Unannounced Care Inspection

Name of Establishment:	**Brooklands (Kilkeel)**
RQIA Number:	**1478**
Date of Inspection:	**18 November 2014**
Inspector's Name:	**Donna Rogan**
Inspection ID:	**IN017282**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 General Information

Name of Establishment:	Brooklands Private Nursing Home (Kilkeel)
Address:	10 Newry Road Kilkeel BT34 4DT
Telephone Number:	028 41764968
Email Address:	kaym@conwaygroup.co.uk
Registered Organisation/ Registered Provider:	Brooklands Nursing Homes Ltd Ms Therese Conway
Registered Manager:	Deborah Campbell
Person in Charge of the Home at the Time of Inspection:	Deborah Campbell
Categories of Care:	NH - I, Nursing Home RC - I, Residential Care NH-LD NH-LD (E)
Number of Registered Places:	Total 57 14 Dementia Nursing 9 Dementia Residential 34 Frail Elderly Nursing
Number of Patients Accommodated on Day of Inspection:	14 Dementia Nursing 7 Dementia Residential 39 Frail Elderly Nursing
Scale of Charges (per week):	Residential £426.00 per week Nursing £537.00-577.00 per week
Date and Type of Previous Inspection:	23 August 2013 Primary Unannounced
Date and Time of Inspection:	18 November 2014 11.30 to 17.30 hours
Name of Inspector:	Donna Rogan

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 are required.

This is a report of an inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being 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.

The Regulation and Quality Improvement Authority aims to use inspection to support providers in improving the quality of services, rather than only seeking compliance with regulations and standards. For this reason, annual inspection involves in-depth examination of a limited number of aspects of service provision, rather than a less detailed inspection of all aspects of the service.

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

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

- Discussion with the registered manager.
- Discussion with staff.
- Discussion with patients individually and to others in groups.
- Discussion with two relatives visiting at the time of inspection.
- Review of a sample of policies and procedures.
- Review of a sample of staff training records.
- Review of a sample of staff duty rotas.
- Review of a sample of care plans.
- Review of the accidents and incidents records.
- Review of the morning routine.
- Observation during a tour of the premises.
- Evaluation and feedback.

5.0 Consultation Process

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

Patients/Residents	**30**
Staff	**10**
Relatives	**4**
Visiting Professionals	**0**

6.0 Inspection Focus

The inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

Standard 19 - Continence Management

Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion 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		
Compliance Statement	**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

Brooklands Private Nursing Home is a purpose built two-storey building situated in its own grounds on the outskirts of Kilkeel.

The bedroom accommodation comprises single and double bedrooms, and an adequate number of bath/shower/toilet facilities are appropriately located throughout the home.

A range of rooms including dining rooms, and a variety of sitting rooms are positioned throughout the home.

A kitchen, laundry, toilet/washing facilities, treatment room, staff accommodation and offices were also available.

The home has satisfactory grounds with scenic views of the Mourne Mountains. An enclosed courtyard area is available for patients/residents, and car parking spaces are available to the front of the building.

All local amenities are nearby in Kilkeel town.
Respite services are regularly provided.

The 'Certificate of Registration' issued by The Regulation and Quality Improvement Authority (RQIA) was displayed in the home.

The home is registered as a nursing home and can provide care under the following categories:

Nursing Care Frail Elderly (34)

I Old age not falling into any other category
PH Physical Disability under pensionable age

Dementia Residential Care (9)

I Old age not falling into any other category

Nursing Care Dementia (14)

Conditions of registration

A maximum of 4 persons in category NH-PH
2 persons in category NH –LD
2 persons in category NH PH (E)
1 person in category NH-DE

Residential care

I old age not falling into any other category
PH physical disability other than sensory impairment under 65
PH(E) physical disability other than sensory impairment over 65 years
DE dementia care

8.0 Executive Summary

This summary provides an overview of the services examined during an unannounced secondary care inspection to Brooklands Nursing and Residential Home (Kilkeel). The inspection was undertaken by Donna Rogan on 18 November 2014 from 11.30 to 17.30 hours.

The inspectors were welcomed into the home by Deborah Campbell, registered nurse manager of the home. Ms Campbell was provided with feedback at the conclusion of the inspection.

