Announced Primary Inspection

Name of Establishment:	**Copperfields**
Establishment ID No:	**1482**
Date of Inspection:	**10 June 2014**
Inspector's Name:	**Teresa Ryan**
Inspection No:	**17133**

The Regulation And Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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1.0 General Information

Name of Home:	Copperfields Private Nursing Home
Address:	1 – 3 Moore Street Aughnacloy Co Tyrone BT69 6AX
Telephone Number:	028 8555 7922
E mail Address:	copperfieldsprivatenurseinghome@outlook.com
Registered Organisation/ Registered Provider:	Edwards Enterprises N.I. Ltd Mr William Henry Hume Edwards
Registered Manager:	Mrs Cherith McKeown
Person in Charge of the Home at the Time of Inspection:	Mrs Cherith McKeown
Categories of Care:	NH-DE, NH-I, NH-LD, NH-LD(E), RC-I
Number of Registered Places:	32
Number of Patients and Residents Accommodated on Day of Inspection:	32: 19 Nursing - I 7 Nursing Dementia 2 Learning Disability Nursing 4 Residential
Scale of Charges (per week):	Nursing: £581.00 Residential: £461.00
Date and Type of Previous Inspection:	09 December 2013 Secondary Unannounced
Date and Time of Inspection:	10 June 2014 07.50 hours -16.30 hours
Name of Lead Inspector:	Teresa Ryan

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 provider

- discussion with the registered manager
- discussion with registered nurses
- discussion with staff
- 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	**8 patients individually and to others in groups**
Staff	**19**
Relatives	**4**
Visiting Professionals	**-**

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

Issued To	**Number issued**	**Number returned**
Patients / Residents	**5**	**4**
Relatives / Representatives	**5**	**3**
Staff	**15**	**9**

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

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

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

7.0 Profile of Service

Copperfields is located in Aughnacloy village, Co Tyrone. The home is owned and operated by Edwards Enterprises N.I. Ltd. The registered provider is Mr William Henry Hume Edwards. The current registered manager is Mrs Cherith McKeown. The home comprises of twenty-two single bedrooms and five double bedrooms, three sitting rooms, two dining rooms, a kitchen, a laundry, toilet and washing facilities, staff accommodation and offices. The home is a two-storey building with access to the first floor via a through floor lift and stairs. There are well-maintained gardens/grounds.

Adequate car parking facilities are provided at the front and side of the home

The home is registered to provide care for a maximum of 32 persons under the following categories of care:

Nursing care

I	old age not falling within any other category
DE	dementia care
LD	learning disability under 65 years
LD(E)	learning disability over 65 years

Residential care

I	old age not falling into any other category

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (announced) to Copperfields. The inspection was undertaken by Teresa Ryan on Tuesday 10 June 2014 from 07.50 hours to 16.30 hours.

The inspector was welcomed into the home by Mrs Cherith McKeown, Registered Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Mr William Henry Hume Edwards, Registered Provider and Mrs McKeown during the inspection feedback.

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. This self-assessment is appended to the report at Appendix One.

During the course of the inspection, the inspector met with patients, staff and a number of 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.

Questionnaires were issued to patients, relatives and staff 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 09 December 2013 three requirements and one recommendation were issued. These were reviewed during this inspection. The inspector evidenced that two of the requirements and the recommendation were fully addressed. One requirement was assessed by the inspector as moving towards compliance. This requirement is therefore restated. 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**

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 patient needs was evidenced to inform the care planning process.

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

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.

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

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.

A requirement is made in regard to training for registered nurses in wound management. A recommendation is made that the template used for repositioning charts be reviewed to address inspection of the patient's skin at each positional change.

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

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

Systems were evidenced with risk assessments and appropriate referrals to GP's, speech and language therapists and/or dieticians being made as required.

Staff spoken with were knowledgeable regarding the individual dietary needs of patients to include their likes and dislikes. Discussion with a number of patients, staff and review of the record of food provided for patients revealed that there was no evidence available to confirm that patients were offered choice in advance of their meals and a requirement is made that the registered person shall provide choice for patients and that the menu is varied at suitable intervals. Records should be held of these choices.

