Unannounced Primary Care Inspection

Name of Establishment:	**Dungannon**
RQIA Number:	**1468**
Date of Inspection:	**25 September 2014**
Inspector's Name:	**Sharon McKnight and Karen Scarlett**
Inspection Number:	**IN017185**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Dungannon Nursing Home
Address:	100 Killyman Road Dungannon BT71 6DQ
Telephone Number:	028 8775 3034
Email Address:	dungannon@fshc.co.uk
Registered Organisation/ Registered Provider / Responsible Individual	Four Seasons Health Care Mr James McCall
Registered Manager:	Mrs Yvonne Diamond
Person in Charge of the Home at the Time of Inspection:	Mrs Rochelle Conde, acting manager
Categories of Care:	NH-LD NH-LD(E)
Number of Registered Places:	36
Number of Patients Accommodated on Day of Inspection:	34
Date and Type of Previous Inspection:	Primary Announced Care Inspection 14 November 2013
Date and Time of Inspection:	25 September 2014 09 55 – 17 00
Name of Inspector:	Sharon McKnight and Karen Scarlett

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

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

4.0 Methods/Process

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

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

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

- Analysis of pre-inspection information
- discussion with the acting manager
- observation of care delivery and care practices
- discussion with staff

- examination of records
- consultation with patients individually and with others in groups
- tour of the premises
- evaluation and feedback.

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

5.0 Consultation Process

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

Patients	6 patients individually and with the majority generally.
Staff	7
Relatives	0
Visiting Professionals	0

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

Issued to	**Number issued**	**Number returned**
Patients / residents	2	2
Relatives / representatives	0	0
Staff	4	0

6.0 Inspection Focus

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

Criteria from the following standards are included;

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

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

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

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

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

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

7.0 Profile of Service

Dungannon Care Home is located centrally to the town of Dungannon. The nursing home is owned and operated by Four Seasons Healthcare. The current registered manager is Mrs Yvonne Diamond.

The home comprises of 36 single bedrooms, four large sitting rooms, a number of quiet rooms, three dining rooms, a multi-sensory room, hairdressing room, toilet/washing facilities, a kitchen, a laundry, staff accommodation and offices.

An enclosed garden area is available in the grounds of the home.

The home is registered to provide care for a maximum of 36 persons under the following categories of care:

Nursing care

LD – learning disability
LD(E) – learning disability over 65 years

8.0 Summary of Inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Dungannon Care Home. The inspection was undertaken by Sharon McKnight and Karen Scarlett on 25 September 2014 from 09 50 to 17 00 hours.

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

The inspectors were welcomed into the home by registered nurse Susy San who was the nurse in charge of the home. Acting manager Mrs Rochelle Conde joined the inspection mid morning and was available for the remainder of the inspection. Verbal feedback of the issues identified during the inspection was given to Mrs Conde at the conclusion of the inspection. Feedback was also provider to regional manager Lorraine Thompson during a telephone conversation on the day following the inspection.

Prior to the inspection, the responsible person/acting manager completed a self-assessment using the standard criteria outlined in the theme inspected. This self-assessment was received on 9 April 2014. The comments provided by the responsible individual/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

During the course of the inspection, the inspectors met with patients and staff to seek their opinions of the quality of care and service delivered. The inspectors also examined the returned questionnaires from patients and staff, observed care practices, examined a selection of records, and carried out a general inspection of the nursing home environment as part of the inspection process.

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

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

As a result of the previous inspection conducted on 14 November 2013 one requirement and three recommendations were issued. These were reviewed during this inspection and the inspectors evidenced that the requirement has not been complied with and is stated for a second time following this inspection. Two of the recommendations have been fully complied with and one is assessed as moving towards compliance and is stated for a second time. Details can be viewed in the section immediately following this summary.

Conclusion

The inspectors observed that staff and patient interaction and communication demonstrated that patients were treated courteously. Good relationships were evident between staff and patients. The majority of patients were well groomed, appropriately

dressed and appeared comfortable in their surroundings. The home was neat, clean, fresh smelling and appropriately heated throughout.

Areas for improvement were identified in relation to care records, patient dignity, the dining experience and the environment.

Therefore, five requirements and seven recommendations are made. Of these one requirement and one recommendation are restated from a previous inspection. The requirements and recommendations are detailed throughout the report and in the quality improvement plan (QIP).

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

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9.0 Follow-Up on the Requirements and Recommendations Issued as a Result of the Previous Inspection on 20 June 2013.

