



The **Regulation** and
Quality Improvement
Authority

Primary Unannounced Care Inspection

Name of Service and ID: Sanville (1497)
Date of Inspection: 08 October 2014
Inspector's Name: Heather Moore
Inspection ID: IN016520

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

General Information

Name of home:	Sanville
Address:	17b Annagher Road Coalisland Dungannon BT71 4NE
Telephone number:	028 8774 8005
E mail address:	manager@sanvillepnh.co.uk
Registered organisation/ Registered provider / Responsible individual	Sanville Mr Brendan Gervin Mrs Alice McAleer
Registered manager:	Mrs Bernadette Mooney
Person in charge of the home at the time of inspection:	Mrs Bernadette Mooney
Categories of care:	NH-DE, NH-I, NH-PH, NH-LD, NH-LD(E), NH-MP(E), NH-MP, RC-I
Number of registered places:	36
Number of patients / residents accommodated on day of inspection:	35
Scale of charges (per week):	£581.00 Nursing £461.00 Residential
Date and type of previous inspection:	04 July 2013 Secondary Unannounced
Date and time of inspection:	08 October 2014: 08.20 hours - 15.25 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 unannounced 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:

- analysis of pre-inspection information
- discussion with the registered provider
- discussion with the registered manager

- observation of care delivery and care practices
- discussion with staff
- examination of records
- consultation with patients 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	10 individually and with others in groups
Staff	10
Relatives	2
Visiting Professionals	0

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	2	2
Staff	8	5

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

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

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

7.0 Profile of service

Sanville is a purpose built facility situated in its own grounds on the outskirts of Coalisland village in Dungannon, Co. Tyrone.

The home is owned and operated by Mr Brendan Gervin and Mrs Alice McAleer. The Registered Manager is Ms Bernadette Mooney.

The home provides accommodation for 36 patients and residents assessed in the following categories:

- NH- I old age not falling within any other category
- NH-DE Dementia (five patients)
- NH-LD/LD(E) Learning disability (for one designated patient)
- RC- I Residential care old age not falling within any other category
- NH-MP-MP (E) Mental disorder excluding learning disability or dementia (two patients)
- NH-PH Physical disability other than sensory impairment .

There are well maintained grounds, with a landscaped secure garden. There is adequate car parking facilities in the grounds of the home.

8.0 Summary of Inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Sanville. The inspection was undertaken by Heather Moore on 08 October 2014 from 08.20 hours to 15.20 hours.

The theme for the 2014 – 15 inspection year is 'Nursing Care' (Standard 5) and the inspection focused on three areas of practice related to:

- management of wounds and pressure ulcers (Standard 11)
- management of nutritional needs of patients and weight loss (Standard 8 & 12)
- management of dehydration (Standard 12).

The inspector also considered the management of patient's human rights during this inspection. The requirement made as a result of the previous inspection was also examined. The inspector evidenced that this requirement was fully complied with.

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. This self-assessment was received on 17 June 2014. The comments provided by the responsible individual/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.

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

Refer to section 11.0 for further details about patients and residents.

The inspector can confirm that at the time of this inspection, the delivery of care to patients/residents was evidenced to be of a satisfactory standard and patients/residents were observed to be treated by staff with dignity and respect

Inspection of a sample of staff duty rosters and discussions with staff confirmed that staffing levels on the day of inspection were satisfactory and in line with RQIA's recommended minimum staffing guidelines. No issues or concerns were brought to the attention of the inspector on the day of inspection.

Conclusion

There were systems and processes in place to ensure the effective management of the standards inspected. However, areas for improvement were identified. Two requirements and two recommendations are made.

These requirements and recommendations are addressed throughout the report and in the quality Improvement Plan (QIP).

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

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

9.0 Follow-up on the requirements and recommendations issued as a result of the previous inspection on 04 July 2013

No	Regulation Ref.	Requirement	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	16 (1)	The registered person shall ensure that a specific care plan on Do Not Attempt Resuscitation (DNAR) is maintained in the identified patient's care record.	Inspection of three patients and one resident's care record confirmed that a specific care plan on Do Not Attempt Resuscitation (DNAR) was maintained in the identified patient's care record.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
		No recommendations were made as a result of this inspection.		

