Unannounced Primary Care Inspection

Name of establishment:	**Kingsland Care Centre**
Establishment ID No:	**1669**
Date of inspection:	**3 June 2014**
Inspector's name:	**Carmel McKeegan**
Inspection No:	**16822**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of home:	Kingsland Care Centre
Address:	252 Seacliff Road Bangor BT20 5HT
Telephone number:	028 91273867
E mail address:	michelle.macmillan@larchwoodni.com
Registered organisation/ Registered provider / Responsible individual	Larchwood Care Homes (NI) Ltd Mr Ciaran Henry Sheehan
Registered manager:	Mrs Michelle MacMillan
Person in charge of the home at the time of inspection:	Registered Nurse Sarah Torley
Categories of care:	NH-I ,NH-PH ,NH-PH(E) ,NH-TI
Number of registered places:	43
Number of patients / residents (delete as required) accommodated on day of inspection:	40
Scale of charges (per week):	£581.00
Date and type of previous inspection:	3 October 2013, Primary unannounced inspection
Date and time of inspection:	3 June 2014 10:00am – 4:30pm
Name of inspector:	Carmel McKeegan

2.0 Introduction

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

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

3.0 Purpose of the inspection

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

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

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

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

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

4.0 Methods/Process

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

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

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

- analysis of pre-inspection information
- discussion with the registered nurse in charge and the regional manager for the home, Mr Martin Doran
- observation of care delivery and care practices
- discussion with staff
- examination of records
- consultation with patients individually and with others in groups
- tour of the premises
- evaluation and feedback.

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

5.0 Consultation Process

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

Patients	10
Staff	6
Relatives	5
Visiting Professionals	0

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

Issued To	**Number issued**	**Number returned**
Patients / Residents	4	4
Relatives / Representatives	3	3
Staff	10	8

6.0 Inspection Focus

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

Criteria from the following standards are included;

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

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

The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.

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

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

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

7.0 Profile of service

Kingsland is a purpose built nursing home situated on the outskirts of the seaside town of Bangor. The home commands panoramic views over Ballyholme Bay from bedrooms and lounges situated to the front of the home. There is a small garden and patio area to the side and rear of the home, and adequate car parking is provided. Local amenities and transport services are available close by in the town.

The home is part of the Care Circle Care Homes group. Mrs Michelle Macmillan is the registered manager and has responsibility for managing all aspects of care and services provided for patients.

The nursing home provides accommodation for patients over both floors. There is a range of single and double rooms, some with en-suite facilities. Toilet and bathroom facilities are located throughout the home and are accessible to all communal and bedroom areas. A variety of sitting areas, which are tastefully decorated, are provided throughout the home and these are popular with the patients. Catering, dining and laundry services are all provided within the home.

The home is registered to provide care for a maximum of 43 persons under the following categories of care:

<u>Nursing care</u>

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
PH (E)	physical disability other than sensory impairment over 65 years
TI	terminally ill

8.0 Summary of Inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Kingsland Care Centre. The inspection was undertaken by Carmel McKeegan on 3 June 2014 from 10:00 to 16:30 hours.

The inspector was welcomed into the home by the registered nurse in charge, Sarah Torley, who was available throughout the inspection. Mr Martin Doran, company director arrived into the home mid-morning and was present in the home throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Mr Doran 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 relatives. The inspector observed care practices, examined a selection of records, issued patient, staff and representative questionnaires and carried out a general inspection of the nursing home environment as part of the inspection process.

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

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

As a result of the previous inspection conducted on 3 October 2013. One requirement and four recommendations were issued. These were reviewed during this inspection. The inspector evidenced that the requirement and two recommendations had been fully complied with. One recommendation was assessed as moving towards compliance and one recommendation was not compliant, both recommendations are restated. 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).

Inspection findings

- **Management of nursing care – Standard 5**

Review of three patient's care records confirmed that there was evidence of comprehensive and detailed assessment of patient needs from the date of admission in two patients' records.

One patient's care records did not have a nutritional assessment, continence assessment or bed rail assessment completed at the time of this inspection, nor was the body mapping skin assessment record completed. This patient had been admitted four days prior to this inspection. It is recommended that specific validated assessment tools are completed on the day of admission in order to establish the patient's current needs and base line observations. The specific risk assessments to be completed on the day of admission to the home are outlined in the Providers Guidance for Nursing Homes on RQIA's web site.