During the course of the inspection, the inspector met with patients and staff and relatives. The inspector observed care practices, examined a selection of records, and carried out a general inspection of the nursing home environment as part of the inspection process.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. This self-assessment was received by RQIA on 1 July 2014. The inspector reviewed the responses provided, however, due to a change in inspection focus has been unable to validate all of the statements provided. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.
As a result of the previous inspection conducted on 23 August 2013, two requirements and two recommendations were made. They were reviewed during this inspection. The inspector evidenced that requirements and recommendations were fully complied with. Details of the previous requirements and recommendations can be viewed in the section immediately following this summary.

Conclusion

The inspector can confirm that at the time of this inspection the delivery of care to patients was evidenced to be of a good standard. There were processes in place to ensure the management of continence care. One requirement was made in regard to this theme.

In addition to the theme inspected the inspectors also reviewed the following;
.

- Care practices
- Patients' views.
- Staffing/staff views.
- Relatives views.
- Environment.
- Meals and mealtimes.
- Care records.

Requirements are also made in relation to care records and the environment. A total of, four requirements are made following this inspection. These requirements are detailed throughout the report and in the quality improvement plan (QIP).

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

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	20 (1) (a)	Ensure all staff receives training in safeguarding vulnerable adults.	A review of the training records evidenced that all staff have received training in safeguarding vulnerable adults.	Compliant
2	21 (1) (b)	Ensure that a full employment history is obtained and recorded and any gaps in employment are explored in keeping with legislation.	A review of two members' staff files evidenced that a full employment history is obtained and recorded. Any gaps in employment were explored in keeping with legislation.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	25.12	Ensure the registered manager signs and dates the Regulation 29 report upon receipt.	A review of Regulation 29 report evidenced that it is signed by the registered manager upon receipt.	Compliant
2	29.6	Ensure all staff receives an annual appraisal.	Staff spoken with confirmed that they have received an annual appraisal.	Compliant

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

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if 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 care inspection on 23 August 2013 RQIA have received a notification of an ongoing complaint from Southern Health and Social Services Trust. RQIA are satisfied that the complaint is being investigated by the Trust. The outcome of the investigation should be shared with RQIA upon conclusion alongside the action taken (if any) by management in the home.

10.0 Inspection Findings

Standard 19 - Continence Management Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**Compliance Level**
Inspection Findings:	
Review of four patients' care records evidenced that bladder and bowel continence assessments were undertaken for patients. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. There was evidence in three patients care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. Review of four patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. The care plans reviewed addressed the patients' assessed needs in regard to continence management. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Compliant

Standard 19 - Continence Management Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**Compliance Level**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place; • Continence management/incontinence management. • Stoma care. • Catheter care. The above policies and procedures should be updated to incorporate up to date best practice guidelines. A requirement is made in this regard. The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines for improving continence care were available. • NICE guidelines for urinary faecal incontinence. • British Geriatrics Society Continence Care in Nursing and Residential Care. Discussion with staff revealed that they had an awareness of the guidelines.	Substantially compliant

Standard 19 - Continence Management Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**Compliance Level**
Inspection Findings:	
Not applicable.	Not applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**Compliance Level**
Inspection Findings:	
Discussion with the registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the registered manager revealed that all the registered nurses in the home were deemed competent in female and male catheterisation and the management of stoma appliances. A review of two members of staff induction programme evidenced that continence care was included in the programme for all grades of care staff.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

During the inspection staff were noted to treat the patients with dignity and respect. Good relationships were evident between patients and staff.

Patients were well presented with their clothing suitable for the season. Staff were observed to respond to patients' requests promptly. The demeanour of patients indicated that they were relaxed in their surroundings.

The afternoon routine was observed to be well organised. Patients spoken with stated that they could choose where to have their lunch. Patients also informed the inspector that their continence needs were tended to in a timely way, they stated that when they sounded the nurse call system that their request was usually answered promptly.

There was a good atmosphere in the home. There is a well organised activity programme ongoing. Patients spoken with stated they enjoyed the activities organised and were looking forward to the social activities organised for Christmas.

11.2 Complaints

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

The inspector discussed the management of complaints with the registered manager and reviewed the complaint record. This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements.

11.3 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.

