as being 'at risk' of developing a

pressure ulcer, a care plan was in place to manage the prevention plan and treatment programme.

The home 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 required to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

As identified in section 9.0, a review of the records of incidents revealed that the incidence of pressure ulcers, grade 2 and above, was not reported on one occasion to RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005**.** A requirement has been restated in this regard.

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

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

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

The home manager confirmed that policies and procedures were in place for staff on making referrals to the dietician. All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment.

The inspector observed one patient who did not eat their lunchtime meal (although offered and encouraged by staff) and was informed by staff that the patient took prescribed nutritional supplements instead of taking main meals. Review of this patient's care records evidenced that the patient was prescribed nutritional supplements and the medicine administration record evidenced that these were taken as prescribed by the patient. The inspector acknowledged that the patient's weight and MUST scores were being monitored by the home, however as the detail of the patient's food and fluid intake was not being recorded, discussion took place with the home manager regarding best practice evidence of promoting food as the first line of intervention. It is recommended that a record is kept of all food and drinks consumed or refused by this patient so that a re-assessment can be made with the patient's GP if any further intervention / referrals are necessary.

Review of the staff training records, evidenced that 67% of staff had undertaken e-learning training in relation to the management of nutrition.

Both registered nurses whom the inspector spoke with confirmed they had attended training in relation to wound care, the home manager informed the inspector that arrangements were in place for ongoing training in wound management for nurses and pressure area care for

staff.

Patients' moving and handling needs were assessed and addressed in their care plans. There was evidence that manual handling aids were used to minimise risk of friction. However, both care staff consulted informed the inspector that there was insufficient hoist slings available. This was discussed with the home and regional manager who confirmed that additional slings were purchased and agreed to ensure that all staff knew they were available for use.

The registered 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	**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 three 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 one patient's 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. The evaluation process included the effectiveness of any prescribed treatments, for example prescribed analgesia. Discussion with one registered nurse and a review of governance documents evidenced that a number of care records were audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process. The home manager also maintained an up to date record of all patients with wounds / pressure ulcers.

Provider's overall assessment of the nursing home's compliance level against the standard criteria assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criteria assessed	**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 three 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 was 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 home manager and both registered nurses on duty confirmed that they had a good awareness of these guidelines.

Discussion with the home manager, registered nurses and a review of care records evidenced that pressure ulcer/wound management was reviewed each time dressings were changed and discussed at each hand over report.

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

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

A review of the training records confirmed that 17% of care staff had undertaken e-learning training on record keeping. The home manager advised that this is an optional training opportunity for care staff, and 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 the food 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 in the case of one patient, a care plan had been devised to manage the patient's 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 this patient, however as identified in Section B, this was incomplete.
As previously stated under Section B, a review of a sample of fluid balance charts for one identified patient revealed that the patient's fluid

intake target was not achieved on four out of seven successive days and the care plan did not include the action to be taken if this occurred. A requirement has been made to address the care planning issues identified.

Staff spoken with were knowledgeable regarding patients' nutritional needs.

Records evidenced that 67% of all staff had undertaken e- learning training in the management of nutrition. The home manager informed the inspector that four care assistants have attended training in the management of dysphagia within the past year 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	**Compliant**
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. As identifed in Section B, a review of three patient's care records, discussion with patients /relatives and review of the responses received from the patient / relative questionaires evidenced that in the main either patients or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions and that changes to the plans of care were discussed with the patient or their representatives. However, from four of the returned patient questionaires and discussion with two patients, there was evidence that a partnership approach to care planning could be further enhanced. This was discussed with the home manager who agreed to address the issues raised. A recommendation has been made that the home manager further explores issues raised by patients during the inspection and monitors the associated care practices, taking any required action in this regard.