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

There have been no issues/concerns raised with the RQIA since the previous inspection.

10.0 Inspection findings

Section A – On admission a registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Standard criterion 5.1, 5.2, 8.1 and 11.1 examined.

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

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

Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart and continence were also completed on admission. Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure ulcer/wound and if required, the specific care plans regarding the management of the pressure ulcer/wound.

Review of three patients / residents care records evidenced that a comprehensive holistic assessment of the patients' and residents' care needs was completed within 11 days of the patient's admission to the home.

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

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

Section B –A registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Care records evidence involvement of the patient and /or their representative and that care planning and delivery reflect the recommendation from relevant health professionals. Referrals to healthcare professionals are made as required and in a timely manner. Standard criterion 5.3, 11.2, 11.3, 11.8 and 8.3 examined.

The inspector observed that a named nurse and key worker system was operational in the home.

Review of three patient's/resident's care records and discussion with patients and residents evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Records evidenced discussion with patients, residents and/or their representatives following changes to the plans of care.

Patients' and residents care records revealed that the pressure relieving equipment in place on the patients'and residents' beds and when sitting out of bed, was also addressed in patients' and residents' care plans on pressure area care and prevention.

The registered manager informed the inspector that there was one patient in the home who required wound management for a wound.

Review of this patient's care records revealed the following:

- The absence of a specific care plan on Methicillin Resistant Staphylococcus Aureus (MRSA). A requirement is made that this shortfall is addressed
- A body mapping chart was completed for the patient on admission. This chart was reviewed and updated when any changes occurred to the patient's skin condition
- A care plan was in place which specified the pressure relieving equipment in place on the patient's bed and also when sitting out of bed
- A daily repositioning and skin inspection chart was in place for the patient with the wound and also for patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these charts revealed that patients' skin condition was inspected for evidence of change at each positional change. It was also revealed that patients were repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention.

In discussion with the registered manager and two registered nurses and a review of three patients' care records, confirmed that where a patient was assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention plan and treatment programme.

The registered manager and registered nurses confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local healthcare Trust. Staff spoken with were knowledgeable regarding the referral process. Discussion with two registered nurses evidenced that they were knowledgeable of the action to take to meet the patients' and residents' needs in the interim period while waiting for the relevant healthcare professional to assess the patient/resident.

Review of the records of incidents revealed that one identified patient who had developed a pressure ulcer had not been reported to RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. A requirement is made in this regard.

The patient's weight was recorded on admission and on at least a monthly basis or more often if required.

The patient's nutritional status was also reviewed on at least a monthly basis or more often if required.

Daily records were maintained regarding the patient's daily food and fluid intake.

Review of wound care in a patient's care plan evidenced that the dressing regime was recorded appropriately.

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

Review of care records for one patient evidenced that the patient was referred for a dietetic assessment in a timely manner.

Discussion with the registered manager, registered nurses, care staff and review of the staff training records, revealed that staff were trained in wound management and pressure area care and prevention on 28 May 2014. Staff were also trained in the management of nutrition and dysphagia on 07 October 2014 and 14 October 2014.

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

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

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	Substantially compliant
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	Moving towards Compliance

Section C - Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans. Standard criteria 5.4 examined.

Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required.

Discussion with two registered nurses and a review of governance documents evidenced that a number of care records were audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

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

Section D – All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. Standard criterion 5.5, 8.4 and 11.4 examined.

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

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

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

- DHSSPS 'Promoting Good Nutrition' A Strategy for good nutritional care in adults in all care settings in Northern Ireland 2011-16
- The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes
- The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care
- The European Pressure Ulcer Advisory Panel (EPUAP).

Discussion with the registered manager and registered nurses confirmed that they had a good awareness of these guidelines.

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

Section E – Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients. Standard criterion 5.6, 12.11 and 12.12 examined.

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

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

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

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

Entries were noted to be timed and signed with the signature accompanied by the designation of the signatory. However a small number of alterations were not recorded appropriately. A recommendation is made in this regard.

The inspector reviewed a record of the meals provided for patients. Records were maintained in sufficient detail to enable the inspector to judge that the diet for each patient was satisfactory.