11.4 NMC Declaration

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

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

11.5 Patients/Residents and Relatives Comments

During the inspection the inspector spoke with approximately 20 patients individually and to others in groups. These patients expressed high levels of satisfaction with the standard of care, facilities and services provided in the home. A number of patients were unable to express their

views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients' comments were as follows:

"I am very happy with everything here."
"Food is very good."
"The home is clean and tidy."
"My room is always kept clean and I am happy with everything."

The inspector also spoke with four relatives visiting at the time of the inspection. All were very positive regarding the care their relatives were receiving in the home. They were confident that they could approach management if they had any issues in the home. All stated that they felt they were kept well informed of changes in their relatives needs and felt they were involved in their care. There were no issues raised by patients/residents or relatives to the inspector during the inspection.

11.6 Staff Comments

During the inspection the inspector spoke with 10 staff. The inspector was able to speak to a number of these staff individually and in private. Staff responses during discussion indicated that staff received an induction, completed mandatory training, completed additional training in relation to continence care and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes. There were no issues raised by staff to the inspector during the inspection.

Examples of staff comments were as follows;

"I am very happy working in the home."
"This is a good home we work well as a team."
"The patients and residents are well cared for."

11.7 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a high standard of hygiene. Three bedrooms were identified to the registered manager as being required to be redecorated.

11.8 Meals and mealtimes

The inspector observed the serving of the lunchtime meal. The meal served was observed to be very appetising. All patients/residents spoken with expressed complete satisfaction with the food in the home. The lunchtime meal is the main meal of the day and it consisted of a choice of chicken or steak pieces served with mash potato, turnip stuffing and gravy. The inspector observed 3 meals left on a trolley in the dementia nursing dining room, they were observed to go cold. Staff spoken with stated that they were for those patients requiring assistance and staff would normally heat these meals in a microwave prior to serving. This practice should be reviewed to ensure that food is served at the correct temperatures in keeping with best practice. The correct menu should be displayed in a timely way in the dining rooms as discussed.

11.9 Care records

The inspector reviewed four patient/residents care records and a number of repositioning charts, fluid balance charts and nutritional intake charts. In general records are being well maintained in accordance with best practice. However the following issues should be addressed;

- Charts are required to be updated contemporaneously in order to reflect the correct delivery of care.
- Ensure the Malnutrition Universal Screening Tool is correctly completed and updated for all patients/residents.
- Weights should be accurately recorded in care records.
- Body maps should be kept up to date and reflect the current state of the patients'/residents' skin.
- Remove care plans no longer applicable to the patients'/residents' needs.
- Ensure all patients who are required to have a fluid balance chart in place have it consolidated at the end of a 24 hour period by a registered nurse and the input and output recorded in the daily evaluation of care.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Deborah Campbell, registered manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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

Enquiries relating to this report should be addressed to:

Donna Rogan
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

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**
A comprehensive, holistic assessment of patients' needs is completed within 11 days of adission. Validated risk assessments used include the Braden risk assessment, the MUST nutritional risk assessment tool, moving and handling risk assessment, falls risk assessment, Abbey pain assessment, continence assessment, oral assessment and where appropriate a wound observation chart. The assessment process is audited as part of the homes governance system against compliance with the Company	Substantially compliant

policies and procedures.	

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**
The home operates a Named Nurse and key worker system. The Named Nurse has responsibility to review and evaluate treatment given and care delivered at identified and agreed time intervals as recorded in the care plan. Following admission to the home the Named Nurse develops a care plan with the patient and their representative,	Substantially compliant

taking into account the identified risks and promoting maximum independence Where advice and support is required from a member of he multi-disciplinary team such as the Dietician or Tissue Viability Nurse, a referral process is followed and documented. On receipt of advice and support the nurse will devise and adhere to the care plan which is reviewed to incorporate the treatment plan..	

