Secondary Unannounced Care Inspection

Name of Establishment:	**Mahon Hall**
Establishment ID No:	**1489**
Date of Inspection:	**20 January 2015**
Inspector's Name:	**Norma Munn**
Inspection ID	**IN017217**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1.0 General Information

Name of Home:	Mahon Hall
Address:	16 Mahon Road Portadown Craigavon BT62 3EF
Telephone Number:	02838350981
Email Address:	mahon.hall@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Health Care Dr Maureen Claire Royston (registration pending)
Registered Manager:	Ms Cheryl King, Acting Manager
Person in Charge of the Home at the Time of Inspection:	Ms Cheryl King
Categories of Care:	NH-I, RC-DE, RC-I, RC-PH, RC-PH(E), NH-PH
Number of Registered Places:	60
Number of Patients Accommodated on Day of Inspection:	56
Scale of Charges (per week):	£ 461 - £581
Date and Type of Previous Inspection:	27 March 2014 Primary Unannounced Inspection
Date and Time of Inspection:	20 January 2015 10:30 – 16:30 hours
Name of Inspector:	Norma Munn

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)
- Other published standards which guide best practice may also be referenced during the Inspection process

4.0 Methods/Process

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

- Discussion with the regional manager
- discussion with the home manager
- discussion with staff
- discussion with patients/residents individually and to others in groups
- consultation with relatives
- review of a sample of care plans
- observation during a tour of the premises
- evaluation and feedback.

5.0 Consultation Process

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

Patients/Residents	26 patients individually and with the majority generally
Staff	16
Relatives	2
Visiting Professionals	0

Questionnaires were provided by the inspector, during the inspection staff to seek their views regarding the quality of the service.

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**5**	**5**
Relatives/Representatives	**0**	**0**
Staff	**6**	**6**

6.0 Inspection Focus

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

However, due to workload pressures and contingency measures within the Regulation Directorate, the themes/standards within the self-assessment were not inspected on this occasion.

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

Standard 19 - Continence Management

Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

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

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

7.0 Profile of Service

Mahon Hall Care Home is registered to care for up to 60 patients and residents. The home is situated on the Mahon Road, a short distance from the centre of Portadown.

The nursing home is owned and operated by Four Seasons Health Care Ltd
The current acting manager is Ms Cheryl King.

The facility is comprised of forty–two single and nine double bedrooms, sitting rooms, two dining rooms, a kitchen, laundry and toilet/washing facilities, staff accommodation and offices over two floors.

The general unit of the home provides nursing and residential care. In addition a designated fourteen bed residential unit is available on the first floor of the home for residents assessed with dementia.

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

Nursing Care

I	Old age not falling into any other category

Residential Care

I	Old age not falling into any other category
DE	Dementia
PH	Physical disability other than sensory impairment
PH(E)	Physical disability other than sensory impairment - over 65 years

For the purpose of this report those living in Mahon Hall are referred to as patients though some of these will be in receipt of residential care.

8.0 Executive Summary

This unannounced inspection of Mahon Hall was undertaken by inspector Norma Munn on 20 January 2015 between 10 30 and 16 30 hours. The inspection was facilitated by Ms Cheryl King, acting manager who was available throughout the inspection. Verbal feedback was given to Ms Cheryl King and Ms Heather Murray, regional manager at the conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection of 27 March 2014.

As a result of the previous inspection three requirements and five recommendations were made. These were reviewed during this inspection and it was evidenced that three requirements and four recommendations have been fully complied with. One recommendation has not been complied with and has been stated for a second time. Details can be viewed in the section immediately following this summary.

Assessments and care plans were reviewed with regard to management of continence in the home. Review of care records evidenced that bladder assessments had been completed however, bowel assessments had not been fully completed for all patients. A recommendation has been made.

Not all patients and/or their representatives had been involved in discussions regarding the ageeing and planning of nursing interventions. A recommendation has been made.

Nursing staff spoken with on the day of the inspection were knowledgeable regarding the management of continence care, urinary catheters and the frequency with which the catheters within the home required to be changed.