Provider's overall assessment of the nursing home's compliance level against the standard criteria assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criteria assessed	**Substantially 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 information provided in this questionnaire required clarification regarding the number of patients in the home who had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014. The home manager confirmed that all patients had a care management review within the past year. The home manager informed the inspector that patients' care reviews are held post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff preferably the patient's named nurse attends each care review. The inspector requested the minutes of two patients' care reviews, however she was informed by the home manager that while these took place in June and July 2014, 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 manager that she would follow this up with the relevant Trust.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	**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 four weekly menu planner in place, however the home is moving towards developing a three weekly menu cycle. The regional manager informed the inspector that the menu planner is currently being reviewed and updated in consultation with patients, their representatives and a nutritionist employed by the company.

The inspector discussed the systems in place to identify and record the dietary needs and preferences of individual patients with the home 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 observation on the day of inspection confirmed that patients were offered choice prior to their meals, however one patient raised concern with the inspector regarding lack of choice to meet their dietary preferences, it was agreed with the home manager that this would be addressed in partnership with the patient through the care planning process, this is incorporated into the requirement made relating to care records.

As identified in Section B, the inspector observed one patient who did not eat their lunchtime meal (although offered) and was informed by staff that the patient took prescribed nutritional supplements instead. Review of this patient's care records evidenced that the patient was prescribed nutritional supplements and the medicine administration record evidenced that these were taken as prescribed by the patient. The inspector acknowledged that the patient's weight and MUST score were being monitored by the home, however as the detail of the patient's food and fluid intake was not being recorded, discussion took place with the home manager regarding best practice evidence of promoting food as the first line of intervention. It is recommended that a record is kept of all food and drinks consumed or refused by this patient so that a re-assessment can be made with the patient's GP if any further intervention / referrals are necessary.

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.

From a 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 revealed that choices were available at each meal time with the exception of weekends and some Fridays. The regional manager advised that she would review why choice was not provided in accordance with the menu planner on a few specific dates. The home manager and staff confirmed choices were also available to patients who were on therapeutic diets.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Substantially 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.
Discussion with registered manager confirmed that meals were served at appropriate intervals throughout the day. The registered manager confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning afternoon and at supper times. The inspector observed that a choice of fluids to include fresh drinking water were available and refreshed regularly. Staff were observed offering patients fluids at regular intervals throughout the day. Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. While the home manager did not have overall compliance rates for staff undertaking dysphagia training, Ms Palmer confirmed that four care assistants had received dysphagia awareness training within the past year and it is recommended that this training is delivered to all care staff. The home manager confirmed that 97% of staff had completed their first aid training and this includes care in the event of choking. On the day of the inspection, the inspector observed the lunch meal. Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely 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. Discussion with two registered nurses evidenced they had received recent training in the assessment, management and treatment of wounds. The home manager advised that two registered nurses and two care assistants had attended training on wound care and pressure area care and that plans were in place for two additional registered nurses and care assistants to attend the same training in November 2014. In addition, the home manager advised how she supported all registered nurses through the supervision process in terms of enhancing wound care documentation. Care staff spoken with by the inspector were aware of the importance of timely reposition changes in the prevention of pressure ulcers. The home manager confirmed that 35% of staff (care assistants and registered nurses) have completed the e-learning Pressure Ulcer Prevention training and 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	**Compliant**
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

The home manager confirmed that there were no patients accommodated in the home who were subject to guardianship arrangements.

11.3 Quality of Interaction Schedule (QUIS)

In addition to observing care practices while undertaking a tour of the premises, the inspector undertook one period of enhanced observation in the home which lasted for thirty minutes observing care practices and staff interactions with patients prior to and while the lunch meal was being served in the dining room. The majority of patients had their meal in the dining room, the deputy manager informed the inspector that six patients had their lunchtime meal in their bedroom as this was their preferred choice.

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	25
Positive interactions	24
Basic care interactions	1
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.

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 returned questionnaire indicated that one complaint was received in 2013.

The inspector discussed the management of complaints with the home manager who evidenced that she was knowledgeable of how to assess complaints to identify any safeguarding issues contained therein and how to refer them to the designated officer for safeguarding in accordance with SOVA regional guidance.

