Unannounced Care Inspection

Name of Establishment:	**Meadows**
RQIA Number:	**1500**
Date of Inspection:	**4 March 2015**
Inspector's Name:	**Sharon Loane**
Inspection ID:	**IN017263**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Meadows
Address:	15 Newline Road Richill Armagh BT61 9QR
Telephone Number:	028 3887 0005
Email Address:	meadowspnhome@gmail.com
Registered Organisation/ Registered Provider:	Armagh Care Services Mrs Pamela Halliday and Mr Daniel McHugh
Registered Manager:	Mr Daniel McHugh
Person in Charge of the Home at the Time of Inspection:	Mr Daniel McHugh
Categories of Care:	RC-LD, RC-LD(E), NH-LD, NH-LD(E)
Number of Registered Places:	46
Number of Patients Accommodated on Day of Inspection:	43
Scale of Charges (per week):	Nursing: £581.00 - £997.00 Residential: £518.00 -£997.00
Date and Type of Previous Inspection:	5 December 2013 Primary Announced Inspection
Date and Time of Inspection:	4 March 2015 10:00 – 14:45 hours
Name of Inspector:	Sharon Loane

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- discussion with the Registered Nurse Manager
- discussion with staff
- discussion with patients individually and to others in groups
- review of a sample of policies and procedures
- review of a sample of staff training records
- review of a sample of staff duty rotas
- review of a sample of care plans
- review of the complaints, accidents and incidents records
- review of Regulation 29 reports
- observation during a tour of the premises
- evaluation and feedback

5.0 Consultation Process

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

Patients/Residents	14
Staff	8
Relatives	0
Visiting Professionals	0

Questionnaires were provided during the inspection, to patients / residents, their representatives and staff to seek their views regarding the quality of the service.

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	5	4
Relatives/Representatives	6	4
Staff	10	9

6.0 Inspection Focus

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

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

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

Standard 19 - Continence Management

Patients receive individual continence management and support.

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

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

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

7.0 Profile of Service

The Meadows is located in Richill and consists of one large home divided into two areas, one which is known as Ross House and a larger unit called the Meadows.

The main building comprises of twenty single bedrooms and four double bedrooms. Three communal lounges, a foyer area to the entrance of the home, dining areas, kitchen, laundry, toilet/washing facilities, staff accommodation and offices are also located in the main building.

Three flats are integrated on the first floor of the main building and are occupied by residents.

There are three self-contained bungalows comprising of five bedrooms, accommodating fifteen patients in the grounds of the home. Each bungalow has a living room, dining area and kitchen.

The gardens and grounds are well maintained.

The home is registered to provide care for a maximum of 46 persons under the following categories of care:

Nursing care

NH- LD learning disability
NH-LD (E) learning disability over 65 years

Residential care

RC-LD learning disability
RC-LD (E) learning disability over 65 years

The nursing home is owned and operated by Armagh Care Services.
The current registered manager is Mr Daniel Mc Hugh.

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) was reviewed and was displayed in the foyer of the home.

8.0 Executive Summary

The unannounced inspection of The Meadows was undertaken by Sharon Loane on 4 March 2015 between 10:00 – 14:45 hours. The inspection was initially facilitated by, Aine Mc Sheery, designated nurse in charge, and was later joined by Daniel Mc Hugh registered manager, both who were available for verbal feedback at the conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection on 5 December 2013. Prior to the inspection taking place the completed self-assessment and additional information was submitted by the registered manager as part of the pre-inspection process (refer to appendix 1).

During the course of the inspection, patients and staff were consulted. At the commencement of the inspection, the majority of patients were attending day care facilities, however, returned to the home for lunch, at which stage there was an opportunity to speak the patients individually and in small groups. Patients spoken to expressed high levels of satisfaction with the care and other services provided to them.

