

Announced Primary Inspection

Name of Establishment:	Chestnut Lodge
Establishment ID No:	1479
Date of Inspection:	23 June 2014
Inspector's Name:	Heather Moore
Inspection No:	16500

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544

1.0 General Information

Name of Home:	Chestnut Lodge
Address:	47 Carrickaness Road Benburb Dungannon BT71 7NH
Telephone Number:	028 3754 8706
E mail Address:	chestnut.lodge@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Health Care Mr James McCall
Registered Manager:	Mr Paul Gildernew
Person in Charge of the Home at the time of Inspection:	Mr Paul Gilder new
Registered Categories of Care and number of places:	NH-DE, NH-I, NH-PH, RC-I, RC-MP, RC- MP(E) 40
Number of Patients/Residents Accommodated on Day of Inspection:	31
Scale of charges (per week)	£581.00 - £624.00
Date and time of this inspection:	23 June 2014: 08.25 hours - 15.00 hours
Date and type of previous inspection:	31 October 2013 Secondary Unannounced

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 a primary announced 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 the inspection visit by the inspector.

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

- analysis of pre-inspection information
- discussion with the registered manager
- examination of records

- consultation with stakeholders
- tour of the premises
- evaluation and feedback.

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

5.0 Consultation Process

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

Patients	6
Staff	10
Relatives	1
Visiting Professionals	0

Questionnaires were provided, during the inspection, to patients, their representatives and staff to seek their views regarding the service. Matters raised from the questionnaires were addressed by the inspector in the course of this inspection.

Issued To	Number issued	Number returned
Patients	6	6
Relatives / Representatives	1	1
Staff	10	10

6.0 Inspection Focus

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

The criteria from the following standards are included;

- Management of Nursing Care – Standard 5
- Management of Wounds and Pressure Ulcers –Standard 11
- Management of Nutritional Needs and Weight Loss – Standard 8 and 12
- Management of Dehydration – Standard 12

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

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

The 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

Chestnut Lodge Care Home is located approximately two miles from Benburb in its own landscaped grounds.

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

Nursing Care

I - old age not falling into any other category
DE - dementia

Residential Care

RC - I - Old age not falling into any other category.

MP - care for one resident in the mental health category of care excluding learning disability (under the age of 65).

MP (E) - Mental disorder excluding learning disability or dementia (over the age of 65).

Chestnut Lodge Care Home is also registered to provide day care for two service users.

The home comprises of 30 single bedrooms, five double bedrooms, three sitting rooms, dining room, kitchen, laundry, bathroom, shower and toilet facilities, staff accommodation and offices.

Adequate car parking facilities are provided at the front of the home.

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) accurately reflected the categories of care and was appropriately displayed in a prominent position of the home.

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (announced) to Chestnut Lodge. The inspection was undertaken by Heather Moore on 23 June 2014 from 08.25 hours to 15.00 hours.

The inspector was welcomed into the home by Mr Paul Gildernew Registered Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to the registered manager at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector met with patients, staff and one relative. 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.

Questionnaires were issued to patients, staff and one relative during the inspection.

The inspector spent a number of 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 is designed to help evaluate the type and quality of communication which takes place in the nursing home. A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix two.

As a result of the previous inspection conducted on 31 October 2014, one requirement and one recommendation were issued. This requirement and recommendation were reviewed during this inspection. The inspector evidenced that the requirement and recommendation had been fully complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

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

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

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

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

Inspection Findings:

- **Management of Nursing Care – Standard 5**

The inspector can confirm that at the time of the inspection there was evidence to validate that patients receive safe and effective care in Chestnut Lodge.

The inspector inspected three patients care records and there was evidence of comprehensive and detailed assessment of patient needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of the patient's needs was evidenced to inform the care planning process.

Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis plus as required.

Inspection of three patients care records revealed the absence in one patient's care record that written evidence was maintained to indicate that discussions had taken place with patients, and their representatives in regard to planning and agreeing nursing interventions. A recommendation is made in this regard.

There was also evidence that the referring HSC Trust maintained appropriate reviews of the patient's satisfaction with the placement in the home and the quality of care delivered.

Compliance Level: Substantially Compliant

- **Management of Wounds and Pressure Ulcers –Standard 11**

The inspector evidenced that wound management in the home was well maintained. There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment. Care plans for the management of risks of pressure ulcers and wound care were maintained to a professional standard.

Compliance level: Compliant

- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**

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

Robust systems were evidenced with risk assessments and appropriate referrals to GP's, speech and language therapists and or dieticians being made as required. Inspection of staff training records revealed that staff as appropriate required a training update on Dysphagia. A requirement is made in this regard.