From a review of the available evidence, discussion with relevant staff and observation, it was evidenced that the level of compliance with the standard inspected is substantially compliant.

Additional Areas Examined

Care Practices
Staffing
Patients/Residents and Relatives Comments
Questionnaire Findings/Staff Comments
Environment

Details regarding the inspection findings for these areas are available in the main body of the report. Areas for improvement regarding staffing levels, care practices and the environment have been identified.

Conclusion

At the time of this inspection, the delivery of care to patients was evidenced to be of a good standard and patients were observed to be treated by staff with dignity and respect. Good relationships were evident between staff and patients. Patients were well groomed, appropriately dressed and appeared comfortable in their surroundings.

As a result of this inspection five recommendations have been made and one recommendation made during the previous inspection has been stated for a second time.

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

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9.0 Follow-Up on Previous Issues from Care Inspection 27 March 2014

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	Regulation 19(1)(a), schedule 3, 2(k)	The registered person shall maintain contemporaneous notes of all nursing provided to the patient. Records must be maintained to evidence that all prescribed nursing care is being delivered.	Review of patients' care records evidenced that prescribed care delivered had been recorded in the progress notes.	**Compliant**
2	Regulation 13(1)(b)	The registered person must ensure that the nursing home is conducted so as to make proper provision for the nursing and where appropriate, treatment and supervisions of patients. The registered manager must ensure that prescribed dressing regimes are adhered to.	Discussion with staff and a review of two patients' care records who required wound management evidenced that prescribed dressing regimes were being adhered to.	**Compliant**
3	Regulation 25(b)	Staff must be supported to meet and maintain the standards and requirements of their relevant codes of practice. Records must be maintained in keeping with the NMC guidance for record keeping. All entries must be legible.	Review of patients' care records evidenced that entries examined were legible.	**Compliant**

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	20.2	It is recommended that the frequency of checks is reviewed and increased to daily in keeping with the DHSSPS Nursing Homes Minimum Standards. Records must be maintained of the checks.	Discussion with staff and a review of the emergency equipment check list evidenced that recording of emergency equipment has been completed on a daily basis.	**Compliant**
2	16.2	It is recommended that all induction programmes are reviewed, and where required developed, to ensure that an awareness of the procedures for protecting vulnerable adults are included in the induction programme for all staff.	Discussion with the staff and a review of a sample of staff induction records evidenced that the procedure for safeguarding vulnerable adults is included during induction.	**Compliant**
3	5.1	It is recommended that all patients have a Baseline pain assessment completed and an on-going pain assessment where indicated.	Review of patients' care records evidenced that pain assessments had been completed where required.	**Compliant**

4	5.3	Repositioning charts should contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each positioning	Review of three patients' repositioning charts did not evidence that a skin inspection had taken place each time the patients were repositioned. This recommendation has been stated for a second time.	**Not compliant**
5	5.3	It is recommended that: • the frequency with which wounds require to be dressed is included in the care plan • an assessment of the wound is recorded following each dressing change	Discussion with staff and a review of two patients' care records who required wound management evidenced that the frequency of dressing change had been recorded in the care plan and the assessment of the wounds had been recorded in the ongoing wound chart following each dressing change.	**Compliant**

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

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if there is considered to be a breach of regulation as stated in the Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

There have been no notifications to RQIA regarding safeguarding of vulnerable adults (SOVA) incidents since the previous inspection.

