Announced Primary Inspection

Name of Establishment:	**St Macartans**
Establishment ID No:	**1538**
Date of Inspection:	**11 August 2014**
Inspector's Name:	**Heather Moore**
Inspection No:	**16511**

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

Name of Home:	St Macartans
Address:	74 Main Street Clogher BT76 0AA
Telephone Number:	028 8554 8250
E mail Address:	stmacartans@btconnect.com
Registered Organisation/ Registered Provider:	Kilmorey Care Ltd Mrs Peggy O'Neill
Registered Manager:	Mrs Veronica McElmurry
Person in Charge of the Home at the time of Inspection:	Mrs Veronica McElmurry
Registered Categories of Care and number of places:	NH-I ,NH-PH ,NH-PH(E), NH-DE (8 patients), NH-LD, NH-LD(E), RC-I, RC-LD, RC-LD(E) 33
Number of Patients Accommodated on Day of Inspection **Scale of charges(per week)**	32 £581.00 Nursing £461.00 Residential
Date and time of this inspection:	11 August 2014: 08.20 hours to 14.40 hours
Date and type of previous inspection:	04 December 2013 Secondary Unannounced

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

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

4.0 Methods/Process

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

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

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

Review of any notifiable events submitted to RQIA since the previous inspection

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

- consultation with patients/residents individually and with others in groups
- discussion with patients/ residents /'relatives/representatives
- observation of care delivery and care practices
- examination of records
- 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	**Six patients/residents individually and with others in groups**
Staff	**10**
Relatives	**2**
Visiting Professionals	**0**

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

Issued To	**Number issued**	**Number returned**
Patients /Residents	**6**	**6**
Relatives / Representatives	**2**	**1**
Staff	**10**	**10**

6.0 Inspection Focus

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

The criteria from the following standards are included;

- Management of Nursing Care – Standard 5
- Management of Wounds and Pressure Ulcers –Standard 11
- Management of Nutritional Needs and Weight Loss – Standard 8 and 12
- Management of Dehydration – Standard 12

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

The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are

safeguarded and actively promoted within the context of services delivered by the home.

The 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

St Macartans is located in the town of Clogher, and provides care for the following categories of care:

Nursing Care

NH (I) - Old age not falling within any other category
NH – LD – Learning Disability
NH-PH - Physical disability (under 65 years)
NH – PH (E) – Physical disability other than sensory impairment
NH-DE (8) Nursing Dementia

Residential Care

RC – Residential care
RC – LD - Learning disability (maximum of 6 service users in the category learning disability)

The home comprises of: nine single and 20 double bedrooms, two sitting rooms, a conservatory, an activity room, two dining rooms, an oratory, a kitchen, a laundry, toilet and washing facilities, staff accommodation and offices over four floors.

The grounds around the home are spacious and well maintained.

This home does not currently provide day care.

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

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (announced) to St Macartans. The inspection was undertaken by Heather Moore on 11 August 2014 from 08.20 hours to 16.40 hours.

The inspector was welcomed into the home by Mrs Veronica McElmurry, Registered Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to the registered manager at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector met with patients, 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 inspection process.

Questionnaires were issued to patients, staff and one relative during the inspection.

The inspector spent a number of extended periods observing staff and patient interaction. Discussions and questionnaires are unlikely to capture the true experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience.

These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool is designed to help evaluate the type and quality of communication which takes place in the nursing home. A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix two.

As a result of the previous inspection conducted on 04 December 2013, one requirement and two recommendations were issued. This requirement and the recommendations were reviewed during this inspection. The inspector evidenced that the requirement and recommendations had been fully complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

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

Standard 8: Nutritional needs of patients are met. (Selected criteria)
Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)
Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria)

8.1 Inspection Findings:

8.1.1 Management of Nursing Care – Standard 5

The inspector can confirm that at the time of the inspection there was evidence to validate that patients receive safe and effective care in St Macartans.

There was evidence of comprehensive and detailed assessment of patient's needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patients' needs was evidenced to inform the care planning process.

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

There was also evidence that the referring HSC Trust maintained appropriate reviews of the patient's satisfaction with the placement in the home and the quality of care delivered.

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

8.1.2 Management of Wounds and Pressure Ulcers –Standard 11 (Selected criteria)

The inspector examined one patient's care record in regard to wound management. There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment.

Care plans for the management of risks of pressure ulcers were maintained to a professional standard.

Inspection of staff training records confirmed that registered nurses were trained in wound management care assistants were also trained in pressure area care.

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

8.1.3 Management of Nutritional Needs and Weight Loss – Standard 8 and 12 (Selected criteria)

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

Robust systems were evidenced with risk assessments and appropriate referrals to GP's, speech and language therapists and or dieticians being made as required. The inspector also observed the serving of the lunch meal and can confirm that the patients were offered a choice of meal and that the meal service was well delivered. Patients were observed to be assisted with dignity and respect throughout the meal.

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

8.1.4 Management of Dehydration – Standard 12 (Selected criteria)

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

Patients were observed to be able to access fluids with ease throughout the inspection, staff were observed offering patients additional fluids throughout the inspection.