The inspector also observed the serving of the lunch meal and can confirm that the patients were offered a choice of meal and that the meal service was well delivered. Patients were observed to be assisted with dignity and respect throughout the meal.

Compliance level: Substantially Compliant

- **Management of Dehydration – Standard 12**

The inspector also examined the management of dehydration during the inspection. The home maintained fluid intake of those patients assessed at risk of dehydration. However examination of a sample of patients' fluid balance charts confirmed that charts were not totalled over a 24 hour period. The patient's daily fluid intake was also not recorded in the patient's daily evaluation of care and treatment. A requirement is made in this regard.

Compliance level: Substantially Compliant

Patients / their representatives and staff questionnaires

Some comments received from patients and their representatives;

- "I always have access to my buzzer."
- "The quality of care I receive is good."
- "I think it can't be improved upon."
- "My visitors are always made welcome."
- "Staff are always polite."
- "Everything is fine."
- "The staff are all very pleasant and go out of their way, they are 100%."
- "They are all very obliging and very hospitable with me and all the family."

Some comments received from staff;

- "Care is always given to the best of the carer's ability."
- "I work in the office but I do see a very high quality of care from all the staff to the residents."
- "I am very happy working here."
- "There is good co-operation between staff and good team work."
- "The residents within Chestnut Lodge are treated with dignity and respect; they are encouraged to be independent and are always listened to."
- "In addition, the staff are all very friendly and always happy to help the residents."
- "The manager is very good, there is good teamwork."

A number of additional areas were also examined

- Records required to be held in the nursing home
- Guardianship
- Human Rights Act 1998 and European Convention on Human Rights (ECHR)
- DHSSPS and Deprivation of Liberty Safeguards (DOLS)
- Patient and staff quality of interactions (QUIS)

- Complaints
- Patient finance pre-inspection questionnaire
- NMC declaration
- Staffing and staff comments
- Comments from representatives/relatives *and visiting professionals*
- Environment.

Full details of the findings of inspection are contained in section 11 of the report.

Conclusion

The inspector can confirm that at the time of inspection the delivery of care to patients was evidenced to be of a good standard. There were processes in place to ensure the effective management of the themes inspected.

The home's general environment was well maintained however one requirement is made in regard to the replacement of floor covering.

Patients were observed to be treated with dignity and respect.

However areas for improvement are identified three requirements and one recommendation is made. These requirements and recommendation are addressed throughout the report and in the Quality Improvement plan (QIP).

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

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

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

No	Regulation Ref.	Requirement	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	21 (c) (i)	The registered person shall ensure that registered nurses receive training in cardio pulmonary resuscitation.	Inspection of staff training records confirmed that registered nurses had received training in cardio pulmonary resuscitation on 16 December 2013.	Compliant

No	Minimum Standard Ref.	Recommendation	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	20.4	It is recommended that written evidence is maintained in the home to indicate registered nurses competencies and capabilities in cardio pulmonary resuscitation.	Inspection of a sample of registered nurses staff files confirmed that staff had written evidence of their competency and capability in cardio pulmonary resuscitation.	Compliant

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

Since the previous care inspection on 31 October 2013, RQIA have received one notification of safeguarding of vulnerable adult (SOVA) incidents in respect of Chestnut Lodge.

11.0 Additional Areas Examined

11.1 Documents required to be held in the Nursing Home

Prior to the inspection a checklist of documents required to be held in the home under regulation 19(2) schedule 4 of The Nursing Homes Regulations (Northern Ireland) was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required documents were maintained in the home and were available for inspection. The inspector reviewed the following records:

- The home's statement of purpose
- The patient's guide
- Sample of reports of unannounced visits to the home under regulation 29
- Sample of staff duty rosters
- Record of complaints
- Sample of incident/accidents
- Record of food provided for patients
- Statement of the procedure to be followed in the event of a fire
- Sample of the minutes of patients/relatives and staff meetings.

11.2 Patients under guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) order 1986.

At the time of the inspection, and living in or using this service was sought as part of this inspection. During the inspection there were no patients in the home who were subject to a guardianship order.

11.3 Human Rights Act 1998 and European Convention on Human Rights (ECHR)

DNSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspector discussed the Human Rights Act and the Human Rights Legislation with the registered manager. The inspector can confirm that copies of these documents were available in the home.

11.4 Quality of interaction schedule (QUIS)

The inspector undertook a number of periods of observation in the home which lasted approximately 30 minutes each.

The inspector observed the patients' lunch meal which was served in the dining room. The inspector also observed a small number of patients having their lunch meal in the small day room.