Apart from this one patient's care records, the inspector was able to verify in other records reviewed that a variety of risk assessments were also used to supplement the general assessment tool. The assessment of patient need was evidenced to inform the care planning process. Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis plus as required.

It is recommended that any documents from the referring Healthcare Trust are dated and signed when received.

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

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

The inspector evidenced that wound management in the home was well maintained.

There was evidence of appropriate assessment of the risk of development of pressure ulcers which demonstrated timely referral to tissue viability specialist nurses (TVN) for guidance and referral to the HSCT regarding the supply of pressure relieving equipment if appropriate.

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

- **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.

The nurse in charge stated that the nursing home is participating in a Nutritional Research Project being undertaken by the Southern Eastern Health and Social Care Trust, discussion with staff members confirmed that they were very aware of the nutritional needs and preferences of the patients accommodated in the nursing home.

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

The inspector also observed the serving of the lunch time meal and can confirm that patients were offered a choice of meal and that the meal service was well managed and supervised by registered nurses. Patients were observed to be assisted with dignity and respect throughout the meal.

The four weekly menu planner was not on display in the main nursing home. Discussion with the cook revealed that the menu planner was displayed in the kitchen. It is recommended that the current menu planner is dated to show when the menu planner had been reviewed and/or implemented.

The inspector was unable to ascertain the menu on the day of the inspection, as the daily menu was not displayed in either of the two dining rooms. The inspector spoke with several patients in both dining rooms who not aware of the mid-day meal choices available. It is recommended that the daily menu is displayed to inform patients and their relatives of the meals planned for that day.

- **Management of dehydration – Standard 12 (selected criteria)**

The inspector examined the management of dehydration during the inspection which evidenced that fluid requirement and intake details for patients at risk of dehydration was being recorded however improvement is needed. It is recommended that evidence is maintained to validate that the patient's fluid intake is adequate to minimise the risks of dehydration, as follows;

- where risk of dehydration is identified the patient's care plan should state the patient's daily fluid intake target amount
- the patient's daily progress record should provide an effective reconciliation of the patient's actual total fluid intake against the fluid target established, and
- the patient's daily progress record should state the action to be taken if targets were not being achieved.

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

The inspector can confirm that based on the evidence reviewed, presented and observed; that the level of compliance with the standards inspected was compliant.

Patient, representatives and staff questionnaires

Some comments received from patients and their representatives:

"I am a very independent person so need very little help but I couldn't meet nicer staff and treated as a friend".
"I am happy with the care and attention shown by all staff, they are all very kind"
"I am quite happy, I would rather be in my own home, but I know that I would not be safe, the staff are all very kind to me".

Some comments received from staff:

"I am quite satisfied with the care provided to the patients in the Nursing Home and I think the residents are happy too"
"Very homely, neat and tidy, needs are always attended to, friendly staff, spectacular views from all the rooms. If I was older and needed a nursing home, my own wish would be for this one."
"Kingsland is a pleasant home to work in. Care staff work very hard and residents have expressed being very happy living here. Families and residents are very much involved and input and opinions are valued. I have loved working here."

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 and visiting professionals
- environment

A requirement is made that a nurse in charge competency and capability assessment is completed with each nurse delegated responsibility of the nursing home in the absence of the registered manager.

A recommendation is made that the staff duty roster clearly identifies the nurse in charge of the home in the absence of the registered manager.

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

Conclusion

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

The home's general environment was well maintained and patients were observed to be treated with dignity and respect.

One requirement and eight recommendations are made. These recommendations are detailed throughout the report and in the quality improvement plan (QIP).