Fresh water /various cordials were available to patients in lounges, dining rooms and bedrooms.

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

8.2 Patients / residents their representatives and staff questionnaires

Some comments received from patients:

- "I enjoy the food that I am given."
- "I am very happy here."
- "I have no complaints."
- "I am always given a choice of food and drink."
- "The quality of care I receive here is good."

Some comments received from patients'/ residents' representatives:

- "We have no problems the care here is good, it is a pleasure to visit my sister here. It is like home from home, I am always made so welcome."
- "One relative wrote to the inspector following the inspection and expressed deep appreciation for the high standard of care that was provided."

Some comments received from staff.

- "I feel that the residents receive excellent care and attention, are treated with dignity and respect at all times."
- "I would recommend St Macartans to any member of the public."
- "I have worked here for a long in this home, there is a good standard of care here."
- "I feel the standard of care here is excellent."
- "I enjoy coming to work everyone works well together."
- "There is an excellent manager in the home, the residents are all well looked after and everyone is treated as a person and they are all respected."

8.3 A number of additional areas were also examined

- Records required to be held in the nursing home
- Guardianship
- Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)
- Patient and staff quality of interactions (QUIS)
- Complaints
- Patient finance pre-inspection questionnaire
- NMC declaration
- Staffing and staff comments
- Comments from representatives/relatives
- Environment.

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

Conclusion

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

However areas for improvement are identified. One requirement and one recommendation are made. This requirement and recommendation are addressed throughout the report and in the Quality Improvement plan (QIP).

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

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

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirement	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	27 (2) (b)	The registered person shall ensure that the identified chairs in the day room are replaced.	Discussion with the registered manager and observation during a tour of the environment confirmed that the identified chairs in the day room were replaced.	**Compliant**

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	20.4	It is recommended that the emergency equipment is checked daily (unless otherwise recommended by the manufacturer's instructions).	Inspection of the records of emergency equipment confirmed that the equipment was checked and recorded daily.	**Compliant**
2	20.4	It is recommended that a trolley is used to store the emergency equipment.	It was observed on the day of inspection that a trolley was used to store the emergency equipment.	**Compliant**

11.0 Additional Areas Examined

11.1 Documents required to be held in the Nursing Home

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

- The home's statement of purpose
- The patient's guide
- Sample of reports of unannounced visits to the home under regulation 29
- Sample of staff duty rosters
- Record of complaints
- Sample of incident/accidents
- Record of food provided for patients
- Statement of the procedure to be followed in the event of a fire
- Sample of the minutes of patients/relatives and staff meetings.

11.2 Patients under guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) order 1986.

At the time of the inspection, and living in or using this service was sought as part of this inspection. During the inspection there were no patients in the home who were subject to a guardianship order.

11.3 Human Rights Act 1998 and European Convention on Human Rights (ECHR)
DNSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspector discussed the Human Rights Act and the Human Rights Legislation with the registered manager. The inspector can confirm that copies of these documents were available in the home.

11.4 Quality of interaction schedule (QUIS)

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

The inspector observed the patients' lunch meal which was served in the dining room. The inspector also observed care practices in the main sitting room following the lunch meal.

The observation tool used to record these observations was the Quality of Interaction Schedule (QUIS). This tool uses a simple coding system to record interactions between staff, patients and visitors.

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

A description of the coding categories of the Quality of Interaction Tool is appended to the report at Appendix 2.

The staff were observed seating the patients in preparation for their lunch in an unhurried manner.

The staff explained to the patients their menu choice and provided adequate support and supervision.

Observation of care practices during these periods of observation revealed that staff were respectful in their interactions with the patients.

Overall the periods of observations were positive in regard to the care of patients in the home.

11.5 Complaints

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

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

11.6 Patient Finance Questionnaire

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

11.7 NMC declaration

Prior to the inspection the 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 manager were registered with the NMC.

11.8 Staffing /Staff Comments

Discussion with the registered manager and a number of staff and review of a sample of staff duty rosters evidenced that registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients and residents currently in the home.

Currently there is no deputy manager/lead nurse employed in the home. A recommendation is made that a deputy manager/lead nurse be employed to support the registered manger in the operation and management of the home.

The inspector spoke to 10 staff on the day of inspection, 10 staff completed questionnaires.

Examples of staff comments were for as follows:

- "I feel that the residents receive excellent care and attention, are treated with dignity and respect at all times."
- "I would recommend St Macartans to any member of the public."
- "I have worked here for a long in this home, there is a good standard of care here."
- "I feel the standard of care here is excellent."
- "I enjoy coming to work everyone works well together."
- "There is an excellent manager in the home, the residents are all well looked after and everyone is treated as a person and they are all respected."

11.9 Patients'/Residents Comments

The inspector spoke to six patients individually and with others in groups. Six patients completed questionnaires.

Examples of their comments were as follows:

- "I enjoy the food that I am given."
- "I am very happy here."
- "I have no complaints."
- "I am always given a choice of food and drink."
- "The quality of care I receive here is good."