The observation tool used to record these observations uses a simple coding system to record interactions between staff, patients and visitors.

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix 2.

The staff were observed seating the patients in preparation for their lunch in an unhurried manner.

The staff explained to the patients their menu choice and provided adequate support and supervision.

Observation of care practices during these periods of observation revealed that staff were respectful in their interactions with the patients.

Overall the periods of observations were positive.

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. One compliant was recorded since the previous inspection this complaint was investigated appropriately.

11.6 Patient Finance Questionnaire

Prior to the inspection a patient 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.

11.7 NMC declaration

Prior to the inspection the 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 manager were registered with the NMC.

11.8 Staffing /Staff Comments

On the day of inspection the inspector examined staff duty rosters for four weeks. Inspection confirmed that registered nurses and care staff staffing levels for day and night duty were in accordance with the RQIA's recommended minimum staffing guidelines.

The inspector spoke to 10 staff members during the inspection process and eight staff completed questionnaires.

Examples of staff comments were for as follows:

- “Care is always given to the best of the carer’s ability.”
- “I work in the office but I do see a very high quality of care from all the staff to the residents.”
- “I am very happy working here.”
- “There is good co-operation between staff and good team work.”
- “The residents within Chestnut Lodge are treated with dignity and respect; they are encouraged to be independent and are always listened to.”
- “In addition, the staff are all very friendly and always happy to help the residents.”
- “The manager is very good, there is good teamwork.”

11.9 Patients’ Comments

The inspector spoke to six patients individually and with others in groups. Six patients completed questionnaires.

Examples of their comments were as follows:

- “I always have access to my buzzer.”
- “I think the home can’t be improved upon.”
- “The quality of care here is good.”
- “My visitors are always made welcome.”
- “Staff are always polite.”
- “Everything is fine.”

11. 10 Relatives’ Comments

The inspector spoke to one relative and this relative completed a questionnaire.

An example of the relative’s comments is:

- “The staff are very pleasant and go out of their way 100% for my mother, also they are all very obliging and very hospitable with myself and my family.”

11.11 Environment

The inspector undertook an inspection of the home and viewed a number of patients’ bedrooms, communal facilities and toilet and bathroom areas

The home was generally clean, warm and comfortable. However there was a malodour noted in the Oak day room. A requirement is made that the floor covering is replaced.

The ambience in the home was relaxed and friendly.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr Paul Gildernew, 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:

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

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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission. Criterion 8.1 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 : Regulations 12(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 carries out a pre admission assessment. The assessment is completed when information is obtained from the client/relative (if possible) and the care manager. Following a review of all the information a decision is made in regard to the home's ability to meet the client's needs. If the admission is an emergency, then a pre admission assessment can be carried out over the telephone and written comprehensive documentation can be faxed or emailed to the home by the care manager. The admission will only take place when the manager is satisfied that the home can fully meet the needs of the client. On admission to the home an identified nurse completes initial assessments using a patient centred approach. The nurse	Compliant

<p>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.</p> <p>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.</p> <p>In addition to these two documents, the nurse completes risk assessments immediately 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,</p> <p>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.</p> <p>The Home Manager and Regional Manager will complete audits on a regular basis to quality assure this process</p>	
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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

<p>agreed with relevant healthcare professionals.</p> <p>Criterion 11.8</p> <ul style="list-style-type: none"> • 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. <p>Criterion 8.3</p> <ul style="list-style-type: none"> • 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. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1); 14(1); 15 and 16</p>	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
<p>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 required. Any recommendations made by other members of the multidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable.</p> <p>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. .</p> <p>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.</p> <p>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</p>	Compliant

<p>home and faxed to the gpl. The dietician is also available over the telephone for advice. 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.</p>	
Section C	
<p>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.</p>	
<p>Criterion 5.4</p> <ul style="list-style-type: none"> • Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16</p>	
<p>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</p>	<p>Section compliance level</p>
<p>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.</p> <p>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.</p> <p>The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.</p>	<p>Compliant</p>

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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented. Criterion 8.4 <ul style="list-style-type: none"> 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
<p>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.</p> <p>The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading system. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime or if the condition of the pressure ulcer changes.</p> <p>There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', 'PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in</p>	Compliant

relation to nutritional care, diabetic care, care of subcutaneous 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.	
<p>Criterion 5.6</p> <ul style="list-style-type: none"> 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. <p>Criterion 12.11</p> <ul style="list-style-type: none"> 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. <p>Criterion 12.12</p> <ul style="list-style-type: none"> 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. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25</p>	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
<p>Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are contemporaneous 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.</p> <p>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.</p>	Compliant