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

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

9.0 Follow-up on the requirements and recommendations issued as a result of the previous inspection on 3 October 2013.

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1.	20 (1) (a)	It is required that staffing levels are urgently reviewed to ensure that staff are working in such numbers as are appropriate for the health and welfare of the patients.	Review of the staff duty rota for three weeks during verified that staffing provision for this period of time met with the RQIA minimum staffing standards. Discussion with five staff members and review of completed staff questionnaires indicated that staff were satisfied that they had sufficient time to meet the needs of the patients accommodated in the nursing home. This requirement is assessed as compliant.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1.	12.1	It is recommended that the registered person ensures that evidence is maintained to validate that the patient's fluid intake is adequate to minimise the risks of dehydration. Where a patient's care plan states a daily fluid intake target amount, then the patients daily (24hour) fluid intake should be recorded in their daily progress record in order to show that this area of care is being properly monitored.	The inspector reviewed care records of three patients where the patient's care records stated that the patient's fluid intake should be monitored. One patient's daily progress stated the patient's total fluid intake for each 24hour period; the other two daily progress records did not. The inspector was unable to verify that the patient's daily total was correlated with the patient's daily fluid intake target. This recommendation is assessed as moving towards compliance and is restated.	Moving towards compliance
2.	6.4	It is recommended that the registered person ensures that bowel function, reflective of the Bristol Stool Chart, is appropriately recorded in daily progress records.	The inspector reviewed a random sample of five patient's daily progress records and was unable to verify that bowel activity was recorded in each patient's daily progress record on a consistent basis. This recommendation is assessed as not compliant and is restated.	Not compliant

3.	16.1	The Safeguarding Policy should be further developed to include the contact details of all relevant persons for onward referral.	Review of the Safeguarding Policy confirmed that that relevant contact details for onward referral were provided. This recommendation is assessed as compliant.	Compliant
4.	32.1	Staff training material should be removed from the patient's lounge on the ground floor to establish the sole function of the room as a communal lounge for patients use.	The inspector was able to confirm that training materials had been removed from the patient's lounge. This recommendation is assessed as compliant.	Compliant

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

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

There has been one notification to RQIA regarding a safeguarding of vulnerable adults (SOVA) incident since the previous inspection. The incident is being managed in accordance with the regional adult protection policy by the safeguarding team within the South Eastern Health and Social Care Trust.

10.0 Inspection Findings

Section A

Standard 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** **Standard 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission** **Standard 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** **Standard 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.**
Inspection Findings:
Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance. The inspector reviewed three patients' care records which evidenced that patients' individual needs were established on the day of admission to the nursing home through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks. Specific validated assessment tools such as moving and handling, Braden scale, falls, Bristol stool chart and continence were also completed on admission. However the Malnutrition Universal Screening Tool (MUST) was not undertaken for these patients until several days following admission. A recommendation is made that this shortfall be addressed. Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure

ulcer/wound and if required, the specific care plans regarding the management of the pressure ulcer/wound. It is recommended that any documents from the referring health and social care Trust are date and signed when received.

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

The registered nurse in charge demonstrated a good awareness of the patient who required wound management intervention for a wound and the number and progress of patients who were assessed as being at risk of weight loss and dehydration.

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

Section B

Standard 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.**

Standard 11.2

- **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.**

Standard 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.**

Standard 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**

Standard 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.**

The inspector observed that a named nurse and key worker system was operational in the home. The roles and responsibilities of named nurses and key workers were outlined in the patient's guide.

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

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

Review of two patient's care records confirmed that pain assessments were appropriately used for patients with an active pain prescription, and care plans on pain management were in place for these patients.

The nurse in charge informed the inspector that there were two patients in the home who required wound management for wounds. Review of these patient's care records revealed the following;

- A body mapping chart was completed for each patient on admission. This chart was reviewed and updated when any changes occurred to the patient's skin condition.

- A care plan was in place which specified the pressure relieving equipment in place on the patient's bed and also when sitting out of bed.

- The type of mattress in use was based on the outcome of the pressure risk assessment. The specialist mattresses in use were being safely used and records were available to reflect they were appropriately maintained.

- A daily repositioning and skin inspection chart was in place the patients with the wounds and also for patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these charts revealed that patients' skin condition was inspected for evidence of change at each positional change. It was also revealed that patients were repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention. As previously stated the inspector was able to confirm that pain assessment and pain management care plans were undertaken for the patients.

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

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

Review of the records of incidents revealed that the incidence of pressure ulcers, grade 2 and above, were reported to the RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005**.**

A review of a random sample of three patient's care records (separate records from those records referred to in Section A) confirmed that patient's weight had been recorded on admission and on at least a monthly basis or more often if required.

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

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

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

Review of care records for one patient evidenced that the patient was referred for a dietetic assessment in a timely manner. This patient was also referred to the speech and language therapist. The patient's care plan had been reviewed and updated to reflect and address the dietician's and also the speech and language therapist's recommendations.