Care practices were observed, a selection of records examined, and patient and staff questionnaires were issued. A sample of questionnaires were provided to management, to forward to relatives/patient representatives as they do not visit during the day, due to patients attending external activities. A tour of the nursing home and attached bungalows was completed as part of the inspection process.

Four patient's records were examined in relation to continence management and support. The care records evidenced that the standard of record keeping in relation to this aspect of care reflected an assessment, care plan and evaluation process which included the promotion of continence / management of incontinence and patient dignity. However, the continence assessment tool being used requires development to enable the assessment of additional indicators which would facilitate more effective management of the standard. Assessments examined did not provide adequate detailed information on bowel function / management. A recommendation in regards to these findings has been made for the effective management of the standard. Refer to section 10.0 of the report.

A range of policies/guidance and training was in place to support registered nurses and care staff in relation to the continence management.

A continence link nurse who had completed a two day training programme facilitated by the SHSCT was working in the home and was involved in the review of continence management and education programmes for staff. This is good practice and is commended.

From a review of the available evidence and from discussion with relevant staff and observation, the level of compliance with standard 19 inspected was compliant.
The home's general environment was comfortable and all areas were maintained to an acceptable standard of cleanliness.

Additional areas were also examined including:

- care practices / care records
- complaints
- providers visits reports (Regulation 29)

- patients and residents views
- staffing and staff views
- environment
- Details regarding these areas are contained in section 11.0 of this report.

At the time of this inspection, the delivery of care to patients was evidenced to be of a satisfactory standard and patients were observed to be treated by staff with dignity and respect. There were processes in place to ensure the effective management of the themes inspected.

As a result of the previous inspection conducted on 5 December 2013, two requirements and four recommendations were made.

These were reviewed during this inspection and it was evidenced that all requirements and recommendations had been complied with. Details can be viewed in the section immediately following this summary.

As a result of this inspection, no requirements are made and one recommendation has been made. Details can be found in the report and in the quality improvement plan.

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

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	16 (2)	It is required that patients' and residents' care records are reviewed and updated in order to fully address their assessed needs.	Four patient's records were examined. All records had relevant completed assessments with a care plan reflective of the assessed need. Care plans and assessments were updated on a monthly basis or as required. Care plans had been reviewed annually with relevant changes made.	Compliant
2.	18(2)(c)	The registered person shall having regard to the size of the nursing home and the number and needs of patients provide in rooms occupied by patients adequate furniture, bedding and other furnishings, including curtains and floor coverings, and equipment suitable to the needs of patients and screens where necessary.	The majority of patient bedrooms were examined and were observed as having adequate furniture and soft furnishings. The shared bedrooms had appropriate screens installed to protect patient's dignity and privacy.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	25.12	In order to provide readers of reports with adequate information to forms their views on the overall operation and management of the home It is recommended that additional details be provided in reports of unannounced visits undertaken in the home under Regulation 29.	Regulation 29 reports for visits completed in January & February 2015 were examined. The reports included detailed information regarding the overall operations and management of the home. Staff, patient and relatives views were incorporated.	Compliant
2.	5.3	It is recommended that the roles and responsibilities of named nurses and key workers be outlined in the patient's and resident's guide.	The patients guide had been reviewed in February 2015 and outlined the roles and responsibilities of staff as indicated.	Compliant
3	30.1	It is recommended that the registered manager undertakes regular audits of the registered nursing staffing levels rostered on night duty in order to ensure that these staffing levels are adequate to meet the assessed needs including the supervision levels required to ensure the safety of the patients.	Audits pertaining to the operations of night duty completed by the registered manager were examined. Audits were initially completed weekly, however, are now completed at monthly intervals. Audits examined a range of events and factors relevant to the operations of the home during the night and took cognisance of staffing levels to ensure they are adequate to meet the assessed needs and patient safety.	Compliant

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

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if 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.