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10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of six patients' care records evidenced that bladder continence assessments were undertaken as part of the assessment process within the home. However, two out of six care records reviewed did not contain completed bowel assessments. A recommendation has been made to ensure that bowel assessments are completed for all patients. The outcome of these assessments, including the type of incontinence product to be used, was incorporated into the patients' care plans on continence care. The care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Review of care plans evidenced that not all patients and/or their representatives had been involved in discussions regarding the ageeing and planning of nursing interventions. A recommendation has been made. Care plans reviewed adressed the patients' assessed needs in regard to continence management. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home on the day of the inspection. However, staff informed the inspector that occasionally there is insufficient stock of incontinence pads and gloves. This was discussed with the acting manager who gave assurances that the ordering and supply of incontinence products has been reviewed to ensure there is an adequate supply at all times.	Substantially Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The following policies and procedures were in place; • continence management/incontinence management • stoma care • catheter care There was evidence that the correct equipment was in place regarding the management of patients' with an indwelling catheter and stoma appliance. The following guidance documents were in place; • RCN continence care guidelines • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not assessed.	Not assessed
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the acting manager confirmed that staff were assessed as competent in continence care. The acting manager confirmed that further continence training had been booked to take place in January 2015. Discussion with the staff revealed that several registered nurses in the home were deemed competent in female catheterisation and the management of stoma appliances. One registered nurse was deemed competent in male catheterisation and training had been arranged from the Trust for registered nurses to attend further training in male catheterisation. Regular audits of the management of incontinence are undertaken and the findings acted upon to enhance already good standards of care.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

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

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

The serving of the lunch time meal in the first floor nursing unit was observed. The tables were well set with napkins, cutlery, crockery and condiments. Patients were being served in a timely manner. However, there was no menu displayed and several patients were not aware of the choices of food being offered. A recommendation has been made.

During lunch a patient was observed seated in a specialised chair on an airwave cushion. Discussion with staff indicated that the patient required a specialised cushion for pressure relief. However, the cushion had not been plugged in and had deflated. This was immediately brought to the attention of staff and the cushion was inflated to ensure the patient was receiving adequate pressure relief.

11.2 Staffing

On the day of the inspection several staff raised concerns regarding staffing levels in the nursing units. Discussion with the acting manager confirmed that there had been a deficit in care staff numbers between 14:00 and 16:00 hours. Review of the staff duty rota weeks commencing 5 January 2015 and 12 January 2015 identified that on several occasions the numbers of staff on duty were below the RQIA's recommended minimum staffing guidelines. The acting manager gave assurances that staffing levels were under review and future planned duty rotas would reflect an increase in staffing levels. The inspector requested a copy of planned duty rotas to be forwarded to RQIA for review following the inspection.

A recommendation has been made that staffing levels are kept under review to ensure that at all times there are sufficient numbers of staff and skill mix deployed to meet the needs of the patients in the home.

11.3 Patients/Residents Comments

Twenty six patients were spoken with individually and the majority of others in smaller groups. Five patients completed questionnaires. Patients spoken with and the questionnaire responses confirmed that patients were treated with dignity and respect, that staff were polite and respectful, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home. Several patients were nursed in bed. One revealed that they had no means of calling for assistance if needed. The patient requested that they had the use of a nurse call bell. This was discussed with the acting manager who agreed to address the issue. .

Examples of patients' comments were as follows:

"I am very well looked after"
"I am happy and they are very good to me"
"This is a first class home"
"The food is good here"

11.4 Questionnaire Findings/Staff Comments

Sixteen staff including registered nurses, care staff and ancillary staff were spoken with. Six staff completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

Three members of staff raised issues in relation to staffing levels. These issues were discussed with the acting manager and as discussed in section 11.2 a recommendation has been made.

11.5 Environment

A tour of the premises was undertaken which included the majority of patients 'bedrooms, bathrooms, shower and toilet facilities and communal areas. The majority of bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling and appropriately heated throughout.

The inspection the hairdresser was observed setting up her equipment and attending to patients in the bathroom of the nursing unit. Discussion with the hairdresser revealed that there was no suitable area in the home to provide hairdressing and patients were being attended to by the hairdresser in close proximity to the toilet. This is not in keeping with good infection, prevention and control practices and a recommendation has been made.