Discussion with two registered nurses, three care staff and review of completed staff questionnaires revealed that registered nursing staff had attended in wound management and pressure area care and care assistant staff were provided training in pressure area care and prevention.

The registered nurse in charge confirmed that as part of the research programme ongoing in the nursing home, all staff have had awareness training in the management of nutrition. Training records were not reviewed as Mr Doran; company director was conducting an audit of training processes in the nursing home at the time of this inspection. Mr Doran stated he would inform RQIA of the outcome of the audit in terms of compliance of mandatory training requirements.

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

The registered nurses informed the inspector that pressure ulcers were graded using an evidenced based classification system; this was verified by the inspector when reviewing patient's wound management records.

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

Section C

Standard 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 Homes Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**
Review of three patients' care records evidenced that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care including wound care for each patient. Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. Review of one patient's care records in relation to wound care indicated that these care records were reviewed each time the dressing was changed and also when the dressing regime was changed or the condition of the wound had deteriorated. Review of care records also evidenced that nutritional care plans for patients were reviewed monthly or more often as deemed appropriate. The evaluation process included the effectiveness of any prescribed treatments, for example prescribed analgesia. Discussion with the registered nurse in charge and review of governance documents evidenced that a number of care records were audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

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

Section D

Standard 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.**

Standard 11.4

- **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.**

Standard 8.4

- **There are up to date nutritional guidelines that are in use by staff on a daily basis.**

Nursing Homes Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)

As previously stated the inspector examined three patients' care records which evidenced that two patient's care records did not have the MUST assessment completed at the time of this inspection. Mr Doran stated that nursing staff may have assumed that the Community Dietician would complete the MUST as part of the ongoing research project. The MUST is an essential risk assessment that should be completed on the day of admission to the nursing home, in order to establish the patient's specific and immediate nutritional needs. A recommendation is made in this regard.

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

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

Discussion with two registered nurses confirmed that they had a good awareness of these guidelines. Review of patients' care records evidenced that registered nurses implemented and applied this knowledge.

The registered nurse in charge confirmed that wound management was audited monthly by the registered manager. Registered nursing

staff were found to be knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care.

Three care staff consulted could identify patients who required support with eating and drinking and were knowledgeable of patient's individual dietary preferences.

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

Section E

Standard 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.** **Standard 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.** **Standard 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.**
A policy and procedure relating to nursing records management was available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance. Registered nurses spoken with during this inspection were aware of their accountability and responsibility regarding record keeping. Review of three patients' care records revealed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient. These statements reflected wound and nutritional management intervention for patients as required. Entries were noted to be timed and signed with the signature accompanied by the designation of the signatory. Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patients' status or to indicate communication with other professionals/representatives concerning the patients. The inspector reviewed a record of the meals provided for patients. Records were maintained in sufficient detail to enable the inspector to judge that the diet for each patient was satisfactory. The inspector reviewed the care records of three patients identified of being at risk of inadequate or excessive food and fluid intake. This

review confirmed that;

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

As previously stated in Section B the nursing home is participating in a nutritional research project being undertaken by the Southern Eastern Health and Social Care Trust, discussion with staff members confirmed that they were very aware of the nutritional needs and preferences of the patients accommodated in the nursing home.

Review of a sample of fluid balance charts for three patients showed that patients were offered and provided drinks throughout the night time period. There was also evidence that the patient was offered fluids on a regular basis throughout the day.

The fluid intake records reviewed evidenced the following that the total fluid intake for patients over 24 hours was recorded in fluid intake monitoring charts. The inspector was unable to verify the following areas of fluid management and a recommendation is made that;

- an effective reconciliation of the total fluid intake against the fluid target established
- action to be taken if targets were not being achieved
- a record of reconciliation of fluid intake in the daily progress notes

Discussion with staff members confirmed that the Dietician involved in the nutritional research project, has provided advice and guidance in management of nutrition.

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

Section F

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

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

Section G

Standard 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**

Standard 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.**

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

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

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

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

Section H

Standard 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.

Standard 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.

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

The four weekly menu planner was not on display in the main nursing home. Discussion with the cook revealed that the menu planner was displayed in the kitchen.