Review of the four weekly menu planner revealed that this planner should be reviewed and updated in consultation with the patients and their representatives to address a variety of choices for the morning, afternoon and suppertime snacks. There is currently one choice recorded for each of these snacks. There was one choice recorded for the lunch meal on Sundays and this should be addressed. There were no records in place to confirm the choices recorded on the menu planner for the patients on therapeutic diets were provided to these patients. The choices provided on the menu planner for patients on therapeutic diets should be varied as the choices provided for the evening meals were similar in a number of instances to the lunch meal.

On the day of the inspection, the inspector observed the lunch meal in the dining rooms in the home Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely manner.

Staff were observed preparing and seating the patients for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients with their meal and patients were offered a choice of fluids. The tables were well presented with condiments appropriate for the meal served. However it was noted that the

potatoes were mashed and not pureed for the patients on pureed diets. Taking into account the risks associated with this practice a requirement is made that food and fluids are properly prepared, wholesome and nutritious and meets the patients' nutritional requirements and are suitable for the needs of the patients.

A requirement is made in regard to staff training in the following areas:

- Management of nutrition
- Fortification of foods
- Preparation and presentation of pureed meals
- Dysphagia awareness
- Nutritional Guidelines and Menu Checklist For Residential and Nursing Homes (2014)
- Record keeping

- **Management of Dehydration – Standard 12 (selected criteria)**

The inspector also examined the management of dehydration during the inspection. The home was evidenced to identify fluid requirements for patients and records were maintained of the fluid intake of those patients assessed at risk of dehydration.

Patients were observed to be able to access fluids with ease throughout the inspection.

The inspector can confirm that based on the evidence reviewed, presented and observed; that the level of compliance with this standard was assessed as substantially compliant.

Patients, their representatives and staff questionnaires

Some comments received from patients and their representatives:

"This is a very good home I am happy"
"Staff treat me and my belongings with respect"
"My visitors are always made welcome"
"I feel safe in this home"
"I am very happy with the standard of care provided to my relative"
"I am very happy with the care that my brother receives in this home"
"Staff make me feel welcome when I visit".

Some comments received from staff:

"Copperfields is a great place to work staff and management are friendly and helpful"
"The patients are treated with the utmost dignity and respect, the care is excellent, care staff are hardworking and promote quality care"
"Very, very happy in my 25 years working in the home"
"I am very happy with the standard of care provided to the patients".

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
- environment

.A recommendation is made that an activity therapist be employed to take the lead in the provision of age appropriate, failure free and meaningful activities for the patients.

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. The home's general environment was well maintained and patients were observed to be treated with dignity and respect. However, areas for improvement are identified. Three requirements and two recommendations are made. These requirements and recommendations are addressed throughout the report and in the Quality Improvement Plan (QIP).

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

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	17 (1)	The registered person shall introduce and ensure systems are maintained for reviewing at appropriate intervals the quality of nursing and other service provision in or for the purposes of the nursing home and that any such review is undertaken not less than annually. An annual quality review report should be drawn up and a copy of the report of this review should be held in the home.	An annual quality review report had been drawn up and a copy of this report was held in the home and made available to the inspector.	Compliant
2	20 (1)(c)(i)	Staff as appropriate should be trained in the following areas Wound care – registered nurses Restraint including the safe use of bedrails	Review of the staff training records revealed that nine registered nurses were trained in wound management in March 2013 and May 2014. 17staff were trained in restraint including the safe use of bedrails on 30 January 2014.	Compliant
3	12 (2) (b)	The registered person shall ensure that all aids and equipment used in or for the purposes of the nursing home is properly maintained and in good working order.	Review of the records of checks of emergency equipment held in the home revealed that this equipment was being checked on a daily basis.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	25.12	It is recommended that the following details be recorded in reports of unannounced visits undertaken under Regulation 29: • The number of patients / residents spoken to and provide examples of patient / residents comments on the quality of care and services provided in the home; • Information in regard to accidents, incidents, complaints and outcome of audits undertaken in the home; • Information in regard to the quality of care, facilities and services provided to the patients and residents in the planned improvements for the home; • Detail improvements with timescales in action plans.	Review of a sample of these reports revealed that all elements of this recommendation were being addressed.	Compliant

10.0 Inspection Findings

Section A

Standard : 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**

Standard 5.2

- **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission**

Standard 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**

Standard 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.**

Inspection Findings:

Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

The inspector reviewed four patients' care records which evidenced that patients' individual needs were established on the day of admission to the nursing home through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks.