The inspector reviewed the complaint record from the date of the last inspection (23 April 2013). This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements. However, as it was unclear which patients some of the complaints referred to, a recommendation is made that all complaint records include the name of the patient whom the complaint refers to in addition to the name of the person who makes the complaint.

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 indicated that patients' monies were being managed in accordance with legislation and best practice guidance.

11.6 NMC declaration

Prior to the inspection the acting home 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 were appropriately registered with the NMC. This was also verified by examining records during the inspection.

11.7 Questionnaire findings

11.7.1 Staffing levels and staff comments

Discussion with the home manager and review of the nursing and care staff duty roster for week commencing 29 September 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 home manager informed the inspector that the home is currently using agency care staff to cover sick leave. Ms Palmer also informed the inspector that the home have recently recruited four additional part-time care staff and that they will take up post upon satisfactory confirmation of the relevant pre-employment checks. A personal activities leader is also employed in the home.

The home manager confirmed that two domestic assistants are on duty Mon- Fri 09.00 – 13.15 hours and 09.00 – 14.00 hours respectively and that there is a total of nine hours per day domestic assistant cover on Saturdays and Sundays.

Training records indicated that staff were provided with a variety of training, including mandatory training, since the previous inspection.

During the inspection, the inspector spoke individually with four staff ; two registered nurses and two care staff and seven 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. 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 several staff indicated that they did not have enough time to listen and talk to patients. Staff raised concern regards being "short staffed" and commented on the reliance on agency care staff and the impact this had when staff were not familiar with the patients' individual needs. Reference was also made to disharmony among staff and lack of clear communication between registered nurses and care staff in relation to patients' care needs. Issues were also raised in relation to domestic staff working in the kitchen and helping carers and in relation to care staff helping in the kitchen every Sunday evening during the month of September.

The inspector discussed at length the issues raised by staff with the home manager and the regional manager. As indicated above, the home have recruited for additional care staff and the home manager advised that when these staff take up post all vacancies will be filled. The home and regional manager were both aware of the disharmony/ communication issues experienced among staff and the inspector was provided with evidence in the minutes of a recent staff meeting that this issue was being managed and staff were being supported by the home manager in addressing this challenge and that staff morale had improved recently.

The home and regional manager explained that there was an agreement with domestic staff (when patients moved from Donaghcloney House to Monree Lodge) that their contracted hours would be maintained by undertaking shifts in the kitchen. The home manager advised that very occasionally (for example in the event of staff attending to an unexpected care activity), domestic staff are asked to help with the serving of meals and the home manager provided an assurance that infection control measures are taken on these occasions. The home manager reviewed the kitchen rota with the inspector for the month of September 2014 and advised the inspector that only on one Sunday during September, the kitchen assistant was on unplanned leave and replacement cover could not be provided which necessitated care staff helping out. The home manager confirmed that the duty rota was worked as planned for the remaining Sundays in September and this included having a cook on duty from 09.00 – 16.30 hours and a kitchen assistant from 09.00 – 18.00 hours.

11.7.2 Patients/residents and relatives comments

During the inspection, the inspector spoke with fourteen patients individually and nine patient questionnaires were returned to the inspector.

Patient spoken with and the questionnaire responses confirmed that patients were generally happy living in the home, enjoyed the food and felt well cared for. Comments included:

- "food lovely, staff good, happy with everything"
- I like living in the home, no complaints, staff kind"
- "would get alternative if food not liked"
- "no complaints, well looked after"
- "staff very friendly and nice – like my own house"
- "I am very happy here and staff are all very good to me"
- "staff is first class"
- "laundry can be a problem, sometimes I get someone else's"

One patient informed the inspector that "some of the food is not so good" and agreed to the inspector informing the manager that they felt the menu choice was limited to them as there were a number of menu choices which were not appealing. The home manager agreed to follow up this issue through a partnership approach to care planning by reviewing the patient's dietary likes and dislikes.

Another patient raised concerns regarding aspects of their care with the inspector which were immediately referred to the home manager and regional manager as a potential safeguarding of vulnerable adult (SOVA) issue. The home manager referred the concern to SHSCT safeguarding team who are managing the SOVA concern under the regional adult protection policy/procedures.