The cook informed the inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home. It is recommended that the current menu planned is dated to show when the menus had been reviewed and/or implemented.

The inspector was unable to ascertain the menu on the day of the inspection, as the daily menu was not displayed in either of the two dining rooms. The inspector spoke with several patients in both dining rooms who not aware of the mid-day meal choices available. A recommendation is made in this regard.

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

Staff spoken with were knowledgeable regarding the individual dietary needs of patients to include their likes and dislikes. Discussion with

staff and review of the record of the patient's meals confirmed that patients were offered choice prior to their meals.

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

As previously stated under Section D relevant guidance documents were in place.

Review of the records of patients' choices and discussion with a number of patients, registered nurses and care staff it was revealed that choices were available at each meal time. The registered manager confirmed choices were also available to patients who were on therapeutic diets. A recommendation is made that the menu plan be reviewed to include choices for snacks for patients on therapeutic diets.

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

Section I

Standard 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.**

Standard 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.**

Standard 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:**
    - **risks when patients are eating and drinking are managed**
    - **required assistance is provided**
    - **necessary aids and equipment are available for use.**

Standard 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.**

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

Discussion with the cook confirmed that training had been provided by the Southern Eastern Health and Social Care Trust, Community Dietetics department for the catering managers in home participating in the research.

As previously stated, staff training records were not scrutinised as an audit of staff training was ongoing at the time of this inspection. It is recommended that the registered person ensures that all relevant staff receive training in the safe of thickening agents, and care of the patient with swallowing difficulties.

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

Staff consulted confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices

were offered midmorning afternoon and at supper times. The inspector observed the serving of midmorning and mid-afternoon beverages and snacks and was able to confirm that a suitable range of snacks were provided and offered to patients and also those visiting in the nursing home.

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

Both registered nurses spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Five staff consulted could identify patients who required support with eating and drinking. Care staff confirmed that information in regard to each patient's nutritional needs including aids and equipment recommended to be used was communicated to nursing and care staff at shift handover reports.

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

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

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

11.0 Additional Areas Examined

11.1 Records required to be held in the nursing home

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

- the patient's guide
- sample of staff duty rosters
- record of complaints
- sample of incident/accident records
- record of food and fluid provided for patients

These records were found to be maintained in accordance with the regulation and good practice guidance.

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.

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

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

The inspector discussed the Human Rights Act and Human Rights Legislation with the registered nurse in charge. The inspector was able confirm that copies of these documents were available in the home.

The registered nurse in charge demonstrated an awareness of the details outlined in these documents.

Mr Doran confirmed that these documents are being discussed with staff during staff meetings and that staff are made aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patients care and accompanying records.

The inspector also discussed the Deprivation of Liberty Safeguards (DOLs) with registered nurses including the recording of best interest decisions on behalf of patients.

11.4 Quality of interaction schedule (QUIS)

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

The inspector observed the lunch meal being served in the dining room on both floors. The inspector also observed care practices in the main sitting room on the ground floor following the lunch meal.

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

Positive interactions	All positive
Basic care interactions	0
Neutral interactions	0
Negative interactions	0

On the day of the inspection, the inspector observed staff preparing for and serving the mid-day meal. Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely manner.

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

The inspector evidenced that the quality of interactions between staff and patients was generally positive. Staff were polite and courteous when speaking with patients, conversation was relaxed with a natural flow, interactions between staff and patients indicated an environment where patients were respected and patients' needs were given priority.

Staff and relative interactions showed that staff had developed professional relationships with relatives, conversations centred on the patient and any changes in their health and wellbeing since the relative's previous visit.

There were no negative interactions were observed.

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

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.

Mr Doran informed the inspector that lessons learnt from investigations were acted upon.

11.6 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.

11.7 NMC declaration

Prior to the inspection the registered manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC. This was also evidenced by the inspector on the day of inspection.

11.8 Questionnaire findings

Staffing/Staff Comments

Discussion with the registered manager and a number of staff and review of a sample of staff duty rosters evidenced that the registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients currently in the home. It is recommended that the nurse in charge of the home in the absence of the registered manager is clearly identified on the staff duty roster.