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	16(1)	A care plan must be developed to clearly guide staff in the management of patients' behaviour if they become physically aggressive towards staff. It is further required that any interventions prescribed are discussed and agreed with the relevant healthcare professionals and family. Prescribed interventions must be reflective of best practice guidance.	The inspector reviewed the care records of two patients who displayed challenging behaviour towards staff. Care plans did not provide clear guidance for staff with regard to disengagement techniques. On the day of inspection this requirement was assessed as not compliant and is stated for a second time following this inspection. Given that this requirement was stated ten months ago the acting manager is required to confirm to RQIA by Thursday 2 October 2014 that care plans were in place. Confirmation that care plans were in place was received via electronic on 30 September 2014.	Not 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 all induction programmes are reviewed, and where required developed, to ensure that an awareness of the procedures for protecting vulnerable adults are included in the induction programme for all staff.	The inspector reviewed three completed induction programmes all of which contained written statements that the procedures for protecting vulnerable adults had been discussed.	Compliant
2	32.8	It is recommended that lapstraps on chairs are checked on a regular basis to ensure they are in proper working order. Records should be maintained of these checks.	The inspector reviewed the records of two patients who have lap belts on their chairs. Records evidenced that lap straps were checked regularly to ensure that they were in proper working order.	Compliant
3	5.1	It is recommended that all patients have a baseline pain assessment completed and an on-going pain assessment where indicated.	The inspectors observed that a greater number of patients had a baseline pain assessment recorded. However only one out of the five care records reviewed contained a pain assessment. This recommendation is assessed as moving towards compliance and is stated for a second time.	Moving towards compliance

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

It is not the remit of RQIA to investigate complaints made by or on 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.

There have been notifications to RQIA regarding potential safeguarding of vulnerable adults (SOVA) incident since the previous inspection. The incidents were being managed in accordance with the regional adult protection policy by the safeguarding team within the Southern HSC Trust.

10.0 Inspection Findings

10.1 Management of Nursing Care – Standard 5

There was evidence of comprehensive and detailed assessment of patient needs from date of admission. A variety of risk assessments were also used to supplement the general assessment tool. It is recommended that a nutrition risk assessment and a body map should completed for all patients on admission. The assessment of patient need was evidenced to inform the care planning process.

A review of the assessments of need, the risk assessments and the care plans evidenced that they were reviewed and evaluated on a regular basis plus as required.

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

Patients spoken with commented positively in regard to staff and the care they receive and that they were happy in the home. Those patients who were unable to verbally express their views were generally observed to be well groomed, appropriately dressed in clean matching attire and were relaxed and comfortable in their surroundings.

The inspectors observed one patient whose dignity was compromised by the choice of clothes they had been dressed in. The specific issues of dignity were brought to the attention of the staff who, prompted by the inspectors, changed the patients clothes. It was concerning to note that, whilst the change of clothing provided addressed the dignity issues which had been discussed with staff, the clothes compromised the patients dignity in other areas. The needs of the identified patient were discussed at length with the acting manager. The inspectors acknowledged that the patient had complex needs however it is required that there are suitable arrangements in place to ensure that the privacy and dignity of patients is respected. It is therefore required that the needs of the identified patient are reviewed with the relevant health and social care trust and a time scale identified for the purchase of new clothes. Arrangements to ensure the ongoing provision of appropriate clothing, which maintain the patients' dignity, must be agreed.

Compliance Level: Substantially compliant

10.2 Management of Wounds and Pressure Ulcers – Standard 11 (selected criteria)

The inspectors examined a number of patient care records as part of the inspection process to validate the provider's self-assessment. Records were generally evidenced to be maintained to an acceptable standard.

Following review of patient's care records in regard to wound management the inspectors evidenced that wound management in the home was generally well managed. Details of the wounds and frequency with which they required to be dressed were recorded in patients' care plans on wound management. The care records contained an initial wound assessment and an assessment of the wound following each dressing renewal. Review of completed wound assessment records evidenced that prescribed dressing regimes were adhered to.

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

Care plans for the management of risks of developing pressure ulcers and wound care were maintained. Improvements are required to the recording of repositioning charts of those patients identified as at high risk of developing pressure ulcers. Currently records do not evidence regular repositioning and do not include an assessment of the patients' skin condition at each position change. A requirement has been made.

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

Compliance Level: Substantively Compliant

10.3 Management of Nutritional Needs and Weight Loss – Standard 8 and 12 (selected criteria)

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

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

Review of care records, including the monitoring of patients weights, evidenced that staff were actively managing those patients at risk of weight loss and those at risk of eating excessively.