The inspector was satisfied that the home manager dealt with the potential SOVA issue in the appropriate manner and in accordance with regional guidelines and legislative requirements and has agreed to keep RQIA informed regarding the outcome.

A number of issues were raised by patients through the patient questionnaires, identifying aspects of their care needs which they consider could be improved. Recurring issues raised by three or more patients were in relation to the following:

- having access to a buzzer always
- the timeliness of the staff response to buzzer calls
- choice regarding meeting toilet needs for example, choice regarding use of toilet, commode or bedpan
- level of involvement in discussing and planning their care
- staff not knocking bedroom door before entering or introducing themselves
- frequency of checks to see if patient needs anything
- occasions when feels rushed when care being provided

All issues raised were shared with the home manager who agreed to further explore the issues with the patients generally and monitor the identified care practices, taking appropriate action if required. A recommendation is made in this regard.

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. There were no patients nursed continuously on bed-rest, however the deputy manager advised that some patients have a "nap" in the afternoon and get up again for their evening meal.

Refer also to inspector's comments at 11.3 above

The inspector spoke with two relatives during the inspection and one questionnaire was returned at the end of the inspection. Relatives' responses indicated that they were content with the care their relatives were receiving.

One person who wished to remain anonymous informed the inspector that it was unusual to see patients in the sitting room in the afternoon (as on the day of inspection) as patients are usually left unattended in the dining room after the activities end at 14.30 hours until after they had their evening meal and that it is usually 18.30 hours before they leave the dining room. The inspector subsequently spoke with two care assistants, one registered nurse and the home manager individually and asked them to describe the usual routine in the afternoon for patients. All staff responses concurred that a few patients (naming the patients) request to remain in the dining room after the activities end and that the other patients are transferred to the sitting room or room of their choice. This concern was then discussed with the home manager who also concurred with the staffs' account. The home manager confirmed that the dining room is within view of the main entrance corridor and in addition to regular supervision, a call bell is available for patients to use in the dining room. The regional manager also advised that during afternoon visits to the home, she has not observed patients remaining in the dining room with the exception of a few who wish to remain there.

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 then acting home manager 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 staff meetings
- record of training
- record of visitors to the home

Review of specific aspects of four patient care records evidenced that generally a good standard of record keeping was maintained. However, a number of areas for improvement were identified as follows:

- contemporaneous notes should be maintained pertaining to all nursing provided to patients, including accurate recording of food / fluid and repositioning charts
- the action to be taken when a patient's fluid intake target has not been met should be included in the care plan
- the care record of one identified patient should reflect a partnership approach with regard to having the opportunity to review menu choice

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, seventeen bedrooms and toilet / bathroom facilities. All areas were maintained to an acceptable standard of hygiene and décor.

One bathroom was changed to a shower-room, a retrospective application for variation must be made to RQIA in this regard. A requirement is made.

12.0 Quality Improvement Plan

The details of the quality improvement plan appended to this report were discussed with Ms T Palmer, home 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:

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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**
Prior to admission to the home, the Home Manager or a designated representative from the Home carries out a pre admission assessment. Information obtained from the resident/representative (were possible), the care records and information from the Care Management Team forms this assessment. Risk assessments such as the Braden Tool are carried out, if possible, at this stage. Following a review of all information a decision is made in regard to the home's ability to meet the needs of the resident. If the admission is an emergency admission and a pre admission is not possible in the resident's current location then - a pre admission assessment is completed over the telephone with written comprehensive, multidisciplinary information regarding the resident being faxed or left into the home. Only when the Manager is satisfied that the home can meet the residents needs will the admission take place.	Compliant

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

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
A named nurse completes a comprehensive and holistic assessment of the resident's care needs using the assessment tools as cited in section A, within 7 days of admission. The named nurse devises care plans to meet identified needs in consultation with the resident/representative. The care plans demonstrate the promotion of maximum independence and focuses on what the resident can do for themselves as well as what assistance is required. Any recommendations made by other members of the mutidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable.	Compliant