Since the previous inspection in December 2013, RQIA have been notified by the home of ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues. All incidents were managed in accordance with SOVA regional guidance and there were no ongoing investigations at time of inspection.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of four patient's care records evidenced that bladder and bowel continence assessments were undertaken for all patients. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patient's care plans on continence care. However, the continence assessment tool being used requires development to enable the assessment of additional indicators which would facilitate more effective management of the standard. Assessments examined did not provide adequate detailed information on bowel function management and did not reference the Bristol Stool Chart. This matter was discussed with the management team. A recommendation has been made. There was evidence in all care records examined that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their General Practitioner as appropriate. Review of four patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The following policies and procedures were in place; • continence management / incontinence management • catheter care The home advised they do not have a policy on Stoma Care and if the need arose they would action accordingly. The following guideline documents were in place: • RCN continence care guidelines • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence • British Geriatrics Society Continence Care in Residential and Nursing Homes. Additional reference information on continence management developed by the Southern Health and Social Care Trust was also available to staff. Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not applicable.	Not applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the manager revealed that registered nurses in the home were deemed competent in female, male and suprapubic catheterisation. In addition, three registered nurses were attending training in the management of suprapubic catheterisation on the day of inspection. Staff had also completed training on the use and application of continence aids in February 2015. A continence link nurse who had completed a two day training programme facilitated by the SHSCT was working in the home and was involved in the review of continence management and education programmes for staff. This is good practice and is commended. Discussion with staff evidenced that they were knowledgeable about the important aspects of continence care including privacy, dignity, skin care, fluid intake and the reporting of any concerns. Staff consulted demonstrated new learning from all training provided. The home had contacted the continence specialist for SHSCT for information pertaining to audits of continence management.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

During the inspection, staff were observed to treat the patients with dignity and respect. Good relationships were evident between patients and staff. It was apparent from observation and discussion; the staff were knowledgeable and familiar with the intricate needs and preferences of the patients.

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

11.2 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 management of complaints record was reviewed and discussed with the registered manager. This evidenced that no complaints had been received since June 2011. The complaints process was displayed appropriately. There was evidence of regular relatives/patient representatives meetings, the minutes of which were examined. All comments were positive indicating good partnerships in the delivery of care and other areas regarding the operations of the home.

11.3 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.

11.4 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.

11.5 Patients' Views

During the inspection the majority of patients were observed. Some patients were consulted individually and others in small groups. These patients expressed high levels of satisfaction with the standard of care, facilities and services provided in the home. Patients expressed their satisfaction with living in the Meadows and the lifestyle experience this provided them with. They advised of a number of upcoming social events that added to their quality of life. A small number of patients were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients' comments were as follows:

"I never had a home until I came to live in the Meadows"
"The manager and staff spoil us "
"I help out with jobs and this increases my confidence"
"I am happy living in the Meadows"

11.6 Questionnaire Findings/Relatives' Comments

On the day of inspection, no relatives were available for consultation. However, six questionnaires were provided for relatives to complete. Four completed questionnaires were returned to RQIA post inspection. Responses received provided positive feedback in regards to the care delivered. The following are examples of the relative's comments received in the returned questionnaires;

"My son is very happy living in The Meadows. He is well cared for and is always turned out clean and tidy"

"The Meadows has proved to be an excellent home for my relative. There is always a happy atmosphere around the home when I visit, and staff at all levels demonstrate a real caring ethos and commitment to the general well-being of all the residents".

11.7 Questionnaire Findings/Staff Comments

During the inspection, eight staff were spoken with individually and others in small groups; including the deputy manager, registered nurses, care assistants, catering and ancillary staff. A large number of staff had worked in the home for a significant period of time.

All staff commented on the homely atmosphere, good team relationships. Staff demonstrated a thorough knowledge of the patients' needs and preferences.

