Announced Primary Inspection

Name of establishment:	**Rathowen**
Establishment ID No:	**1495**
Date of inspection:	**18 August 2014**
Inspector's name:	**Heather Moore**
Inspection No:	**16512**

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

1.0 General information

Name of home:	Rathowen Private Nursing Home
Address:	118 Portadown Road Tandragee Craigavon BT62 2LT
Telephone number:	028 3884 0226
E mail address:	rathowen@btinternet.com
Registered organisation/ Registered provider / Responsible individual	Mr Desmond Watt
Registered manager:	Position Vacant
Person in charge of the home at the time of inspection:	Miss Mandy Murphy, Nursing Sister
Categories of care:	NH-I ,RC-I
Number of registered places:	19
Number of patients / residents accommodated on day of inspection:	13 Patients 5 Residents
Scale of charges (per week):	£581.00 Nursing £461.00 Residential
Date and type of previous inspection:	02 April 2014 Secondary Unannounced
Date and time of inspection:	18 August 2014: 08.15 hours to 15.00 hours
Name of inspector:	Heather Moore

2.0 Introduction

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

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

3.0 Purpose of the inspection

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

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

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

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

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

4.0 Methods/process

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

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

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

- Review of notifiable events since the previous inspection
- Analysis of pre-inspection information
- Discussion with the registered provider
- Discussion with the nursing sister

- Observation of care delivery and care practices
- Discussion with staff
- Examination of records
- Consultation with patients/residents individually and with others in groups
- Tour of the premises
- Evaluation and feedback.

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

5.0 Consultation process

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

Patients/Residents	**6**
Staff	**8**
Relatives	**1**
Visiting Professionals	**-**

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

Issued To	**Number issued**	**Number returned**
Patients / Residents	**6**	**6**
Relatives / Representatives	**0**	**0**
Staff	**8**	**8**

6.0 Inspection focus

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

Criteria from the following standards are included;

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

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

The 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 person 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

Rathowen is a 19 bedded residence which provided accommodation and services on two floors. The home is situated in private grounds and is within easy access to Tandragee and a short distance from Portadown.

The nursing home is owned and operated by Mr Desmond Watt.

Currently the registered manager's position is vacant.

The bedroom accommodation comprises of eight single bedrooms, double bedrooms and one treble bedroom. Two dining/day rooms are situated on the ground floor. Bath/shower rooms and toilets are accessible to all communal and bedroom areas thought out the home.

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

Nursing Care (i) - old age not falling into any other category
Residential Care (i) - old age not falling into any other category.

The home is approached by a drive way with landscaped gardens at the front and ample car park facilities are at the front and back of the home.

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

8.0 Summary of inspection

This summary provides an overview of the services examined during an announced primary care inspection to Rathowen. The inspection was undertaken by Heather Moore on 18 August 2014 from 08.15 hours to 15.00 hours.

The inspector was welcomed into the home by Miss Mandy Murphy, Nursing Sister who was available throughout the inspection. Verbal feedback of the issues identified during the inspection were given to Mr Desmond Watt, Registered Provider and to the nursing sister at the conclusion of the inspection.

Prior to the inspection, the registered person completed a self-assessment using the criteria outlined in the standards inspected.

The comments provided by the registered person in the self-assessment were not altered in any way by RQIA. See Appendix one.

During the course of the inspection, the inspector met with six patients/residents, eight staff and one relative. The inspector observed care practices, examined a selection of records, issued patient, resident and staff questionnaires and carried out a general inspection of the nursing home environment as part of the inspection process.

The inspector also spent a number of extended periods observing staff and patient /resident interaction. Discussions and questionnaires are unlikely to capture the true

experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience.

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

As a result of the previous inspection conducted on 02 April 2014, four requirements and two recommendations were issued. These were reviewed during this inspection. The inspector evidenced that three requirements were addressed one requirement was not addressed and was therefore restated. Four recommendations had been complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

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

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

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

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

8.1 Inspection findings

8.1.1 Management of nursing care – Standard 5

The inspector can confirm that at the time of the inspection there was evidence to validate that patients/residents received safe and effective care in Rathowen.