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

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The Needs Assessment, risk assessments and care plans are reviewed and evaluated. If there is a change in the resident's condition these are re-evaluated. The resident is assessed on an ongoing daily basis with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the Home Manager's attention. The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to. The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading system. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime or if the condition of the pressure ulcer changes. There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', ' PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in relation to nutritional care, diabetic care, care of subcuteanous fluids and care of percutaneous endoscopic gastrostomy (PEG)..	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 records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are comtemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines - Record keeping:Guidance for nurses and midwives. Records of the meals provided for each resident at each mealtime are recorded on a daily menu choice form. The Cook also keeps records of the food served and include any specialist dietary needs. Residents who are assessed as being 'at risk' of malnutrition, dehyration or eating excessively have all their food and fluids recorded in detail on a daily basis using a FSHC food record booklet or fluid record booklet. These charts are recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. The nurse utilises the information contained in these charts in their daily evaluation. Any deficits are identified with appropriate action being taken and with referrals made to the	Compliant

relevant MDT member as necessary. Any changes to the resident's plan of care is discussed with them and/or their representative. Care records are audited on a regular basis by the Manager with an action plan compiled to address any deficits or areas for improvement - this is discussed during supervision sessions with each nurse as necessary.	

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care delivered is monitored and recorded on a daily basis on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan of care or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their representatives are involved in the evaluation process.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care Management Reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the resident's file. Any recommendations made are actioned by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The home follows FSHC policy and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs on admission and review on an ongoing basis. The care plan reflects type of diet, any special dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if necessary. The home has a 4 week menu. The menu is compiled following consultation with residents and their representatives - residents meetings, one to one meetings and food questionnaires. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied. Copies of instructions and recommendations from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs. Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything from the daily menu an alternative meal of their choice is provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room and on the wall	Compliant

outside the Dining Room.	

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Registered nurses have received training on dysphagia and enteral feeding techiques (PEG). Further training on dysphagia and feeding techiques is arranged for all care and kitchen staff on 24/4/14. The Speech and Language therapist and dietician also give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document - 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for	Compliant

feeding, equipment to use and assistance required. The kitchen receive a copy of the SALT's recommendations and this is kept on file for reference by the kitchen. Special diets are displayed on a board in the kitchen. Meals are served at the following times:- Breakfast - 9am-10.30am Morning break - 11am Lunch - 12.45pm-12.50pm Afternoon break - 3pm Evening tea - 5.00pm Supper - 7.30pm-8pm There are variations to the above if a resident requests to have their meals outside of these times. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. There are foods available outside of these times for those resident's who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedrooms, these are replenished on a regular basis. Any matters concerning a resident's eating and drinking are detailed on each individual care plan - including for eg. likes and dislikes, type of diet, consistency of fluid, any special equipment required and if assistance is required. A diet notification form is completed for each resident with a copy given to the kitchen and one held in the care file. Meals are not served unless a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Appropriate aids such as plate guards and specialised cutlery are available as necessary and as indicated in the plan of care. Each nurse has completed an education e-learning module on pressure area care. The home has a link nurse who has received enhanced training, to provide support and education to other nurses within the home on an ad hoc basis. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the home have a competency assessment completed. Competency assessments have a quality assurance element built into the process.	

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

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Primary Unannounced Care Inspection