Specific validated assessment tools such as moving and handling, pain, infection control, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart and continence were also completed on admission.

Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure ulcer/wound and if required, the specific care plans regarding the management of the pressure ulcer/wound.

Review of four patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 11 days of patients' admission to the home.

In discussion with the registered manager she demonstrated a good awareness of the patients who required wound management intervention for wounds and the number and progress of patients who were assessed as being at risk of weight loss and dehydration.

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

Section B

Standard 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.**

Standard 11.2

- **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.**

Standard 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.**

Standard 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**

Standard 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.**

Inspection Findings:

The inspector observed that a named nurse and key worker system was operational in the home. The roles and responsibilities of named nurses and key workers were outlined in the patient's guide.

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

The registered manager informed the inspector that there were three patients in the home who required wound management for wounds.

Review of two of these patients' care records revealed the following;

- Body mapping charts were completed for the patients on admission. These charts were reviewed and updated when any changes occurred to the patients' skin condition.
- Care plans were in place which specified the pressure relieving equipment in place on the patients' beds and also when sitting out of bed.
- The type of mattresses in use was based on the outcome of the pressure risk assessments.
- Daily repositioning and skin inspection charts were in place for the patients with wounds and also for patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these charts revealed that patients' skin condition was not inspected for evidence of change at each positional change. A recommendation is made that the template used for this chart be reviewed to address this shortfall. It was revealed that patients were repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention.
- The patients' weights were recorded on admission and on at least a monthly basis or more often if required.
- The patients' nutritional status was also reviewed on at least a monthly basis or more often if required.
- Daily records were maintained regarding the patients' daily food and fluid intake.
- Review of wound care in two patients' care plans evidenced that the dressing regimes were recorded appropriately.

Patients' moving and handling needs were assessed and addressed in their care plans. There was evidence that manual handling aids were used to minimise risk of friction. Staff consulted confirmed there was sufficient nursing equipment available to move and handle patients appropriately.

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

Discussion with the registered manager, four registered nurses and review of four patients' care records confirmed that where a patient was

assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention plan and treatment programme.

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

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

Policies and procedures were in place for staff on making referrals to the dietician. These included indicators of the action to be taken and by whom. All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment.

Review of care records for one patient evidenced that the patient was referred for a dietetic assessment in a timely manner. Review of this patient's care plan on eating and drinking revealed that the dietician's instructions were addressed.

Discussion with the registered manager, registered nurses, care staff and review of the staff training records revealed that nine registered nurses were trained in wound management in March 2013 and May 2014. A requirement is made that additional registered nurses be trained in this area of care.

Care staff were trained in pressure area care and prevention in March, April and May 2014. Staff as appropriate require their knowledge and skills in the management of nutrition updated. The registered manager informed the inspector that staff training in the use of the MUST was planned for 18 July 2014.

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

Section C

Standard 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 Homes Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**
Inspection Findings:
Review of four patients' care records evidenced that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care including wound care for each patient. Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. Review of two patients' care records in relation to wound care indicated that these care records were reviewed each time the dressings were changed and also when the dressing regimes were changed or the condition of the wounds had deteriorated. Review of care records also evidenced that nutritional care plans for patients were reviewed monthly or more often as deemed appropriate. The evaluation process included the effectiveness of any prescribed treatments, for example, prescribed analgesia. Discussion with the registered manager and review of governance documents evidenced that a number of care records were audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