The storage of personal toiletries, items and equipment was observed in a shower room in the dementia unit. This was discussed with the acting manager who agreed to address this issue.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Cheryl King, acting manager and Ms Heather Murray, regional manager at the conclusion of the inspection 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:

Norma Munn
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5 Lanyon Place
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BT1 3BT

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Prior to admission, the Home Manager or a designated representative from the Home undertakes a pre-admission assessment. Information gathered from the resident/representative, the care records and information from the multi-disciplinary team informs the assessment. Following a review of all information a decision is made in regard to the Home's ability to meet the resident's needs. If the admission is an emergency and a pre-admission is not possible, an assessment is completed over the telephone with written comprehensive, multi-disciplinary information being faxed to or left at the Home. When the manager is fully satisfied an admission is granted. On admission , the nurse completes initial assessments using a person centred approach. Using effective communication the nurse communicates and involves family as well as referring to information within the assessment	Substantially compliant

and from the care management team. Within twelve hours of admission, two documents are completed - an Admission Assessment which includes photograph consent, record of personal effects, a record of My Preferences and a Needs Assessment.. In addition the nurse completes a number of risk assessments. 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. Other assessmenst completed within seven days are a continence and bowel assessment. Following discussion with the resident and /or their representative, a plan of care is developed to meet the holistic needs of the resident.	

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

independence as well as providing any assistance that is required. Information gleaned from other members of the multi-disciplinary team may be included in the care plan. Registered nurses are fully aware of the process of referral to a TVN when necessary. Further guidance for staff is contained within the senior cover file. When a resident is assessed as being at risk of developing pressure ulcers, a management/ treatment plan is commenced. A care plan is devised to include skin care, frequency of repositioning, mattress type and setting. The care plan may also include advice from members of the multi-disciplinary team (MD).The plan of care is agreed with the resident/relative. The regional manager is updated via a monthly report and during the REG 29 visit. The registered nurse decides to refer a resident to the dietician based on the MUST score and their clinical judgment. All advice, treatment or recommendations are recorded on the MD form and a care plan devised or updated to refelct the advice or recommendations. Residents, representatives, staff and other members of the MD team are kept updated of any changes.	

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The needs assessment, risk assessments and care plans are reviewed at least monthly or more often if there is a change in the identified needs of residents.The resident is assessed on an ongoing daily basis with any changes noted in the daily notes and care plan evaluation forms. Any changes are recorded on a 24 hour shift report for the attention of the manager. The manager and regional manager complete audits of care notes to ensure this process is undertaken to a high standard. Action plans are formed to address any deficits.	Substantially compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The Home refers to up to date guidelines, defined by professional bodies and national standards eg NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA. These are available to staff. The validated pressure ulcer screening tool used to screen residents who have damage to their skin is the EPUAP. If a pressure ulcer is present on admission or developes during admission, an initial wound assessment is completed along with a plan of care which includes the grade of pressure ulcer, dressing regime, cleaning regime of wound, freuency of re-positioning, pressure relieving equipment used and time scales for review. An ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime or if the condition of the pressure ulcer changes There are up to date nutritional guidelines within the Home for staff to refer to . FSHC policies and procedures in relation to nutritional care, diabetic care and care of percutaneous endoscopic gastrostomy (PEG) are aslo available..	Provider to complete

Section E

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

Criterion 5.6

- **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.**

Criterion 12.11

- **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.**

Criterion 12.12

- **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.**
  Where a patient is eating excessively, a similar record is kept.
  All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing records are kept of all nursing interventions, activities and procedures that are undertaken in relation to each resident. These records are maintained in accordance with the NMC guidleines. All care delivered include an evaluation and outcome. Nurses have access to policies and procedures in relation to record keeping. 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 includes any specialist dietary needs. 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 the FSHC food / fluid record booklet. These are recorded over a 24 hour period with the fluid intake totalled at the need of the 24 hours. The nurse uses this information in their daily evaluation. Any issues of concern are identified and referred to the appropriate member of the MD team for advice. Any subsequent changes to care plans are discussed with the resident/ representative.	Substantially compliant

Audits of documentation are undertaken by management and any deficits are raised with staff.	
Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care provision is monitored and recorded on a daily basis in the daily progress notes with at least one entry during the day and night. When there is a change in the identified needs of residents, the plan of care is amended with the involvement of the resident and/or their representative to ensure a realistic outcome can be achieved.	Substantially compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care management reviews are generally held 6-8 weeks following admission and then annually thereafter. These however can often be delayed by the Trust despite frequent reminders. Reviews can also be arranged in response to changing needs, expressions of disatisfaction with our service provision or at the request of the resident and/or their representative. The Trust are responsible for organising these reviews. Copies of the minutes are forwarded to the Home for the resident and/or their representative. A copy is retained in the residents file. Any recommendations made are actioned and care plans are reviewed as necessary.	Moving towards complian