<p>Residents who are assessed as being 'at risk' of malnutrition, dehydration 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.</p> <p>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.</p>	
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.	
<p>Criterion 5.7</p> <ul style="list-style-type: none"> 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. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16</p>	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
<p>The outcome of care delivered is monitored and recorded on a daily basis on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan of care or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their representatives are involved in the evaluation process.</p>	<p>Compliant</p>

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.	
<p>Criterion 5.8</p> <ul style="list-style-type: none"> 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. <p>Criterion 5.9</p> <ul style="list-style-type: none"> 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. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)</p>	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
<p>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.</p> <p>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.</p>	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 <ul style="list-style-type: none"> 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 dietitians and other professionals and disciplines. Criterion 12.3 <ul style="list-style-type: none"> 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
<p>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.</p> <p>The home has a 4 week menu displayed in folder and 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.</p> <p>Copies of instructions and recommendations from the dietician and speech and language therapist are made available</p>	Substantially compliant

in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs.

Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything from the daily menu an alternative meal of their choice is provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display in the dining room, with the 4 week menu displayed in a menu display folder 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:
 - risks when patients are eating and drinking are managed
 - required assistance is provided
 - 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
<p>Registered nurses have received training on enteral feeding techniques (PEG) on 06/02/2014. The Speech and Language therapist and dietician also give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document - 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for 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. Meals are served at the following times:-</p> <p>Breakfast - 9am-10.30am Morning tea - 11am Lunch - 12.40pm-13.30pm Afternoon tea - 3pm Evening tea - 4.50pm Supper - 8.30pm-9pm</p> <p>There are variations to the above if a resident requests to have their meals outside of these times. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. There are foods available outside of these times for those resident's who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedrooms, these are replenished on a regular basis.</p> <p>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.</p> <p>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.</p>	Compliant

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)

<p>Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.</p>	<p>Basic Care: (BC) – basic physical care e.g. bathing or use of 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.</p>
<ul style="list-style-type: none"> • 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 where 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 	<p>Examples include: Brief verbal explanations and encouragement, but only that that is necessary to carry out the task</p> <p>No general conversation</p>

<p>Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.</p>	<p>Negative (NS) – communication which is disregarding of the residents' dignity and respect.</p>
<p>Examples include:</p> <ul style="list-style-type: none"> • 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 	<p>Examples include:</p> <ul style="list-style-type: none"> • 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

Announced Primary Inspection

Chestnut Lodge

23 June 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 **Mr Paul Gildernew, Registered Manager** either during or after the inspection visit.

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

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

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

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

Statutory Requirements This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on the HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and the Nursing Homes Regulations (NI) 2005					
No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	20 (1) (c) (i)	<p>The registered person shall ensure that staff as appropriate are trained in Dysphagia.</p> <p>Ref: Management of Nutritional Needs and Weight Loss</p>	One	Dysphagia training to be delivered by SALT team from the SHSCT, date to be confirmed.	Two Months
2	13 (1) (a)	<p>The registered person shall ensure that the nursing home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. This requirement is made in regard to the maintenance of patients fluid balance charts. Patients recommended daily fluid targets should be recorded in their care plans on Eating and Drinking. Action to be taken if the target is not achieved should also be recorded.</p> <p>The patient's total fluid intake should also be recorded in the evaluation of care provided to patients.</p> <p>Ref: Management of Dehydration</p>	One	All staff to ensure fluid balance charts completed appropriately and nursing staff to document fluid intake and output in appropriate care documents. Clinical supervision to ensure proper completion of fluid balance charts to be undertaken by deputy manager and manager.	From the date of this inspection
3	27 (2) (d) 13 (7)	<p>The registered person shall ensure that the carpet in the Oak day room is replaced.</p> <p>Ref: Section 11.12 (Additional Areas Examined)</p>	One	An order has been placed for carpet replacement in the oak room. Awaiting works to begin.	Two Months

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	Recommendation	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.3	It is recommended that written evidence is maintained in patients care records to indicate that discussions had taken place with patients and their representatives in regard to planning and agreeing nursing interventions. Ref: Management of Nursing Care	One	Nursing staff have contacted relatives to meet and discuss care plans and agree a plan of action for each resident.	One Month

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	Paul Gildernew
Name of Responsible Person / Identified Responsible Person Approving Qip	Jim McCall <i>Carol Cousins</i> CAROL COUSINS DIRECTOR OF OPERATIONS

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	<i>[Signature]</i>	19.8.14
Further information requested from provider			