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

Individual food and fluid records for each patient, with any specific dietary requirements recorded on each booklet for ease of reference. The actual amount eaten and drank was recorded following each meal time.

The inspectors discussed the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients with the registered manager and a number of staff. Staff spoken with were knowledgeable regarding the individual dietary needs of patients and their likes and dislikes.

The inspector also observed the serving of the lunch time meal and can confirm that patients were offered a choice of meals. Areas for improvement were identified with the meal service and are further discussed in section 10.4.

Review of training records revealed that 35 staff had attended training in dysphagia and the management of thickening agents in April 2014.

Compliance Level: Substantively compliant

10.4 Management of Dehydration – Standard 12 (selected criteria)

The inspector examined the management of hydration during the inspection which evidenced that fluid requirements and intake details for patients were recorded and maintained for those patients assessed at risk of dehydration. Fluid intake charts were reconciled at the end of each 24 hour period. A daily fluid target was identified for each patient and recorded in individual patient care records. It is recommended that the daily fluid target is also recorded on the 7 day fluid intake booklet.

Compliance Level: 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 confirmed that the required records were maintained in the home and were available for inspection.

11.2 Patients under Guardianship

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

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

The inspector discussed the Human Rights Act and Human Rights Legislation with the home manager and one of the registered nurses.

The inspectors were informed by a registered nurse that one identified patients' toiletries were not stored in their bedroom but locked in the treatment room. The registered nurse informed the inspectors that the reason for this was for the patient's safety. Discussion with the acting manager identified other patients whose toiletries were also not freely accessible to them. The acting manager fully recognised that this was a restrictive practice. However following discussion with staff and review of patients' care records there was no clear rationale recorded. It is recommended that the decision making process with regard to any restriction on patients access to their belongings is clearly recorded in their individual care records. Records should include who was involved in the decision making process.

11.4 Quality of Interaction Schedule (QUIS)

The inspectors undertook two periods of observation in the home which lasted for approximately 20 minutes each.

The inspector observed the interactions between patient and staff during the serving of lunch in Killybracken suite and Cedaridge suite.

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

Positive interactions	11
Basic care interactions	3
Neutral interactions	1
Negative interactions	5

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

The lunchtime meal was homemade vegetable soup followed by a choice of fish and chips or savoury mince with broccoli and creamed potatoes.

Killybracken Unit

Four residents who did not require assistance with their meal were served lunch in the small dining room. The tables were nicely set with cutlery and condiments. Dress protectors were available if patients wished to use them. The menu choices were on the board on the wall in words and pictorial form. Staff were observed offering patients a choice of drinks and providing assistance as required. Patients were observed chatting to each other and commenting positively with regard to their meal.

Those patients who required full assistance were served their meals in the lounge. Meals were transported from the kitchen in a heated trolley where they were stored until staff were available to provide assistance. Some patients were provided with aids to enable them to eat independently.

The inspectors observed one staff member offering regular, gentle encouragement to patients. However generally there was a lack of interaction between staff and patients throughout the serving of lunch. It was also noted that the patients in the lounge had been in this room all morning, were served their meal in this room and although some went to bed for a rest in the afternoon, other patients continued to sit in this room. It is recommendation that the dining experience is reviewed to ensure that it is positive for all patients.

Cedaridge Unit

The inspectors arrived in the unit prior to lunch being served. Those patients who came to the dining room were already seated when the inspector arrived. Patients were restless waiting for lunch to be served. It is recommended that the patients are brought to the table in a timely manner. A trolley with the drinks was brought into dining room. The arrival of the trolley caused one patient to become agitated and noisy. The patient left the dining room. Staff quickly recognised that the patient wanted their lunch which was then brought from the kitchen immediately. The patient received their lunch whilst sitting on the floor away from the dining room. Whilst it was good to note that staff were knowledgeable regarding the trigger to this patients distressed reaction it is recommended that staff use their knowledge of patients' behaviour proactively to minimise the risk of distress reactions.

The inspector observed the serving of lunch and the following areas for improvement were identified:

- Staff did not interact with patients during the serving of the meal. For example there was no explanation given to the patients of the meals being served. Staff did not offer encouragement to those patients who refused to eat their meal.
- the inspector observed a covered meal sitting on the trolley approximately ten minutes after the meals had been brought from the kitchen. Staff informed the inspector that this meal for an identified patient who ate slowly. The inspector observed that the patient was still eating their soup. No provision had been made to keep the meal warm until the patient was ready to eat it. A requirement has been made.