11.10 Relatives' Comments

The inspector spoke to two relatives and one relative completed a questionnaire. One relative also wrote to the inspector following the inspector and spoke highly of the standard of care in the home.

An example of the relative's comments is:

- We have no problems the care here is good, it is a pleasure to visit my sister here. It is like home from home, I am always made so welcome."

- “One relative wrote to the inspector following the inspection and expressed deep appreciation for the high standard of care that was provided.”

11.11 Environment

The inspector undertook an inspection of the home and viewed a number of patients’ bedrooms, communal facilities, and toilet and bathroom areas.

The premises presented as warm, generally clean and comfortable. However a requirement is made that the corridor carpet leading to the identified bedrooms in the dementia unit is replaced. The carpet in the living / dining room in the dementia unit should also be replaced.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Veronica McElmurry, 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
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Omagh
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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**
All planned admissons to the Home are pre-assessed by either the nurse Manager or a Senior Nurse, using the Roper Logan and Tierney model in conjunction with the information received from the Care Management team. When patient's are admitted a Nurse undertakes an activities of living assessment, based on the pre-assessment tool and information gained from the Patient and their representatives, and the care management team. This is undertaken within 11 days of admission. The only exceptions are where an emergency/out of hours admission has been arranged. The Roper Tierney Logan	Compliant

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

Each patient is allocated a named Nurse who develops a care plan with both the Patient and their representatives to promote independence in conjunction with the disciplinary team. Nursing Staff have access to MDT including TVN's by telephone, email and a formal referral system. The Braden Scale assists Nurses to identify those patients at risk of developing pressure ulcers. A care plan is then developed to minimise risk and promote comfort for the patient.	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**
Review & Reassessment is an ongoing process with each Named Nurse / Keyworker reviewing Risk Assessments & Careplans every calendar month. By doing so this ensures changing are needs are identified, care plans adapted and referrals followed up.	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**
Nurses are accountable to the NMC to keep themselves up to date and to be aware of current research & guidelines. This is enabled as far as possible through training & supervision within the home. Nurse can then use this knowledge in conjuction with advice of multidisciplinary professionals, validated tools to ensure patients care is relevant, holistic and accurately recorded.	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**
Timely, accurate records are maintained for each patient reflecting the agreed outcomes. Meal choices, meals taken or not, and actions planned are recorded. Referrals are made with follow up action taken where appropriate.	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**
Evauluations of care are recorded at least twice in 24 hour cycle by the staff providing the care. Review of a clients changing needs are dealt with at the time, or as soon as possible with outcomes recorded e.g G.P, Referral. All documentation is then reviewed in conjuction with realtives on a calendar month basis by Keyworker / Named Nurse.	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**
All patients and relatives are as involved as possible in the assessment, planning and evaluation process. Named Nurses / Keyworkers meet regularly with relatives regarding aspects of their care, with the Manager also often involved to ensure best practice. Annual reviews with the Trust take place for all patients. Relatives and patients are invited to attend and regularly attend. These Reviews are recorded & careplans are altered accordingly as soon as possible.	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**
Menus are planned to provide as nutritious and varied diet as possible, suitable for every patients needs. MUST assessments, SALT and Dietician referrals are completed promptly with their advice followed. Patients are offered choice and also advised on the best option for them. Training is provided on MUST, SALT, Diabetic, Fluid thickening agents, food fortification diets with Dietician overseeing all menus. Recent training has been put in place regarding menu planning, choices and differences in Stage 1, 2 & 3 diets for kitchen/catering staff and management with the dietician	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**
Nurses have a responsibility to supervise care staff while feeding patients to ensure all plans of care are followed, assistance provided where necessary, Risks are acknowledged, reduced as far as possible, and records maintained. All nursing staff have been provided with an opportunity in 2014 to update their knowledge of skills in wound products and management. In addition Nurses & Care Staff have been provided with training on the interpretation of Braden scores and their comparison with the properties of available pressure relieving devices to enhance patient care.	Compliant

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

Appendix 2

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

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

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

References

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

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

Quality Improvement Plan

Announced Primary Inspection

St Macartans

11 August 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with **Mrs Veronica McElmurry, 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	Requirement	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	27(2)(d)	The registered person shall ensure that the corridor carpet leading to the identified patients bedrooms in the nursing dementia unit are replaced. The carpet in the living/dining room (Dementia unit) should also be replaced.	One	The carpet identified will be replaced week beginning 14th September 2014. The flooring for the Kilmorey Suit (Dementia Unit) is ordered.	Two Months

Recommendations

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

No.	Minimum Standard Reference	Recommendation	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	30.1	It is recommended that a deputy manager /lead nurse is appointed in the home. **Ref: Section 11 point 11.7 (Additional Areas Examined**.)	One	This position is currently being reviewed by the Managing Director and is dependant on the recruitment of nursing staff.	Two Months

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

Name of Registered Manager Completing Qip	Veronica McElmurry
Name of Responsible Person / Identified Responsible Person Approving Qip	Peggy O'Neill Managing Director

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	Heather Moore	12.9.14
Further information requested from provider			