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

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

Review of a sample of patients fluid balance charts evidenced that these charts were well recorded.

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

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

Section F – 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. Standard criteria 5.7 examined.

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

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

Section G – The management and involvement of patients and/or their representatives in review of care. Standard criterion 5.8 and 5.9 examined.

Prior to the inspection, a patients’ care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that all the patients in the home had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014.

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

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

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

Section H – Management of nutrition including menu choice for all patients. Standard criterion 12.1 and 12.3 examined.

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

There was a three weekly menu planner in place. The registered manager informed the Inspector that the menu planner had been reviewed and updated in consultation with patients, residents, their representatives and staff in the home. The current menu planner was implemented on the 01 June 2014.

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

Staff spoken with were knowledgeable regarding the individual dietary needs of patients and to include their likes and dislikes. Discussion with staff and review of the record of the patient’s meals confirmed that patients were offered choice prior to their meals.

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

From a review of the menu planner and records of patients’ and residents choices and discussion with a number of patients, residents, registered nurses and care staff, it was revealed that choices were available at each meal time. The registered manager confirmed choices were also available to patients who were on therapeutic diets.

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

Section I – Knowledge and skills of staff employed by the nursing home in relation to the management of nutrition, weight loss, dehydration, pressure area care and wounds. Standard criterion 8.6, 11.7, 12.5 and 12.10 examined.

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

Review of training records revealed that staff had attended training in dysphagia awareness on 07 October 2014 and 14 October 2014.

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

The registered manager confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning afternoon and at supper times.

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

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care.

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

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

Discussion with the registered nurses clearly evidenced their knowledge in the assessment, management and treatment of wounds. Review

of the template used to undertake competency and capability assessments for the registered nurses revealed that pressure ulcer/wound care was addressed.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	Substantially compliant
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	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; and review of a selected sample of documents by the inspector confirmed that the required records were maintained in the home and were available for inspection.

11.2 Patients/residents under Guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) Order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection.

There were no patients/residents accommodated at the time of inspection in the home who were subject to guardianship arrangements.

11.3 Quality of Interaction Schedule (QUIS)

The inspector undertook a number of periods of enhanced observation in the home which lasted for 30 minutes each. The inspector observed the lunch meal being served in the dining room. The inspector also observed care practices in the 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. A description of the coding categories of the Quality of Interaction Tool is appended to this report.

Total number of observations	Three
Positive interactions	All Positive
Basic care interactions	
Neutral interactions	
Negative interactions	

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

Staff were observed preparing and seating the patients and residents for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients and residents with their meal and patients and residents were offered a choice of fluids. The staff explained to the patients and residents their meal choice and provided appropriate assistance and support to the patients and residents.

Observation of care practices in the sitting rooms revealed that staff initiated conversations with patients and residents and listened to their views and were respectful in their interactions with them. Overall the periods of observation were positive in regard to the care of patients and residents in the home.

11.4 Complaints

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

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

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

11.5 Patient/ resident 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.

11.7 Questionnaire findings

11.7.1 Staffing levels and staff comments

Discussion with the registered manager and review of the nursing and care staff duty roster for three weeks evidenced that the registered nursing and care staffing levels were satisfactory and in line with the RQIA's recommended minimum staffing guidelines for the number of patients and residents accommodated in the home during the inspection. However a recommendation is made that staff hand over periods be recorded on the staff duty rosters.

During the inspection the inspector spoke to 10 staff. The inspector was able to speak to a number of these staff individually and in private five staff completed questionnaires.

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

- "I love my work here; we work well as a team."
- "I had an induction when I commenced work."
- "I think we provide a good standard of care here."
- "The residents are all well looked after."

- “I am happy to say that all the residents are all well looked after, there is a high standard of care here.”
- “I have had training in wound management.”
- “Yes I have had training in Dysphagia.”
- “Everyone works well together here as a team.”

11.7.2 Patients/residents and relatives comments

During the inspection the inspector spoke with 10 patients/residents individually and with the majority of others in smaller groups.

Patient spoken with and the questionnaire responses confirmed that patients/residents were treated with dignity and respect, that staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home.

The following are examples of patients and residents comments during the inspection and in the questionnaires.