The inspector examined three patients/residents care records.

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 need was evidenced to inform the care planning process.

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

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

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

8.1.2 Management of wounds and pressure ulcers – Standard 11 (selected criteria)

The inspector examined one patient's care record in regard to wound care intervention. 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.

There was evidence of appropriate assessment of the risk of development of pressure care plans for the management of risks of developing pressure ulcers and wound care were maintained to a professional standard. However inspection of the patient's care record revealed the absence of a care plan on:

Pain management, a requirement is made in this regard.
A pain assessment was in place.

A recommendation is made that patients/residents care plans are reviewed and updated to specify the pressure relieving equipment on the patients bed and also when sitting out of bed.

Inspection of a sample of registered nurses competency and capability assessments revealed that wound management was included and that registered nurses had received training in wound management.

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.

8.1.3 Management of nutritional needs and weight loss – Standard 8 and 12 (selected criteria)

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

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

The inspector also observed the serving of the lunch time meal and can confirm that patients were offered a choice of meal and that the meal service was well managed and supervised by registered nurses.

Patients were observed to be assisted with dignity and respect throughout the meal.

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

8.1.3 Management of dehydration – Standard 12 (selected criteria)

The inspector examined the management of dehydration during the inspection which evidenced that fluid requirements and intake details for patients were recorded and maintained for those patients assessed at risk of dehydration.

Examination of a sample of patients fluid balance charts confirmed that these charts were maintained appropriately.

Patients were observed to be able to access fluids with ease throughout the inspection. Staff were observed offering patients additional fluids throughout the inspection. Fresh drinking water/various cordials were available to patients in lounges, dining rooms and bedrooms.

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

8.2 Patient/resident questionnaires

Some comments received from patients/ residents and their representatives:

- “My visitors are always made welcome.”
- “I have always have access to my buzzer.”
- “I am just happy enough here.”
- “I think this is an excellent home.”

The inspector spoke to one relative.

Some comments received from the relative.

- “This is a great home I cannot speak highly enough of the standard of care here.”

Staff questionnaires

Examples of comments received from staff:

- “A high standard of care is provided in Rathowen, I enjoy working here, each resident is a pleasure to work with and all residents receive patient centred care.”
- “I feel that it is important to give residents choice and independence, showing care and respect towards residents is very important to me.”
- “Yes I have had training in wound management.”
- “Care provided here is based on individuals needs and wishes.”
- “Care provided here is based on residents individual needs and wishes.”
- “We work well as a team but sometimes we could do with more staff.”
- “The standard of care here is high in Rathowen.”
- “Residents are all treated with dignity and respect in a homely atmosphere.”
- “Patients are always treated with privacy.”

8.3 A number of additional areas were also examined.

- Records required to be held in the nursing home
- Guardianship
- Patient and staff quality of interactions (QUIS)
- Complaints
- Accidents/incidents
- Patient finance pre-inspection questionnaire
- NMC declaration
- Staffing and staff comments
- Comments from representatives/relatives
- Environment.

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

Conclusion

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

The home's general environment was well maintained and patients were observed to be treated with dignity and respect. However, areas for improvement were identified.

Two requirements, one restated requirement, and one recommendation are made. These requirements and the recommendation are detailed throughout the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients and residents the registered provider, nursing sister, and staff for their assistance and co-operation throughout the inspection process.

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

9.0 Follow-up on the requirements and recommendations issued as a result of the previous inspection on 21 January 2014

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	29 (4) (c)	The registered person shall carry out a monthly unannounced visit to the home and prepare a written report on the conduct of the home.	Inspection of a sample of Regulation 29 unannounced visits confirmed that a written report was available on the outcome of the visit.	**Compliant**
2	20 (3)	The registered person shall ensure that the registered manager carries out a competency and a capability assessment with any nurse who is given the responsibility of being in charge of the home for any period of time in her absence.	Inspection of three registered nurses staff personnel files confirmed that competency and capability assessments were available and were reviewed on an annual basis.	**Compliant**
3	19 (2) Schedule 4	The registered person shall ensure that staff duty rosters are signed by the registered manager to ensure that the hours allocated were actually worked.	Since the previous inspection the registered manager's position is vacant, in the interim period the nursing sister signs the duty rosters to ensure the hours allocated were actually worked.	**Not Applicable**
4	20 (1) (c) (i)	The registered person shall ensure that the	Examination of staff training records confirmed that the newly appointed Activity Therapist had not	**Moving Towards Compliance**