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

Section D

Standard 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.**

Standard 11.4

- **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.**

Standard 8.4

- **There are up to date nutritional guidelines that are in use by staff on a daily basis.**

Nursing Homes Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)

Inspection Findings:

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

- the Roper, Logan and Tierney assessment of activities of daily living
- Braden pressure risk assessment tool
- Nutritional risk assessment such as Malnutrition Universal Screening Tool (MUST)

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

- DHSSPS 'Promoting Good Nutrition' A Strategy for good nutritional care in adults in all care settings in Northern Ireland 2011-16

- The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes
- The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care
- The European Pressure Ulcer Advisory Panel (EPUAP)
- RCN/NMC guidance for practitioners.

Discussion with the registered manager and registered nurses confirmed that they were aware of these guidelines. Review of patients' care records evidenced that registered nurses implemented and applied this knowledge.

Discussion with the registered manager, registered nurses and review of governance documents evidenced that the quality of pressure ulcer/wound management was audited each time dressings were changed and discussed at each handover report. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

Registered nursing staff were found to be knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Staff should be trained in the Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes (2014). A requirement is made in regard to this training.

Ten staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held in the kitchen for easy access by staff**.**

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

Section E

Standard 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.**

Standard 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.**

Standard 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.

Inspection Findings:

A policy and procedure relating to nursing records management was available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

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

A review of the training records revealed that staff training on the importance of record keeping commensurate with their roles and responsibilities in the home should be addressed and a requirement is made in regard to this training.

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

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

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

The inspector reviewed a record of the meals provided for patients.

The inspector reviewed the care records of four patients identified of being at risk of inadequate or excessive food and fluid intake. This review confirmed that:

- daily records of food and fluid intake were being maintained
- the nurse in charge had discussed with the patient/representative their dietary needs
- where necessary a referral had been made to the relevant specialist healthcare professional
- a record was made of any discussion and action taken by the registered nurse
- care plans had been devised to manage the patients' nutritional needs and were reviewed on a monthly or more often basis.

Review of a sample of fluid balance charts for three patients revealed there was evidence that these patients were offered fluids on a regular basis. The patients' recommended daily recommended daily fluid intakes were recorded in their care plans on eating and drinking. The action to take if targets were not being achieved was also recorded. These charts were totalled for the 24 hour period and these totals were recorded in the evaluations of care and treatment provided to patients.

Staff spoken with were evidenced to be knowledgeable regarding patients' nutritional needs.

Staff as appropriate require their knowledge and skills in the management of nutrition updated. The registered manager informed the inspector that staff training in the use of the MUST was planned for 18 July 2014.

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

Section F

Standard 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.**
Inspection Findings:
Please refer to criterion examined in Section E. In addition the review of four patients' care records evidenced that consultation with the patient and/or their representative had taken place in relation to the planning of the patients' care. This is in-keeping with the DHSSPS Minimum Standards and the Human Rights Act 1998.

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

Section G

Standard 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**

Standard 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.**

Inspection Findings:

Prior to the inspection a patients' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that patients with one exception had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014. The care review which was overdue has now been undertaken.
The information provided in this questionnaire also revealed that copies of the minutes/review reports of care reviews for 16 patients were not received by the registered manager from the referring HSC Trust within six weeks of the reviews.

The registered manager informed the inspector that patients' care reviews were held post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff, preferably the patient's named nurse, attends each care review. A copy of the minutes of the most recent care review was held in the patient's care record file.

The inspector viewed the minutes of three care management care reviews which evidenced that, where appropriate, patients and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended, an updated assessment of the patients' needs and a record of issues discussed. Care plans were evidenced to be updated post care review to reflect recommendations made where applicable.

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

Section H

Standard 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.

Standard 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.

Inspection Findings:

A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance.

There was a four weekly menu planner in place. The registered manager informed the inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home. The current menu planner was implemented on 04 May 2014.

The inspector discussed with the registered manager and a number of staff the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients.