On the day of the inspection, the registered nurse in charge stated she had commenced working in the nursing home at the beginning of this year. The inspector requested to review the nurse in charge competency and capability assessment for the nurse, this assessment was not available for the inspector. Mr Doran stated that he would ensure that competency assessments for all nursing staff would be in place within a week. It is required that a nurse in charge competency and capability assessment is completed with each nurse delegated responsibility of the nursing home in the absence of the registered manager.

During the inspection the inspector conversed with the majority of staff. The inspector was able to speak to five staff individually and in private. On the day of inspection seven staff completed questionnaires. The following are examples of staff comments during the inspection and in questionnaires;

"I am quite satisfied with the care provided to the patients in the Nursing Home and I think the residents are happy too"

“Very homely, neat and tidy, needs are always attended to, friendly staff, spectacular views from all the rooms. If I was older and needed a nursing home, my own wish would be for this one.”
“Kingsland is a pleasant home to work in. Care staff work very hard and residents have expressed being very happy living here. Families and residents are very much involved and input and opinions are valued. I have loved working here.”

Patients’ comments

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

The following are examples of patients’ comments made to the inspector and recorded in the returned questionnaires.

“I am a very independent person so need very little help but I couldn’t meet nicer staff and treated as a friend”.
“I am happy with the care and attention shown by all staff, they are all very kind”
“I am quite happy, I would rather be in my own home, but I know that I would not be safe, the staff are all very kind to me”.

Patient Representative/relatives’ comments

During the inspection the inspector spoke with four representatives/relatives/visitors. In addition, on the day of inspection, two representatives/relatives competed and returned questionnaires.

The following are examples of relatives’ comments during inspection and in questionnaires;

“We are always made welcome when we visit, it’s like home from home, we are very happy with the care and everything else”.
“We are not here very long, but first impressions have been good, so we are pleased with everything so far, staff have been very attentive”
“I have no complaints, we, the family are in and out of the home all the time, and we are all happy with the care provided.”

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr Martin Doran, Company Director, 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:

Carmel McKeegan
The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

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 nursing staff employed within the home are familiar with and use the Roper Logan and Tierney method of assessment. All care plans, risk assessments are completed within 72 hours of admission. All staff use the pre admission assessment completed before admission and the admission forms sent by the hospitals. In addition medical history is obtained from the residents doctor.	Compliant

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
On admission to the home a named nurse is assigned to each resident they are responsible for the upkeep of the residents care files, to meet with the residents on a monthly basis to update any changes to care. In addition the named nurse is responsible for ensuring they meet with the resident's families and the resident to complete home care reviews every 3 months to ensure any concerns or changes to care are discussed.	Compliant

If staff are concerned about wounds they are aware of the referral procedure to the tissue viability nurse and are aware of how to complete a detailed wound assessment chart along with detailed care plans and prevention of further deterioration. The home has close involvement with dieticians who see all residents in house or via a virtual ward round. Kingsland has taken part in a study along with the community dieticians which has resulted in both cooks receiving training for food fortification and MUST training for trained staff.	

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All named nurses update their care files on a monthly basis and relevant changes to care are updated accordingly. 3 monthly audits are carried out on all care files by the manager or clinical lead nurses.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All residents before admission receive a full pre assessment and following admission their assessments and all care plans are written and discussed with resident and family following the Roper Logan and Teirny guidelines for holistic care. In addition all nursing staff use the NICE guidelines to assist with ulcer grading and implementation of planned care. Must guidelines are used by staff to assist with nutrition and prevent weight loss.	Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All residents within the home receive a daily choice from the menu, the kitchen staff, nursing and care staff are all aware of any likes, dislikes and any dietary concerns. Records are kept daily of intake and recorded in the diet and nutrition folders. Any residents that are at risk of dehydration remain on a fluid balance chart which is totalled and recorded in nursing notes. All care plans state what diet patient follows and all staff are regularly updated and informed of any changes.	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**
All daily care of residents is recorded in the daily nursing notes. Home care reviews are completed 3 monthly where all care is discussed. Any communication regarding care discussed with relatives, residents or multidisciplinary team is recorded in the relevant sections of the care file.	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**
Residents are all invited to participate in residents meetings quarterly and any concerns are documented. Relatives are also invited to participate in quarterly relatives meetings. Minutes of all meetings are recorded and kept. All residents receive 3 monthly home care reviews where their care is discussed and any concerns are raised and discussed. They also participate in a yearly care review with care management team. Residents and families are always made aware that they can feel comfortable to raise any concerns they have on a daily basi8s to nursing staff or the manager.	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**
All residents receive a daily choice from the menu, any foods they dislike an alternative is given. The kitchen staff, nursing and care staff are all aware of any specialised diets the residents are to follow. Recent training received by the kitchen staff from dietician for food fortification to prevent weight loss.	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**
All staff are trained to deal with residents with specialised diets, swallowing, choke risks and closely liase with the kitchen to ensure guidelines are adhered to. Any changes to care are closely monitored documented and written instructions given to kitchen of any changes.	Compliant