		newly appointed Activity Therapist is provided with training on Activities.	received training in Activities; however it is acknowledged that training is programmed for 01 October 2014. **Restated**	

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 registered person reviews the record of complaints, incidents and accident records ,staffing levels and records their opinion as to their opinion as to the standard of nursing provided in the home at the time of their visit.	Inspection of a sample of Regulation 29 reports confirmed that the registered person reviewed the record of complaints, incidents and accident records, staffing levels and recorded the opinion as to the standard of nursing provided in the home at the time of the visit.	**Compliant**
	25.13	It is recommended that the home's annual quality report is reviewed and updated to include all areas within Regulation17 of the Nursing and Residential Care Homes Regulations (Northern Ireland).	On the day of inspection a draft annual quality report was available in the home.	**Compliant**

11.0 Additional areas examined

11.1 Records required to be held in the nursing home

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

11.2 Patients/residents under guardianship

There were no patients/residents currently resident at the time of inspection in the home.

11.3 Quality of interaction schedule (QUIS)

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

The inspector observed the lunch meal being served in the dining room and in the interactions between patient and staff in upstairs sitting room. The inspector also observed care practices in the main sitting room following the lunch meal.

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

Positive interactions	All positive
Basic care interactions	-
Neutral interactions	-
Negative interactions	-

The inspector evidenced that the quality of interactions between staff and patients/residents was positive.

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

11.4 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. This review evidenced that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought.

11.5 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.

11.6 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.

11.7 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/residents currently in the home.

Staff were provided with a variety of relevant training including mandatory training since the previous inspection. A restated requirement is made that the newly appointed Activity Therapist receives training in Activities.

During the inspection the inspector spoke to eight staff. The inspector was able to speak to a number of these staff individually and in private. On the day of inspection eight staff completed questionnaires.

The following are examples of staff comments during the inspection and in questionnaires;

- "A high standard of care is provided in Rathowen, I enjoy working here, each resident is a pleasure to work with and all residents receive patient centred care."
- "I feel that it is important to give residents choice and independence, showing care and respect towards residents is very important to me."
- "Yes I have had training in wound management."
- "Care provided here is based on individuals needs and wishes."
- "Care provided here is based on residents individual needs and wishes."
- "We work well as a team but sometimes we could do with more staff."
- "The standard of care here is high in Rathowen."
- "Residents are all treated with dignity and respect in a homely atmosphere."
- "Patients are always treated with privacy."

11.8 Patients'/ residents' comments

During the inspection the inspector spoke with 10 patients individually and with a number in groups. In addition, on the day of inspection, six patients completed questionnaires.

The following are examples of patients'/residents' comments made to the inspector and recorded in the returned questionnaires:

- "My visitors are always made welcome."
- "I have always have access to my buzzer."
- "I am just happy enough here."
- "I think this is an excellent home."

11.9 Relatives /Representatives comments

During the inspection the inspector spoke with one relative.

The following is an example of the relative's comments during inspection:

- "This is a great home I cannot speak highly enough of the standard of care here."

11.10 Environment

The inspector undertook an inspection of the home environment and viewed a number of patients/residents bedrooms, communal areas, dining rooms and toilet/bathroom facilities.

The home presented as clean warm and comfortable with a friendly and relaxed ambience. However a requirement is made that the corridor on the ground floor, the doors, architraves, and skirting boards are repainted.

The identified patient's bedroom floor covering should also be replaced.