Staff spoken with were knowledgeable regarding the individual dietary needs of patients to include their likes and dislikes. Discussion with a number of patients, staff and review of the record of food provided for patients revealed that there was no evidence available to confirm that patients were offered choice in advance of their meals and a requirement is made that the registered person shall provide choice for patients and that the menu is varied at suitable intervals. Records should be held of these choices. Review of the four weekly menu planner revealed that this planner should be reviewed and updated in consultation with the patients and their representatives to address a variety of choices for the morning, afternoon and suppertime snacks. There is currently one choice recorded for each of these snacks. There was one choice recorded for the lunch meal on Sundays and this should be addressed. There were no records in place to confirm the choices recorded on the menu planner for the patients on therapeutic diets were provided to these patients. The choices provided on the menu planner for patients on therapeutic diets should be varied as the choices provided for the evening meals were similar in a number of instances to the lunch meal.

Staff spoken with were knowledgeable regarding the indicators for onward referrals to the relevant professionals. eg. speech and language therapist and/or dieticians.

As previously stated under Sections B review of one patient's care records evidenced that the patient was referred for a dietetic assessment in a timely manner and the patient's care plan on eating and drinking had been reviewed and updated to address this professional's recommendations.

As previously stated under Section D relevant guidance documents were in place.

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

Section I

Standard 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.**

Standard 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.**

Standard 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.**

Standard 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.**

Inspection Findings:

The inspector discussed the needs of the patients with the registered manager. It was determined that a number of patients had swallowing difficulties.

Review of training records revealed that eight staff had attended training in dysphagia awareness in May 2014. A requirement is made that staff as appropriate be trained in this area. Staff also require to be trained in the preparation and presentation of pureed meals and the fortification of foods. Staff training in first aid was on-going in the home.

Review of one patient's care records evidenced that the care plan on eating and drinking reflected the speech and language therapist's recommendations.

Discussion with registered manager confirmed that meals were served at appropriate intervals throughout the day and in-keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.

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

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Ten staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held in the kitchen for easy access by staff.

On the day of the inspection, the inspector observed the lunch meal in the dining rooms in the home. Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely manner.

Staff were observed preparing and seating the patients for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients with their meal and patients were offered a choice of fluids. The tables were well presented with condiments appropriate for the meal served. However it was noted that the potatoes were mashed and not pureed for the patients on pureed diets. Taking into account the risks associated with this practice a requirement is made that that food and fluids are properly prepared, wholesome and nutritious and meets the patients' nutritional requirements and are suitable for the needs of the patients.

A tissue viability link nurse was employed in the home.

Discussion with the registered nurses clearly evidenced their knowledge in the assessment, management and treatment of wounds. Review of the template used to undertake competency and capability assessments for the registered nurses revealed that pressure ulcer/wound care was addressed. Review of 13 competency and capability assessments for registered nurses revealed that these had been reviewed within the previous 12 months.

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

11.0 Additional Areas Examined

11.1 Records required to be held in the nursing home

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

11.2 Patients under Guardianship

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) DHSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspector discussed the Human Rights Act and Human Rights Legislation with the registered manager and one of the registered nurses. The inspector can confirm that copies of these documents were available in the home. The registered manager and registered nurse displayed an awareness of the details outlined in these documents. The registered manager informed the inspector that these documents will be discussed with staff during staff meetings and that staff will be made aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patients' care and accompanying records. The inspector also discussed the Deprivation of Liberty Safeguards with the registered manager and registered nurse including the recording of best interest decisions on behalf of patients. A copy of DOLS was also 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 for approximately 30 minutes each. The inspector observed the lunch meal being served in the dining rooms in the home. The inspector observed care practices in the sitting rooms following the lunch meal. The inspector also observed care practices during a tour of the premises. The observation tool used to record this observation was the Quality of Interaction Schedule (QUIS). This tool 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 Two.

Observation of the lunch meal confirmed that meals were served promptly and assistance required by patients and residents was delivered in a timely manner.

Staff were observed preparing and seating the patients for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients with their meal and patients were offered a choice of fluids.

Observation of care practices in the sitting rooms following the lunch meal revealed that staff initiated conversation with patients and listened to their views and was respectful in their interactions with them.