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The Home follows FSHC policy and procedures in relation to nutrition and best practice guidelines eg NICE. The residents dietary needs are fully assessed on admission and are reviewed as necessary.The care plan reflects the type of diet, any special requirements, personal preferences, any specialised eating equipment, level of assistance required, if any and any recommendations made by the dietician or speech and language therapist. The care plan is evaluated monthly or when there is a change in need. The Home has a 4 week menu plan that is reviewed 6 monthly taking into account seasonal foods. Feedback from residents and/or their representatives is used to correlate the menu. Written guidance is also available to refer to eg " Nutritional guidelines and menu checklist" PHA 2014.This assists us in ensuring the menu is nutritious and varied. Recommendations relayed by the dietician and the SALT are made available to the kitchen staff, along with the diet notification form which informs them of each residents specific dietary needs. Residents are offered a choice at all meat times. If a resident does not wish to have what is offered, an alternative meal of their choice can be provided. As much as possible the menu offers the same choices to those on theurapeutic	Substantially compliant

or specialised diets.A variety of condiments, sauces and fluids are offered at each meal. Daily menus are on display in the dining room.	

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

Meals are provided at conventional times but there may be variations if a resident has requested to have their meals outside of these times. Hot and cold drinks and snacks are available at regular intervals throughout the day and evening and are also available at any other times on request. Cold drinks are available at all times in the lounges and bedrooms and are repenished at frequent intervals. All matters concerning a residents eating and drinking are detailed in each individual care plan. A diet notification form is completed for each resident and are sent to the kitchen. These are kept updated as necessary. Meals are served only when staff are present in the dining room. Residents who require assistance or supervision are given individual attention and are assisted at a pace suitable for the resident. Appropriate aids are available as necessary. Each nurse has completed a training e-learning module on pressure area care. The home has a link nurse who has received enhanced training to provide support and education to the other nurses within the Home. Wound competency assessments have been commenced.	

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	**COMPLIANCE LEVEL**
	Substantially compliant

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Secondary Unannounced Care Inspection

Mahon Hall

20 January 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with Ms Cheryl King, acting manager and Ms Heather Murray, regional 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.

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.3	Repositioning charts should contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning **Ref: Section 9.0**	Two	Staff have been advised of this and process now in place. This will be monitored by senior staff and management closely	Ongoing
2	19.1	The registered person should ensure that bowel assessments are completed for patients/residents who require continence management **Ref: Section 10.0 Standard 19.1**	One	Staff have been advised that a bowel assessment must be completed for all residents who require continence management. This has commenced and will be monitored by Home Manager.	By 17 February 2015
3	19.1	The registered person should ensure that care plans are developed in consultation with the patient/resident and/or their representative **Ref: Section 10.0 Standard 19.1**	One	Staff have been advised that all care plans are discussed and signed by the resident and/or next of kin. This will be monitored via audit.	By 17 February 2015
4	12.4	The registered person must ensure that a daily menu is displayed in a suitable format and in an appropriate location, so that patients/residents and their representatives know what is available at each mealtime **Ref: Section 11.1**	One	The correct daily menus are now displayed in all dining rooms. This has been checked daily by management.	By 17 February 2015

5	30	The registered person should ensure that staffing levels are kept under review to ensure that at all times there are sufficient numbers of staff and skill mix deployed to meet the needs of the patients/residents in the home **Ref: Section 11.2 and 11.4**	One	Staffing levels have been reviewed and are in keeping with guidelines.	By 17 February 2015
6	34.1	The registered person should review the provision of hairdressing for all patients to ensure that it is in keeping with good infection, prevention and control practice **Ref: Section 11.5**	One	A more more appropriate hairdressing facility is being pursued within the home.	By 17 February 2015

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	Cheryl King
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall MANAGING DIRECTOR 11/3/15.

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

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	X	Sharon McKnight	20-03-15
Further information requested from provider			