- “This is a great place, I am happy here.”
- “I have access to drinks throughout the day.”
- “The staff here are very good.”
- “They are all very kind.”
- “I am happy here.”
- “I am well looked after.”
- “We didn’t have an outing this summer, I hope we have one before Christmas.”

The inspector spoke with two relatives during the inspection and two relatives completed a questionnaire at the end of the inspection. Relatives’ responses included:

- “The standard of care is excellent I cannot speak highly enough of the staff and the facilities.”
- “The home is lovely the extension is beautiful, it’s lovely for the residents.”

11.8 Environment

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

Since the previous inspection the extension to the home was occupied this additional unit has enhanced the quality of the environment for the patients and residents in the home.

Management are to be commended for their efforts in this regard.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Bernadette Mooney, Registered Manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

Heather Moore
The Regulation and Quality Improvement Authority
Hilltop
Tyrone 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.	
<p>Criterion 5.1</p> <ul style="list-style-type: none"> At the time of each patient’s admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient’s immediate care needs. Information received from the care management team informs this assessment. <p>Criterion 5.2</p> <ul style="list-style-type: none"> A comprehensive, holistic assessment of the patient’s care needs using validated assessment tools is completed within 11 days of admission. <p>Criterion 8.1</p> <ul style="list-style-type: none"> Nutritional screening is carried out with patients on admission, using a validated tool such as the ‘Malnutrition Universal Screening Tool (MUST)’ or equivalent. <p>Criterion 11.1</p> <ul style="list-style-type: none"> A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulations 12(1) and (4); 13(1); 15(1) and 19 (1) (a) schedule 3</p>	
Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section	Section compliance level
<p>5.1 Pre-admission assessments take place unless in the event of an emergency admission to Sanville Private Nursing Home. An initial risk assessment, using validated assessment tools, informs an agreed plan of care to meet patient’s immediate care needs. Information received from the care management team informs this assessment.</p> <p>5.2 A comprehensive, holistic assessment of patient’s care needs using validated assessment tools is completed within 11 days of admission. This assessment is completed in collaboration with the patient and their representative and takes in account information provided by care management at the time of admission..</p> <p>8.1 MUST screening is carried out with patients on admission to Sanville Private Nursing Home</p>	Substantially compliant

<p>11.1 A Braden pressure ulcer risk assessment is carried out on all patients on admission to Sanville Private Nursing Home and is used to inform care planning alongside input from relevant professionals. Care management preadmission reports should also inform pressure ulcer treatment. Sanville Nursing Home also refers to EUASP guidelines as well as Northern Ireland wound care formula guidelines in the application of dressings. Additional assessments for nutrition, pain and continence are also completed prior to admission and on the day of admission to the nursing home management. Registered nurses utilise the information from these assessment tools to inform their clinical judgement when developing care plans to manage patients' assessed care needs.</p>	
<p>Section B</p>	
<p>Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</p>	
<p>Criterion 5.3</p> <ul style="list-style-type: none"> • 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. <p>Criterion 11.2</p> <ul style="list-style-type: none"> • There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability. <p>Criterion 11.3</p> <ul style="list-style-type: none"> • 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. <p>Criterion 11.8</p> <ul style="list-style-type: none"> • There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration. <p>Criterion 8.3</p> <ul style="list-style-type: none"> • There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to. 	

<p>Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1); 14(1); 15 and 16</p>	
<p>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</p>	<p>Section compliance level</p>
<p>5.3A named nurse system is in place in Sanville Private Nursing Home. At present, this is rotational, to ensure continuity of care from all nurses. The named nurse has responsibility for discussing, planning and agreeing nursing intervention to meet identified assessed needs with individual patients and their representatives. The nursing care plan aims to promote maximum independence through empowerment and rehabilitation. Recommendations and advice from other health professionals also informs nursing interventions. Our ethos is that a person centred approach is adapted to the planning of care.</p> <p>11.2 Where appropriate, referrals are made to relevant health professionals who have particular expertise. For example, referrals are made to tissue viability nurses</p> <p>11.3 Where a patient is assessed as 'at risk' of developing pressure ulcers, a care plan is drawn up to document prevention and treatment for a patient ensuring their needs and in particular comfort is met. Consultation and advice from relevant professionals is sought and recorded.</p> <p>11.8 There are also referral arrangements to relevant health professionals who have knowledge and expertise to diagnose, treat and care for patients with lower limb and foot ulceration.</p> <p>8.3 Similarly, there are referral arrangements in place for contacting the dietician to assess patient nutritional requirements. This will inform a nutritional treatment plan.</p>	<p>Substantially compliant</p>
<p>Section C</p>	
<p>Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</p>	
<p>Criterion 5.4</p> <ul style="list-style-type: none"> • Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16</p>	
<p>Provider's assessment of the nursing home's compliance level against the criteria assessed within this</p>	<p>Section compliance</p>