Observation of care practices during a tour of the premises revealed staff treated the patients with dignity and respect. Overall the periods of observation were positive in regard to the care of patients in the home.

11.5 Complaints

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being pro-actively managed. The inspector reviewed the complaints records during the inspection. This review revealed that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought. The registered manager informed the inspector that lessons learnt from investigations were acted upon.

11.6 Patient Finance Questionnaire

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

11.7 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. This was also evidenced by the inspector on the day of inspection.

11.8 Staffing/Staff Comments

Discussion with the registered manager and a number of staff and review of a sample of staff duty rosters evidenced that the registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients currently in the home. The ancillary staffing levels were found to be satisfactory. There was no activity therapist employed in the home and a recommendation is made that an activity therapist be appointed to take the lead in the provision of age appropriate, failure free and meaningful activities for the patients.

Staff were provided with a variety of relevant training including the management of enteral feeding systems, care planning and mandatory training since the previous inspection.

During the inspection the inspector spoke to19 staff. The inspector was able to speak to a number of these staff individually and in private. Nine staff completed questionnaires. The following are examples of staff comments during the inspection and in questionnaires:

"I am very happy with the care the patients receive"
"The quality of care in the home is very good and staff treat the patients very well"
"Very satisfied with the high standard of care all patients receive. Great support from management and lovely atmosphere within the home"
"Patients very well cared for except they need more stimulation" (This comment was made by a number of staff)
"Copperfields is a great place to work staff and management are friendly and helpful"
"The patients are treated with the utmost dignity and respect, the care is excellent, care staff are hardworking and promote quality care"
"Very, very happy in my 25 years working in the home"
"I am very happy with the standard of care provided to the patients".

Additional comments made by staff were brought to the attention of the registered provider and registered manager.

11.9 Patients' Comments

During the inspection the inspector spoke to eight patients individually and to a number in groups. Four patients completed questionnaires. The following are examples of patients' comments during the inspection and in questionnaires:

"This is a very good home I am happy"
"Staff treat me and my belongings with respect"
"My visitors are always made welcome"
"I feel safe in this home"
Staff can make me a snack and a cup of tea at any time"
"We enjoy the food but we are not offered choice before our meals"
Staff always respect my privacy and they always knock my door before entering"
"I am very happy. I love being here. Would like more activities provided in the home".

11.10 Relatives' Comments

During the inspection four relatives visited the home. Three of these relatives completed questionnaires. The following are examples of relatives' comments during the inspection and in questionnaires:

"I am very happy with the standard of care provided to my relative"
"I am very happy with the care that my brother receives in this home"
"Staff make me feel welcome when I visit"
"The staff are very nice. They are very welcoming and often give us a cup of tea and something nice"
"I am very happy with my mother's care in every way, management and staff are excellent and friendly, a very pleasant home".

"Staff include me in discussions about my relative's care".

11.12 Environment

During the inspection the inspector undertook a tour of the premises and viewed the majority of the patients' bedrooms, sitting areas, dining rooms, laundry, bath/shower and toilet facilities. The home was found to be warm and clean. The improvements in the environment standards since the previous inspection are acknowledged. These improvements included the following:

- The replacement of the floor surface on the main corridor in the upstairs part of the home
- The replacement of the carpet on the main corridor in the upstairs part of the home
- The replacement of the carpet in one bedroom
- The refurbishment of a number of armchairs
- The replacement of a number of curtains throughout the home
- The replacement of a number of blankets with suitable duvets and duvet covers.

The registered provider informed the inspector that the following will be addressed on a phased basis:

- The replacement of carpets in a number of bedrooms
- The replacement of blankets with suitable duvets and duvet covers
- The provision of additional profiling beds
- The refurbishment of the armchairs throughout the home
- The replacement of a number of curtains throughout the home.

12.0 QUALITY IMPROVEMENT PLAN

The details of the Quality Improvement Plan appended to this report were discussed with Mr Edwards, Registered Provider and Mrs McKeown, Registered Manager during the inspection feedback.