Examples of staff comments were as follows;
"We treat the patients like our own family".
"I am very happy working in the home."
"Good atmosphere"
"The patients and residents are well cared for"
"Any issues are dealt with effectively by the manager"
"The patients get whatever they need"

11.8 Environment

An inspection of the premises was undertaken and facilitated by the registered manager/ designated nurse in charge. The majority of patient's bedrooms, bathrooms, shower and toilet facilities and communal living areas were observed. There was evidence of personalisation of patient bedrooms. The home was comfortable and was maintained to a satisfactory standard of cleanliness.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Daniel McHugh (registered manager) and Aine Mc Sherry (designated nurse in charge), 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:

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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**
5.1 A pre-admission assessment involving patients and or family and Care Manager is carried out to ensure The Meadows can accommodate the needs of any potential patient/resident. -Prior to admission all relevant risk assessments / assessments / information must be received from Care Manager / Placement Authority.	Compliant

-Where possible all potential patients / residents visit the Meadows. -An initial risk assessment and plan of care must be completed to meet the patient/residents immediate care needs. -Consultation must take place with potential patient / resident and where possible family prior to admission in order to get relevant background information before admission. -A comprehensive assessment of needs is completed within 11 days of admission. This is then updated / reviewed regularly. Multidisciplinary meetings must take place approximately 8 weeks after admission. The only deviation to this is in the event of an emergency situation where as much information as possible is taken on admission and all other information is sought within 2 days of admission 5.2 A comprehensive assessment of needs is completed within 11 days of admission. This is then updated / reviewed regularly. Multidisciplinary meetings must take place approximately 8 weeks after admission. 8.1 The Must Tool is used for nutritional screening of all patients / residents on admission and reviewed monthly or more frequently if necessary. 11.1 Braden Scale MUST Assessment Tool, pain and continence assessments are carried out where possible prior to admission to home and on admission to the home. These are compiled using information received from care manager, patient and next of kin	