It is recommendation that the dining experience is reviewed throughout the home to ensure that it is positive for all patients.

The review should include the following areas:

- the time patients are assisted to the table prior to the serving of lunch
- staff interaction with patients during the serving of the meal
- the serving of meals in the lounge to the patients in the Killybracken unit

11.5 Complaints

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

The inspectors reviewed the complaints records. This review evidenced that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought. In one complaint the record indicated that the complaint was resolved however there was no record to evidence how the acting manager had concluded that the complainant was satisfied. It is recommended that the complaints record is further developed to evidence how a complaint is assessed as resolved.

11.6 Patient Finance Questionnaire

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

11.7 NMC Declaration

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

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

11.8 Stake Holder Participation

11.8.1 Staff Comments

Staff spoken with on the day of inspection stated that they were happy working in the home and were satisfied that they were enabled to delivery care in a timely manner. No issues were raised with the inspectors.

11.8.2 Patients' Comments

During the inspection the inspector spoke with 6 patients individually and with a number in groups. In addition, on the day of inspection, two patients completed questionnaires with the assistance of an inspector. Patient responses were positive with regard to the care they were receiving.

11.8.3 General Environment

The inspectors undertook a general inspection of the home and examined the majority of bedrooms, lounges, dining rooms and communal bathrooms and toilets. The home was neat, clean, fresh smelling and appropriately heated throughout.

A number of toilet and bathroom floors where noted to be stained. Toilet seats were missing from two toilets:

- Assisted Toilet 2 – stained flooring
- Assisted Toilet 5 – stained flooring, toilet seat was missing
- Assisted Bathroom 3 – stained floor under the toilet
- Assisted Shower 1 – grouting in the shower required cleaning. The toilet seat had been removed and was sitting on the floor.

During feedback of the environmental issues the acting manager informed the inspectors that refurbishment of some flooring in the home was planned. A requirement is made that the issues identified are fully addressed and that the replacement of stained flooring must be given priority in the flooring refurbishment plan.

12.0 Quality Improvement Plan

The details of the quality improvement plan appended to this report were discussed with Rochelle Conde, acting manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider / manager is required to record comments on the quality improvement plan.

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

Enquiries relating to this report should be addressed to:

Sharon McKnight
The Regulation and Quality Improvement Authority
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5 Lanyon Place
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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 gleaned from the resident/representative (where possible), the care records and information from the Care Management Team informs this assessment. 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	Compliant

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. On admission to the home an identified nurse completes 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 section within each of the 16 sections includes additional necessary information that is required to formulate a person centred plan of care for the Resident. In addidtion to these two documents, the nurse completes risk assessments immedidiately 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 within seven days of 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 and 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	Compliant

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. 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 in the nurse's office, 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. Dietician referral forms are held within the home. These forms can be completed by staff in the home and faxed directly to the dietician for referral. 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 at a minimum of once a month or more often if there is a change in the resident's condition. The plan of care dictates the frequency of review and re assessment, with the agreed time interval recorded on the plan of care. 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.	Substantially 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 sysytem. 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 -	Substantially compliant

'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)..	

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 Catering Manager also keeps records of the food served and include any specialist dietary needs.	Substantially compliant

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 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 represenatatives 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 which is reviewed on a 6 monthly basis taking into account seasonal foods. 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.	Substantially compliant

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 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 outside the kitchen.	

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Registered nurses have received training on dysphagia and enteral feeding techiques (PEG). Further training on dysphagia and feeding techiques was received for all care and kitchen staff. 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	Substantially compliant

recommendations made by the speech and language therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for 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 white board in the fridge room. Meals are served at the following times:- Breakfast - 9.15am-10am Morning tea - 11am Lunch - 12.40pm-12.50pm Afternoon tea - 3pm Evening tea - 4.50pm Supper - 8.30pm-9.30pm 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 offered 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
	Substantially 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