section	level
5.4 Reassessment of patient needs is carried out on an ongoing, daily basis by both day and night registered nurses. Daily progress notes on the delivery of care including wound management,	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.	
<p>Criterion 5.5</p> <ul style="list-style-type: none"> All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. <p>Criterion 11.4</p> <ul style="list-style-type: none"> A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented. <p>Criterion 8.4</p> <ul style="list-style-type: none"> There are up to date nutritional guidelines that are in use by staff on a daily basis. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)</p>	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
5.5 Validated assessment tools (including the Braden scale) are used to support nursing interventions, activities and procedures. There are also reference documents within the home (e.g. EUASP, Northern Ireland wound care formula and NICE management of pressure ulcers) are available for consultation 11.4 The validated pressure ulcer grading tool used to screen patients who have skin damage in Sanville Private Nursing Home is the Braden scale pressure risk assessment. Treatment plans in conjunction with relevant professionals are devised. There plan are upated and revised when changes occur to pressure wounds or ulcers. 8.4 Sanville nursing Home refers to the Nutritional Guidelines and menu check list published and supplied by the Public Health agency.	Substantially compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
<p>Criterion 5.6</p> <ul style="list-style-type: none"> Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients. <p>Criterion 12.11</p> <ul style="list-style-type: none"> A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory. <p>Criterion 12.12</p> <ul style="list-style-type: none"> Where a patient’s care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed. Where a patient is eating excessively, a similar record is kept. All such occurrences are discussed with the patient and reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25</p>	
Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section	Section compliance level
<p>5.6 Contemporaneous nursing notes are maintained on all patients nursing interventions, activities and procedures. Nursing staff are aware of their accountability to NMC guidelines and required to maintain best practice with these guidelines</p> <p>12.11 Records are maintained in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory</p> <p>12.12 Records are maintained when a patient is unable or chooses not to eat a meal. Alternatively, excessive food intake is also recorded and monitored with outcomes recorded in individual care plans. Relevant referrals are made to health professionals in such occurrences.</p>	Substantially compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 <ul style="list-style-type: none"> The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16</p>	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
5.7 Patients and representatives are involved in the planning of nursing care being delivered. The outcome of care delivered is monitored and recorded at least daily or more often as patient needs change.	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 <ul style="list-style-type: none"> Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate. Criterion 5.9 <ul style="list-style-type: none"> The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)</p>	

<p>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</p>	<p>Section compliance level</p>
<p>5.8 Residents are encouraged, where their health permits, to attend or contribute to formal multi-disciplinary meetings arranged by local Health & Social Care Trust. Outcomes of care are discussed and any concerns they have are raised and discussed to find a suitable outcome if necessary. If residents are unable to attend the review is carried out with next of kin and the local Health & Social Care Trust as appropriate.</p> <p>5.9 The results of all reviews and the minutes of review meetings are recorded and where required, changes are made to the nursing plan with the agreement of resident and relative. Residents and next of kin are informed regarding progress.</p>	<p>Substantially compliant</p>
<p>Section H</p>	
<p>Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</p>	
<p>Criterion 12.1</p> <ul style="list-style-type: none"> • Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences. Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines. <p>Criterion 12.3</p> <ul style="list-style-type: none"> • The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided. A choice is also offered to those on therapeutic or specific diets. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)</p>	
<p>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</p>	<p>Section compliance level</p>
<p>12.1 Policies and Procedures are in place to guide and inform staff in regard to Nutrition and dietary intake. They are reflective of best practice guidance.</p>	<p>Substantially compliant</p>