All meals are served at conventional times, jugs of water/juice are available to residents 24 hours a day and are situated in all lounges, communal areas and in all bedrooms. Any changes to a resident's diet is detailed in a care plan and all staff are updated All trained staff are aware of the assessment tools to be used to assess a wound and write a detailed care plan.	

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 Primary Inspection

Kingsland Care Centre

3 June 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Mr Martin Doran, company director, either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	20 (3)	It is required that a nurse in charge competency and capability assessment is completed with each nurse delegated responsibility of the nursing home in the absence of the registered manager. **Ref: Section 11.8**	One	All Nurses who are delegated responsibility of the nursing home in the absence of the registered manager have undertaken an assessment of competency and capability	30 June 2014

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.	12.1	It is recommended that the registered person ensures that evidence is maintained to validate that the patient's fluid intake is adequate to minimise the risks of dehydration. • where the need is identified the patient's care plan should state the patient's daily fluid intake target amount • the patient's daily progress record should provide an effective reconciliation of the total fluid intake against the fluid target established • the patient's daily progress record should state the action to be taken if targets were not being achieved. **Ref: Follow up on previous issues and Section E**	Two	All patient's care plans who have an identified need for the recording of fluid intake target have had their care plans updated and new fluid charts have been introduced to enable easy reconciliation of fluid intake to be recorded in the daily progress record. Actions if required to achieve daily intake targets are reflected in an updated care plan.	From the date of the inspection
2.	6.4	It is recommended that the registered person ensures that bowel function, reflective of the Bristol Stool Chart, is appropriately recorded in daily progress records. **Ref: Follow up on previous issues**	Two	A copy of the Bristol Stool Chart is in each persons individual file to enable staff to appropriately record bowel function.The MUST	From the date of the inspection
3.	8.1	The Malnutrition Universal Screening Tool (MUST) should be undertaken for patients on	One	The MUST sreening tool is now completed on the day of	From the date of the

		the day of admission to the nursing home. **Ref: Section A and D**		admissiosn.	inspection
4	3.4	Any documents from the referring health and social care Trust should be dated and signed when received. **Ref: Section A**	One	All documents from referring Health and Social care Trusts and now signed and dated.	From the date of the inspection
5.	12.4	The daily menu should be displayed in a suitable format and in an appropriate location, so that patients and their representatives know what is available at each mealtime. **Ref: Section H**	One	A new 4 week menu has be prepared and daily menus are displayed on the dining room tables. Patients are also advised by staff on a daily basis of the choices available to them.	30 June 2014
6.	12.12	The four week rotating menu planner should be dated to show when the current menu plan had been reviewed and/or implemented. **Ref: Section H**	One	The four week rotating menu has be revised taking into account seasonalaspects and is to be implemented August 4th 2014.	From the date of the inspection
7.	8.6	All relevant staff should be provided with training in the safe management and care of patients with swallowing difficulties. Training should include the use of thickening agents. **Ref: Section I**	One	Training is being sought for all staff in the safe management of patients with swallowing difficulties and in the use of thickening agents. A number of staff have already attedned seminars.	31 July 2014
8.	30.7	It is recommended that the nurse in charge of the home in the absence of the registered manager is clearly identified on the staff duty roster. **Ref: Section 11.8**	One	The person in charge of the home is indicated by a star next to his/her name on the duty rota.	From the date of the inspection

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person and return to nursing.team@rqia.org.uk

Name of Registered Manager Completing Qip	Annie Frobisher
Name of Responsible Person / Identified Responsible Person Approving Qip	Ciaran Sheehan

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	Linda Thompson	06/08/14
Further information requested from provider			