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

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
5.3 A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identifed assessed needs with individual patients and their representatives. All individual care plans are aimed at the promotion of maximum independence and rehabilitation and developed in conjunction with assessments completed by other Health Care Professionals. 11.2 All initial referals take place through G.P. Any further referals are made directly to the tissue viability nurse. Policy in place with regards to Referals to all Health Care Professionals. 11.3 Where a patient as assessed as at risk of developing pressure ulcers, an individual care plan is implemented and drawn up up through advise taken by relevant professionals. If any specialist equipment is required it is provided e.g pressure relieving mattress / cushion etc. 11.8 A Policy is in place 'To receive where necessary, treatment, advice and other services from any health care professional and/or social care worker and referral of patient to same'. This includes referral to tissue viability specialist nurse. 8.3 As above, referral arrangemens are in place for dietician. If nutritional treatment plan is devloped, taking into cnsideration reccommendations from relevant health professionals, it is adhered to and reviewed accordingly.	Compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.4 Progress notes are completed on a daily basis including assessment of wounds. Care plans are reviewed at agreed times, depending on the treatment in place and reviewed at least monthly.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
5.5 All nursing interventions are following consultation with tissue viability nurse and other relevant professionals. An individual care plan is developed used the relevant guidance and reviewed accordingly. Relevant guidance is available 11.4 The Braden scoring tool is used to risk assess patients/residents. The NPUAP tool is used to record the grade of the pressure ulcer. An individual care plan is developed taking advise from relevant professionals 8.4 At present the Nutritional Guidelines being used are 'The Nutritional guidelines and menu checklists for residential and nursing homes 2014 / Nutrition in the Workplace and Nutritional Guidelines & Menu Checklist for adults with learning disabilities.	Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
5.6 Daily progress notes are maintained for all patients / residents. in respect of all nursing interventions, activities and procedures. Individual care plans are in place for each intervention, activity and procedure and are evaluated frequently. 12.11 Menus are available in kitchen. Cooking records are kept in relation to all meals served. Patient choice records are kept daily. A record of food consumed is recorded after each meal. 12.12 Patient choice records are kept for all meals. If individual care plan requires fluid/food intake sheets they are completed. In each individual case speech & language therapist and dietician input is recorded and used when compiling care plan. Consultation takes place and as far as possible records are kept in individuals care plan. Individual Care Plans for behavioural modification are compiled for excessive eating and when patients are unable to eat., e.g. – Prader-willi syndrome Food intake sheets are filled out by nursing staff and records are kept in patients care plan. Any changes in eating are reported to nursing staff	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.7 Progress notes are completed daily and care plans reviewed at least monthly. Care plans are completed using information from relevant health care professionals and are discussed with patient / resident and where necessary their representative.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
5.8 A minimum annual formal multi-disciplinary review takes place by local HSC Trust. As far as possible patients and their representatives are encouraged and facilated to participate in all reviews of care and to contribute as far as possible in the ongoing review of care plan Patients are given further opportunity for reviewing outcomes of care through monthly patients meetings and annual questionnaires. Patients representatives are also given opportunity through bi-annual meetings and annual questionnaires. Consultation takes place as far as possible with all patients and patients representatives with all aspects of care. Open door policy to management to give all patients / their representatives every opportunity to discuss any issues relating to their care. 5.9 Minutes of review meetings are recorded and kept in individual patients file. Any required changes in care take place with consultation and agreement with patients and their representatives. Patients and their representatives are kept informed of progress towards agreed goals.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
12.1 Speech & Language Guidelines and Dietician advice in conjunction with Nutritional Guidelines for Adults with Learning Disability in Residential Care are taken into consideration in providing a nutritious and varied diet. This is in evidence in 3-week menu recorded in patient's choice sheets and cooking and reheating records. Individual choice is taken into consideration and is recorded in admission details sheet.Individual patient preferences are kept on white board in kitchen.Care Plans in individual files with guidance provided by relevant professionals are kept in nursing station with copies of reports in kitchen.All food supplement are recorded in Kardex and Thickening Agent usage is recorded on sheet in kitchen 12.3 Two choices are available at all meal times. If patients don't want this an alternative is provided. This is evidenced in menus and patients choice records.Gluten Free diets are offered choice and recorded in patients choice records. Alternatives are always available. Same recorded in Patients Choice file.	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
8.6 Nurses have up to date annual training, knowledge and skills in managing feeding techniques for patients who have swallowing difficulties. 12.5 Breakfast is provided from 7am-11am. Lunch 12.30pm-2pm. Tea 4.45pm-6pm. Supper 8pm. Snacks are provided throughout the day and hot/cold drinks are provided at 11am & 3pm or whenever requested 12.10 Staff are all aware of individual patients care plan and recommendations by Speech & Language Therapist and Dietician. Adequate numbers of staff are present at meals, usually a ratio of 1:5.Kitchen staff have copy of above recommendations, plate guards, place mats, special cups, spoons are available for individual patients. When required referrals are made to Occupational Therapist for aids and equipment. Evidenced in individual Care Plans 11.7 All trained nurses have had relevant training on Wound Care Management in the past 12 months. Nursing staff are aware of relevant wound management guidelines and referral pathways to G.P and other relevant persons e.g Tissue Viability Nurse, Dietitician, Occupational Therapist etc. Advice and guidance is then followed from all of the above. If further training is required it will be provided as required	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

Unannounced Care Inspection

Meadows

4 March 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with Mr Daniel Mc Hugh (registered manager) & Aine Mc Sherry (designated nurse in charge) during the inspection visit.

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

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

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

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

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	19.1	The registered manager should ensure that the continence assessment tool is further developed to include a comprehensive assessment of bowel function / management. This assessment should include; • The patient's normal bowel pattern in regards to frequency of movements and referencing the Bristol Stool Chart Ref: Section 10.0	One	The continence assessment tool has been developed further to include : normal bowel pattern in regards to frequency of movements and refencing the Bristol Stool Chart, through consultation with continence assesment adviser from the Southern Trust.	15 April 2015

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Mr. Daniel James McHugh
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Mr. Daniel James McHugh

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	Sharon Loane	9 April 2015
Further information requested from provider			