Dungannon Care Home

25 September 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Conde 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	16(1)	A care plan must be developed to clearly guide staff in the management of patients' behaviour if they become physically aggressive towards staff. It is further required that any interventions prescribed are discussed and agreed with the relevant healthcare professionals and family. Prescribed interventions must be reflective of best practice guidance. **Ref section 9**	Two	All care plans have been reviewed to identify ways on how to keep the safety of staff when residents became aggressive towards them.	2 October 2014
2	13(8)(a)	It is required that there are suitable arrangements in place to ensure that the privacy and dignity of patients is respected. The needs of the identified patient must be reviewed with the relevant health and social care trust and a time scale identified for the purchase of new clothes. Arrangements to ensure the ongoing provision of appropriate clothing, to maintain the patient's dignity, must be agreed. RQIA to be informed of the outcome of the discussion with the relevant health and social care trust. **Ref 10, 10.1**	One	Care Management meeting held. Finances of the identified resident were discussed and how to access these. New appropriate clothing has been purchased to maintain the dignity of the resident..	The process to obtain clothing to begin from the day of inspection.

3	19(1)(a) Schedule 3, 3(k)	It is required that contemporaneous notes of all nursing provided are maintained. Repositioning charts must evidence regular repositioning and include an assessment of the patients' skin condition at each position change. **Ref section 10, 10.2**	One	Repositioning charts are completed as needed and evidence the assessment of the residents skin condition at each position change.	From the date of inspection.
4	12(4)(b)	The registered person must ensure that meals are properly prepared. Meals must be kept warm until they are served to the patients. **Ref section 11, 11.4**	One	Meals are kept warm inside the food trolley until served. Staff have been reminded and this will be monitored by the Nurse in charge of each unit.	From the date on inspection.

5	27(2)(b)	The following environmental issues must be addressed: • Assisted Toilet 2 – stained flooring • Assisted Toilet 5 – stained flooring, toilet seat was missing • Assisted Bathroom 3 – stained floor under the toilet • Assisted Shower 1 – grouting in the shower required cleaning. The toilet seat had been removed and was sitting on the floor. The replacement of stained flooring must be given priority in the flooring refurbishment plan. **Ref section 11, 11.8**	One	Assisted Shower 1- grouting in the shower cleaned and toilet seat was replaced. Assisted toilet 5- toilet seat was replaced. Replacement flooring is incorporated into the refurbishment plan over the next 3 months	Refurbishment plan, with timescales, to be submitted to RQIA within 28 days from the date of inspection.

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.1	It is recommended that all patients have a baseline pain assessment completed and an on-going pain assessment where indicated. **Ref section 9**	Two	All new admissions have a baseline pain assessment completed on admision and ongoing if required.	One month from the date of inspection.
2	5.2	It is recommended that a nutrition risk assessment and a body map should completed for all patients on admission. **Ref section 10, 10.1**	One	All new admissions have a baseline nutrition risk assement and body map.	From the day of inspection
3	12.12	It is recommended that patients' daily fluid target is recorded on the 7 day fluid intake booklet. **Ref section 10, 10.4**	One	Daily fluid targets are recorded on the fluid booklets.	From the day of inspection
4	1.1	It is recommended that the decision making process with regard to restricting patients access to their belongings is clearly recorded in their individual care records. Records should include who was involved in the decision making process. **Ref section 11, 11.3**	One	Staff have recorded in residents carepalns the decision making process with regards to restricting residents access to their belongings and who was involved in the process recorded.	One month from the date of inspection

5	10.4	Staff should use their knowledge of patients' behaviour proactively to minimise the risk of distress reactions. **Ref section 11, 11.4**	One	Staff are reminded to use their knowledge of residents behaviour proactively to minimize the risk of distress reaction.	From the date of inspection
6	25.2	It is recommendation that the dining experience is reviewed throughout the home to ensure that it is positive for all patients. The review should include the following areas: • The time patients are assisted to the table prior to the serving of lunch • staff interaction with patients during the serving of the meal • the serving of meals in the lounge to the patients in the Killybracken unit. **Ref section 11, 11.4**	One	Staff are reminded to ensure that dining experience is positive to all residents as reasonably practicable. A dining experience audit is completed twice per year, but this is to completed monthly for a set period of time. Serving meals in the lounge of Killybracken unit is currently under review.	The review should start from the date of inspection and be completed with an action plan developed in one month.
7	17.10	It is recommended that complaints record is further developed to evidence how a complaint is assessed as resolved. **Ref section 11, 11.5**	One	This is under review.	From the day 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	Rochelle Conde
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall DIRECTOR OF OPERATIONS 12.12.14.

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

QIP Position Based on Comments from Registered Persons				Inspector	Date
		Yes	No		
A.	Quality Improvement Plan response assessed by inspector as acceptable	X		Sharon McKnight	**15-12-14**
B.	Further information requested from provider				