<p>A copy of the Nutritional Guidelines and menu checklist for residential and nursing Homes for older people and for those providing community meals (2014) and “Promoting Good Nutrition” a strategy for good nutritional care for adults in care settings in Northern Ireland 2011 – 2016 (DHSSPS) are available in the home. Our cook also meets with patients on an individual basis.</p> <p>12.3 Our menu offers patients a choice of meal at each mealtime. Alternative meals will also be offered if requested or necessary. Choices are also offered to patients on therapeutics diets.</p>	
<p>Section I</p>	
<p>Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</p>	
<p>Criterion 8.6</p> <ul style="list-style-type: none"> • 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. <p>Criterion 12.5</p> <ul style="list-style-type: none"> • 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. <p>Criterion 12.10</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ risks when patients are eating and drinking are managed ○ required assistance is provided ○ necessary aids and equipment are available for use. <p>Criterion 11.7</p> <ul style="list-style-type: none"> • 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. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20</p>	
<p>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</p>	<p>Section compliance level</p>

<p>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 .</p> <p>12.5 Meals were served at appropriate intervals throughout the day and in keeping with best practice guidance contained within The Nutritional Guidelines and menu checklist for residential and nursing homes for older people and for those providing community meals. A choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements are offered mid-morning, afternoon and supper times. Yogurts and fresh fruit are also available on request.</p> <p>12.10 Care staff are consulted regarding specific needs of patients and to include any risks identified, assistance required and any necessary aids and equipment. Appropriate training is also supplied.</p> <p>11.7 Nurses have up to date knowledge, skills and expertise in wound care management that include the ability to carry out a wound assessment and apply wound care products and dressings .</p>	<p>Substantially compliant</p>
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<p>PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5</p>	<p>COMPLIANCE LEVEL</p>
	<p>Substantially compliant</p>

Appendix 2

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

<p>Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.</p>	<p>Basic Care: (BC) – basic physical care e.g. bathing or use of toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.</p>
<ul style="list-style-type: none"> • Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc. (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are tailored to the individual, the language used easy to understand, and non-verbal used where appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away • Staff respect older people’s privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual’s care in front of others 	<p>Examples include: Brief verbal explanations and encouragement, but only that which is necessary to carry out the task</p> <p>No general conversation</p>

<p>Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.</p>	<p>Negative (NS) – communication which is disregarding of the residents' dignity and respect.</p>
<p>Examples include:</p> <ul style="list-style-type: none"> • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions • Not showing interest in what the patient or visitor is saying 	<p>Examples include:</p> <ul style="list-style-type: none"> • Ignoring, undermining, use of childlike language, talking over an older person during conversations • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness') • Seeking choice but then ignoring or over ruling it • Being angry with or scolding older patients • Being rude and unfriendly • Bedside hand over not including the patient

References

QUIS originally developed by Dean, Proudfoot and Lindsay (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

Unannounced Primary Inspection

Sanville

08 October 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 **Ms Bernadette Mooney, Registered Manager** either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	16 (1)	<p>The registered person shall ensure that a specific care plan on MRSA is maintained in the patient's care plan on wound management.</p> <p>Ref: Section B</p>	One	This has been communicated to all staff and implemented with immediate effect	From the date of this inspection
2	30 (1) (d)	<p>The registered person shall ensure that grade 2 pressure ulcers/wounds are reported to RQIA in a timely manner.</p> <p>Ref: Section B</p>	One	Communicated to all staff -	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	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	6.3	It is recommended that any alterations or additions are dated, timed and signed, and made in such a way that the original entry can still be read. Ref: Section E	One	Communicated to all staff	From the date of this inspection
2	30.8	It is recommended that time is scheduled at change of shifts for handover reports to be given on patient care and other areas of accountability. This information should be recorded on staff duty rotas. Ref: Section 11.7.1 (Additional Areas Examined)	One	Implemented with immediate effect	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	Bernie Mooney
Name of Responsible Person / Identified Responsible Person Approving Qip	Alice Mc Aleer

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Heather Moore	03 December 2014
Further information requested from provider			