Donaghcloney

1 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 Ms T Palmer, home 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	Regulation 19(1)(a) Schedule 3, 2(k)	The registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence prescribed care. Ref – Follow-up on previous issue (section 9.0 & 10.0 B & E)	Two	Further training has been provided to care staff and nursing staff in regards to documentation. The Home Manager and the Registered nurses will continue to monitor the documentation within the Home and action any areas if required.	From date of previous inspection
2	Regulation 12(1)(a)	The registered person shall ensure that the treatment and other services provided reflect current best practice. RQIA must be notified of pressure ulcers, graded two or above. Ref – Follow-up on previous issue (section 9.0 & 10.0 B)	Two	All Grade 2 and above wounds have been reported in accordance with regulations and evidence maintained in the home.	From date of 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: • accurate recording of food / fluid charts • the action to be taken when a patient's fluid intake target has not been met should be included in the care plan • reflect a partnership approach with regard to an identified patient having the opportunity to review menu choice Ref- Section10.0 (B, E, F & H) & 11.8	One	Further training has been provided and will continue to be ongoing and monitored with regards to food/fluid charts GP's have been contacted and letters regarding targets are in place in each residents file that it is appropriate for. Resident food questionnaires have been completed for residents to determine if there is an issue with choice, however at present there appears to be no issues identified , but it will be reviewed and monitored by Home Manager	From date of inspection
4	12 (2) Registration Regulations	The registered person must ensure that an application for variation is submitted to RQIA in accordance with regulations. A retrospective application should be made in respect of the change made to the identified bathroom. Ref – Section 11.9	One	Variation form submitted 04.11.14, copy maintained in the home for reference.	By 31 October 2014

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	16.2	It is recommended that induction records are further developed to include a general awareness of the correct use of restraint. Ref – Follow-up on previous issue (section 9.0)	Two	Induction records are currently under review, however as part of the induction process, each member of staff completes an e-learning madatory modue which includes the awareness of restraint within the SOVA module. These records are available when required.	From date of previous inspection
2	10.7	It is recommended that alarms mats are managed as a form of restraint. Ref – Follow-up on previous issue as not reviewed (section 9.0)	One	These were not in use on the day of inspection and still are not being used, however staff are aware of the assessment process needed should a resident require this. Discussion was held during staff meetings which can be evidenced.	From date of previous inspection
3	5.1	It is recommended that all patients have a baseline pain assessment completed and an ongoing pain assessment where indicated. Ref – Follow-up on previous issue (section 9.0)	Two	All residents in the home have a pain assessment in place and also an ongoing pain assessment where needed.	From date of previous inspection

4	1.2	It is recommended that all issues identified through the responses in the patient questionnaires/ discussion with patients are further explored by the home manager with the patients generally and the identified care practices are monitored, with appropriate action taken if required. The issues raised relate to: • having access to a buzzer always • the timeliness of the staff response to buzzer calls • choice regarding meeting toilet needs for example, choice regarding use of toilet, commode or bedpan • level of involvement in discussing and planning their care • staff not knocking bedroom door before entering or introducing themselves • frequency of checks to see if patient needs anything • occasions when feels rushed when care being provided • clothing mislaid in the laundry Ref- Section 10.0 (B) & 11.7.2	One	All issues addressed with staff at meetings and also at Head of Department meetings. Supervision sessions will also take place in relation to issues raised. The Home Manager will continue to monitor compliance with all issues raised and address any areas if required.	From date of inspection
5	12.12	It is recommended that a record is kept of all food and fluids consumed by an identified patient so that a re-assessment can be made with the patient's GP if any further intervention / referrals are necessary. Ref- Section 10.0 (B & H)	One	The resident identified has a food and fluid record in place. At present no re assessment is required.	From date of inspection

6	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	This policy is due review in 2015, however whilst the policy currently reflects the UKCC there is an additional statement in conjunction to this referring to the NMC	By 30 November 2014
7	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	All staff are required to complete their mandatory e-learning modules. During staff meetings staff have been informed of the various optional topics that the Home Manager has requested to be completed. All registered Nurses have completed Wound care and have also attended external trainig on wounds.	From date of inspection and ongoing
8	17.10	It is recommended that all complaint records include the name of the patient whom the complaint refers to, in addition to the name of the person who makes the complaint. Ref – Section 11.4	One	Acioned and addressed on the day of inspection.	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	Tracey Palmer
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	JP Watson 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			
Further information requested from provider			

QIP Position Based on Comments from Registered Persons		Yes	No	Inspector	Date
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		L Fegan	**3/12/14**
B.	Further information requested from provider				