12.0 Quality improvement plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr Desmond Watt, Registered Provider and Miss Mandy Murphy, Nursing Sister as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

Heather Moore
The Regulation and Quality Improvement Authority
Hilltop
Tyrone and Fermanagh Hospital
Omagh
Co Tyrone
BT70 0NS

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **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**
On admission the Roper,Logan,Tierney model of nursing is used and care plans drawn up to meet the assessed need within 11 days of admission. The MUST tool is used to nutritionally screen residents. Braden/Abbey pain score and a contenence assessment is carried out on admission. Falls tool kit (as per guide lines from trust) has been adapted to use within the home.	Compliant

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**
Each resident is assigned a named nurse on admission to the home who is responsible for all aspects of their care. Care plans are updated with any changes noted. Treatment plans and referrals are made as necessary. A multi-	Compliant

disciplinary sheet is provided in all records and notes made of any members of the team visiting.	
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**
All care is updated and reviewed when any changes occur. All care is reassessed on a daily basis and an evaluation sheet completed.	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**
All nursing interventiions, procedures and activities are carried out looking at NICE guidelines NMC documents. The Northern Ireland Wound Care formulae is used to grade pressure ulcers. The new nutritional guidelines are available for all staff to use.	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**
All nursing records are recorded legibly signed and dated. Records include details of any assessments and reviews	Compliant

undertaken reguarding arrangements for future and ongoing care. A food book is kept in the kitchen and completed by staff of foods/fluids taken. If required a food record chart and fluid balance would be in place. If necessary residents are referred to the Dietitian/SALT and this is recorded on the multi-disciplinary sheet.	
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**
A consent to care form is completed on admission to the home. Care is reviewed yearly with relatives/next of kin. Staff record an evaluation sheet on a daily basis and care plans are reviewed monthly.	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**
Patients attend any multi-disciplinary meetings with the trust. A care management form is completed with any concerns or changes. The trust provides the home with a care management review form following any meetings.	Compliant
Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Patients have a choice from a 3/52 menu which has been verified following guidance from the dietitian, the new nutritional guidelines have been used.	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**
Staff have had training on swallowing awareness/food thickeners. Any guidelines provided by SALT are in the patients records. All meals are provided at conventional times and snacks are available at any time. Fresh drinking water is available at regular intervals and care plans are in situ for any patient that has concerns re eating and drinking. Staff have been trained in wound care and the importance of nutrition in healing wounds. New nutritional guidelines are in place within the home.	Compliant

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.

Quality Improvement Plan

Announced Primary Inspection

Rathowen

18 August 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with **Mr Desmond Watt, Registered Provider and Miss Mandy Murphy, Nursing Sister** either during or after the inspection visit.

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

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

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

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

Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on the HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and the Nursing Homes Regulations (NI) 2005

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	20 (1) (c) (i)	The registered person shall ensure that the newly appointed Activity Therapist is trained in Activities. **Ref: Section11 point 11.7 (Additional Areas Examined)**	Two	Course booked for 7 Oct 2014	Two Months
2	27 (2) (d)	The registered person shall ensure the following environmental issues are addressed: • Repaint the corridor, doors, architraves and skirting boards (Ground Floor) • Replace the identified patient's bedroom floor covering **Ref: Section 11 point 11.10 (Additional Areas Examined)**	One	Painter contacted will come asap Bedroom floor covering being ordered	Two Months
3	16 (1)	The registered person shall ensure that a pain management care plan is maintained for patients who require wound care intervention. (if applicable) **Ref: Management of wounds and pressure ulcers**	One	Implemented	From the date of this inspection

Recommendations

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

No.	Minimum Standard Reference	Recommendation	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.3	It is recommended that patients' pressure relieving equipment in use on patients beds and when sitting out of bed be addressed in patients' care plans on pressure area care and prevention. **Ref: Management of wounds and pressure ulcers**	One	Implemented	From the date of this inspection

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

Name of Registered Manager Completing Qip	Mr Desmond Watt
Name of Responsible Person / Identified Responsible Person Approving Qip	Mr Desmond Watt

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Heather Moore	06 October 2014
Further information requested from provider			