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:

Teresa Ryan
The Regulation and Quality Improvement Authority
Hilltop
Tyrone and Fermanagh Hospital
Omagh
Co Tyrone
BT70 0NS

APPENDIX ONE

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**
5.1 When a Resident is admitted to the home a Nurse carries out and records an initial risk assessment,using validated assessment tools and draws up an agreed plan of care to meet the Residents immediate care needs, Information received from care managment team informs this assessment. 5.2 A comprehensive,holistic assessment of the Residents care needs is drawn up using validated assessment tools and completed within 11 days of admission	Compliant

8.1 Nutritional screening is carried out on all Residents using MUST tool,on admission . 11.1 During the pre -admission assessment the nurse will determine from the Resident or their family if there is any risk of pressure ulcers. Hospital / care management records should indicate whether or not the Resident suffers or is likely to suffer from pressure ulcers. All Residents on admission have a Braden,Nutrition,pain,continence assessments completed .	

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**
5.3 Each Resident has a named Nurse who has the responsibility of planning and discussing nursing interventions with the Nurse Manager, various health professionals ,the Resident where applicable and family representatives which meets their assessed needsand is documented in their care plan A holistic approach is under taken with the focus of maintaining and promoting the Residents independance.	Compliant

11.2 Referral arrangements are in place with the relevant health professionals who can and will give surport and advice should it be required . 11.3 When a Resident is assessed as "at risk" of developing pressure ulcers , advice sought from the revelant professionals, will be implemented to include a prevention / treatment programme to meet their individual needs and comfort. 11.8 Referral arrangements are in place to relevant health professionals who should have the required knowledge and expertise to diagnose, treat and care for the Resident who have lower limb or foot ulceration . 8.3 Referral arrangments are in place to the dietician to assess the Residents nutritional requirements ,and draw up a treatment plan which will take into account recommendations from other health professionals.	

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**
5.4 Re-assessments of the Residents care is ongoing through daily evaluations, and at hand over reports 3 times daily. Residents care plans are updated at least monthly or more often if required .	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**
5.5 Validated assessments tools such as the Roper,Logan and Tierney assessment of the twelve activities of daily living and Braden pressure risk assessments ,Nutritional risk assessment,and N.I.C.E guidelines for wound management are used. Other guide lines used include:- D.H.S.S R.C.N N.M.C Nursing home regulations and minimun standards 11.4 Residents who have skin damage are assessed using Braden scale and NICE wound care guidelines.Nurses grade pressure ulcers in accordance with European Pressure Ulcer Advisory panel, and NICE/RCN guidelines. A treatment plan is implemented . 8.4 Nutritionl guidlines 2014 are in place for staff to use / refer to.	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**
5.6 Contemporaneous nursing records , in accordance with NMC guidelines are kept on all nursing interventions,activities and procedures ,Outomes are recorded and actioned in relation to each Resident. 12.11 Records are in place of meals provided so as to enable any person suitabley qualified to judge whether the diet for each Resident is satisfactory. 12.12 A record of all food and drinks consumed is maintained for those Residents that are unable or choose not to eat a meal, and of those Residents who eat excessively, Where necessary a referral is made to the relevant professionals.	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**
5.7 Evaluations of each Resident are maintained 3 times daily ,care plans are reviewed at least monthly or more often if required . An Annual review includes Resident and Family involvment in the planning ,discussing and agreement of care delivered.	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**
5.8 Residents are encouraged and facilitated to participare in all aspects of reviewing outcomes of care and attend or contribuate to ,formal multidisciplinary review meetings arranged by local HSC Trusts. 5.9 Results of review meetings are recorded and if required changes made to the nursing care plan with the agreement of the Resident and their representatives.	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**
12.1 Residents are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferrances .full account is taken of relevant guidance documents,or guidance provided by dieticans and other professionals . 12.3 A choice of meal is offered to all Residents at meal times, alternative meals are provided if required ,A choice is offered to those on therapeutic or specific diets .	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**
8.6 Nurses have up to date knowledge and skills in managing feeding techniques for Residents who have swallowing difficulties ,and in ensuring that instructions drawn up by SALT are adhered to. 12.5, Meals are provided at conventional times ,hot and cold drinks and snacks are available at customary times and fresh drinking water is available at all times . 12.10 Staff are aware of matters concerning Residents eating and drinking , there adequate numbers of staff present at meal times so as to ensure :-	Compliant

risks when Residents are eating and drinking are managed required assistance is provided necessary aids and equipment are available for use All staff have annual first aid training . 11.7 A selection of nurses have received training in wound care	