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Re-assessment is an ongoing process and is carried out daily and at identified, agreed time intervals as recorded in the care plan. Day and night nursing staff record an evaluation in the daily progress notes of the delivery of care to each patient during the span of suty. Entries are correlated to the individual's care plans. Risk assessments and care plans are reviewed on a monthly basis or more frequently as required.	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**
Validated assessment tolls such as the Braden pressure risk assessment and MUST nutritional risk assessment are used by nursing saff to develop care plans, and to inform and guide care pracice in line with evidence based research. Wounds are assessed using a validated pressure ulcer grading tool and an appropriate treatment plan is implemented to include tissue viability advice. All wounds are audited by thee Home Manager as part of the home's governance arragements. Best practice guidelines such as the PHA Nutritional Guidelines and menu checklist for residential and nursing homes 2014 and the DHSSPS Promoting good nutrition resources are followed and are available in the home.	Substantially compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Individual care records are retained for each patient and stored securely and recorded in accordance with the NMC guidance on records and record keeping. The nursing and care staff maintain a food intake record of he food served at each mealtime which includes the specialist dietary needs of patients. Where a patient is identified as being at risk of inadequate food or fluid intake, daily records of food and fluids are maintained as per MUST protocol. Staff inform the nurse in charge and appropriate action is taken to refer to the relevant professional for advice.	Substantially compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Daily progress notes are recorded at each shift by dy and night staff and are cross referenced to the patients' care plan. Care plans and clinical risk assessment are routinely reviewed monthly or more frequently depending on the identified needs of individual patients. The Named Nurse records the outcome of the assessment and the findings in the patients' care plan, significant changes are communicated to teh patient and/or their representative and where appropriate referred onto the relevant health care professional.	Substantially 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 managment reviews normally take place 8 weeks following admission to the home and yearly thereafter unless requested by the patient, patients' representative, the home or care management. Where minutes are provided by care management, care plans are updated to reflecgt any recommendations made following discussion of the patients assessment and needs where applicable.	Substantially compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Patients are provided with a nutritional and varied diet which meets their individual and dietary needs and preferences. A policy and procedure is in place to guide and inform staff in regard to nutrition and dietary intake which reflects best practice guidance. Choice is offered to all patients at all mealtimes. Should any patient not like either choice, an alternative may be offered by the catering staff which is recorded by the chef.	Substantially compliant

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

Staff are aware of any patient at risk of choking, patients with swallowing difficulties and patients who require assistance or supervision. There are adequate staff numbers at mealtimes under the nurse's supervision to reduce risk. Staff are knowledgable in the assessment and management of wounds and are supported through senior staff in the home including the Practice Development Nurse.	

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.

Quality Improvement Plan

Secondary Unannounced Care Inspection

Brooklands (Kilkeel)

18 November 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 Deborah Campbell, registered manager during 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	12 (1) (b)	Ensure the following policies and procedures are updated to reflect best practice; • continence management/incontinence management • stoma care • catheter care **Ref 19.2**	One	All stated policies have been updated to reflect best practice	From the date of inspection
2	27	Ensure the three identified bedrooms are redecorated. **Ref 11.7**	One	Identified bedrooms have been redecorated including new flooring fitted	From the date of inspection
3	12 (4)	Ensure food is served at the correct temperature in accordance with best practice. **Ref 11.8**	One	Temperature of food is checked before service	From the date of inspection
4	15 and 16	Ensure the following issues are addressed in relation to the care records; • Charts are required to be updated contemporaneously in order to reflect the correct delivery of care. • Ensure the Malnutrition Universal Screening Tool is correctly completed and updated for all patients/residents. • Weights should be accurately recorded in care records.	One	Repositioning charts and fluid balance charts have been reviewed and updated accordingly. Charts are now located in residents own rooms where releveant. Staff surpervision carried out to ensure charts are updated at the time of intervention. Staff nurses supervision carried out on the use of the MUST tool.	From the date of inspection

		• Body maps should be kept up to date patients'/residents' skin. • Remove care plans no longer applicable to the patients'/residents' needs. • Ensure all patients who are required to have a fluid balance chart in place have it consolidated at the end of a 24 hour period by a registered nurse and the input and output recorded in the daily evaluation of care. **Ref 11.9**		Body maps are completed on a monthly basis and updated when change in condition. Care plans no longer applicable have been removed and archived. The night nurse consolidates the fluid balance chart at the end of the 24 hour period and records same in the daily progress notes	

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	DEBORAH CAMPBELL
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	THERESE CONWAY

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Donna Rogan	08/03/15
Further information requested from provider			