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

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Primary Announced Inspection

Copperfields

10 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 Mr William Henry Hume Edwards, Registered Provider and Mrs Cherith McKeown during the inspection feedback.

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)	Staff as appropriate are required to be trained in the following areas: • Management of nutrition • Fortification of foods • Preparation and presentation of pureed meals • Dysphagia awareness • Nutritional Guidelines and Menu Checklist For Residential and Nursing Homes (2014) • Wound management • Record keeping Ref. Section B, D,E and I	One	On the day of the inspection 20% of staff had been trained in Dysphagia awareness which included the :- Management of nutrition,Fortification of foods,preparation and presentation of pureed meals.Training for the remainder of the staff has been arranged for the 9th October 2014 . The Nurse Manager has attended a Tissue viability seminar delivered by RCN This has enabled her to train staff . NINE staff members had been trained by outside bodies prior to the inspection and the nurse manager had completed training the remainder of the staff, this was recorded in the staff supervision record and unfortunely was omitted from their training record .	One month

2	12 (4) (b)(c)(d (e)	The registered person shall ensure that food and fluids- are properly prepared, wholesome and nutritious and meets patients nutritional requirements; are suitable for the needs of the patients; provide choice for patients; and that the menu is varied at suitable intervals. Ref. Section H	One	As the inspector is fully aware food and fluids are properly prepared ,wholesome and nutritious. Unfortunately, on the day of the inspection potatoes were mashed rather than pureed for the two Residents currently on pureed diet. This had never happened before. Speach and language therapist has been assessing one of the Residents on pureed diet from January 2014 and is and has been satisifed with the consistuency of the meals prepared . The cook was made aware of this oversight during the inspection . The menu planner is in the process of being updated, in consultation with the Residents and their representatives to address a variety of choices for all meals and all diets .The nutritional guidelines and menu check list for Residential and Nursing homes 2014 document is been used in this process .	One week

3	14 (2)(c)	The registered person shall ensure as far as reasonably practicable that unnecessary risk to the health or safety of patients are identified and so far as possible eliminated. Ref. Section I	One	As far as reasonably practicable, and "without inpeeding", and "always mindful to promote our Residents independence" unnecessary risks to the health and safety of our Residents has always been ,and will continue to be paramount, and will be identified and eliminated as and when the need arises .	One week

These recommendations are based on the Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.					
No.	**Minimum Standard Reference**	**Recommendations**	**Number Of Times Stated**	**Details Of Action Taken By Registered Person(S)**	**Timescale**
1	11.3	It is recommended that the template used for the repositioning chart be reviewed to address inspection of the patient's skin condition at each positional change. Ref. Section B	One	Repositioning charts have been reviewed so as to record the Residents skin condition at each positional change, Staff have been advised to ensure that this is recorded as a matter of good practice so as to enhance the service and quality of care that is already being delivered to our Residents by our team of dedicated staff .	One week
2	30.1	It is recommended that an activity therapist be appointed in the home to take the lead in the provision of age appropriate, failure free and meaningful activities for the patients. Ref. Section 11, point 11.8 (additional areas examined)	One	Employing an activities therapist would not be feasible at this moment in time but the inspectors recommendation may be given consideration at some stage in the future Staff will continue to provide meaningfull activites to those Residents who wish to engage in them	Two months

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	Cherith McKeown
Name of Responsible Person / Identified Responsible Person Approving Qip	Mr H Edwards

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes		6/8/14
Further information requested from provider			