Announced Primary Inspection

Name of establishment:	**Melmount Manor Care Centre**
RQIA number:	**1744**
Date of inspection:	**13 August 2014**
Inspector's name:	**Loretto Fegan**
Inspection number:	**17143**

Hilltop, Tyrone & Fermanagh Hospital,
Omagh, BT79 0NS

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1.0 General information

Name of Establishment:	Melmount Manor Care Centre
Address:	1 Orchard Road Strabane BT82 9QR
Telephone Number:	(028) 7138 3990
E mail Address:	Annie.frobisher@larchwoodni.com
Registered organisation/ Registered provider / Responsible individual	Larchwood Care Homes (NI) Ltd Mr Ciaran Henry Sheehan
Registered Manager:	Mrs Annie Frobisher
Person in Charge of the Home at the Time of Inspection:	Mrs Annie Frobisher
Categories of Care:	NH-DE, NH-I, NH- PH, RC-DE
Number of Registered Places:	81 including 12 RC-DE
Number of Patients Accommodated on Day of Inspection:	67 – Nursing (Residential unit was not inspected)
Scale of Charges (per week):	£581– Nursing
Date and Type of Previous Inspection:	13 August 2013 Primary Care Announced Inspection
Date and Time of Inspection:	13 August 2014 09.30 – 19.00 hours
Name of Inspector:	Loretto Fegan

2.0 Introduction

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

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

3.0 Purpose of the inspection

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

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

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

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

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

4.0 Methods/process

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

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

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

- Analysis of pre-inspection information
- discussion with the registered manager
- observation of care delivery and care practices

- discussion with staff
- examination of records
- consultation with patients individually and with others in groups
- consultation with relatives
- 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	**17**
Staff	**10**
Relatives	**6**
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	**5 (1 was completed by inspector as part of interview with patient)**	**5**
Relatives / representatives	**5(completed by inspector as part of interview with relatives**	**5**
Staff	**11**	**11**

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

Melmount Manor Care Centre is situated on the Orchard Road, a short distance from the centre of Strabane, Co. Tyrone.

The nursing home is owned and operated by Larchwood Care Homes (NI) Ltd.

Mrs A Frobisher is the registered manager.

The home is a single storey building surrounded by neat gardens.

The home is divided into four units: -

Foyle (General Nursing Unit) 12 single bedrooms
Mourne (General Nursing Unit) 19 single bedrooms
Dennett (Dementia Nursing Unit) 38 single bedrooms
Sperrins Unit (Dementia Residential Unit) 12 single bedrooms

The Sperrins Residential Unit is inspected separately by an inspector from the residential care team of RQIA.

The nursing units comprise bedroom accommodation, sitting and dining areas, a library, patients' designated smoking area and a hairdressing room.

The home has a kitchen, laundry, staff accommodation and offices.

There is adequate car parking facilities at the front of the home.

The home is registered to provide care for a maximum of 81 persons under the following categories of care:

Nursing care

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
DE	dementia care to a maximum of 38 patients accommodated within the dementia unit

Residential care

DE	dementia care to a maximum of 12 residents

8.0 Summary of inspection

This summary provides an overview of the services examined during an announced primary care inspection to Melmount Manor Care Centre. The inspection was undertaken by Loretto Fegan on 13 August 2014 from 09.30 to 19.00 hours.

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.

The inspector was welcomed into the home by Mrs A Frobisher, 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. This self-assessment was received by the Authority prior to the inspection taking place. 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 and relatives; all expressed high levels of satisfaction with the standard of care provided. Staff also commented positively regarding the quality of care and how they are supported in their role. Any comments raised by relatives or staff which required further clarification or included as part of the care planning process were brought to the attention of the registered manager.

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 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. Good relationships were evident between staff and patients and communication demonstrated that patients were treated courteously and with dignity and respect. There was evidence that patients were encouraged to be as independent as possible and appropriate assistance was also provided when required.

There was evidence of a comprehensive and detailed assessment of patient needs which informed the care planning process and care was reviewed on an ongoing basis. However, some issues in relation to care planning were identified and a requirement was made in this regard.

As a result of the previous inspection conducted on 13 August 2013, two requirements and seven recommendations were issued. These were reviewed during this inspection. The inspector evidenced that one requirement and six recommendations had been fully

complied with and a further requirement and recommendation were found to be substantially complied with. One recommendation was assessed as moving towards compliance. 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 received safe and effective care in Melmount Manor Care Home.

Specific aspects of three patients' care records were examined by the inspector. There was evidence of a comprehensive and detailed assessment of patients' needs which was updated on a regular basis. Specific assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, pain and continence were used to supplement the general assessment tool. The assessment of patient need was evidenced to inform the care planning process. Comprehensive reviews of the assessment of need, the risk assessments and the care plans were maintained on a regular basis and as required following evaluation.

However deficits identified included the following:

- The Malnutrition Universal Screening Tool (MUST) in respect of one patient should be recorded on at least a monthly basis; the inspector acknowledges that the patient's weight was recorded
- A record of the base-line "Bristol stool assessment" should be maintained on the current chart in respect of all patients
- The care plan should accurately reflect the type of chair used to nurse one identified patient and also include newly prescribed medication for this patient
- The care plans of residents who wear hearing aids should include the frequency batteries are changed

These identified issues are incorporated into a requirement made pertaining to care records.

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.

COMPLIANCE LEVEL: Substantively compliant

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

Care records indicated that wound management in the home was well maintained. There was evidence of appropriate referral to the tissue viability specialist nurse (TVN) for guidance.

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 and treatment programme. However, it was identified that this needs to include the specific type of pressure reducing / relieving equipment in respect of one patient and the frequency of repositioning in accordance with assessed need in respect of two patients. Two formats of repositioning charts were in use in the home, one agreed format which includes the condition of the skin during each positional change should be used. These identified issues are incorporated into a requirement made pertaining to care records.

COMPLIANCE LEVEL: Substantively compliant

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

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

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

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

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

COMPLIANCE LEVEL: Compliant

8.1.4 Management of dehydration – Standard 12 (selected criteria)

The inspector examined the management of dehydration during the inspection which evidenced that details regarding fluid intake were recorded for those patients assessed at risk of dehydration. However, the records examined did not clearly evidence:

- the required daily fluid intake for each patient
- an effective reconciliation of the total fluid intake against the required target intake

These issues are incorporated into a requirement pertaining to care planning.

Patients were observed to be able to access fluids with ease and 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.

COMPLIANCE LEVEL: Substantively compliant

8.3 Patient, representatives and staff views

Patients, representatives and staff all expressed high levels of satisfaction with the standard of care in the home.

Some comments received from patients and their representatives:
"couldn't be better, very content and happy here"
"food is lovely, staff are very good"
"care is great, very happy with the redecoration"
"activities every day, my relative is very content"

Some comments received from staff:
The quality of care is good here, residents seem happy and are given choice and various activities"
"Excellent care standards, staff morale good"

8.4 A number of additional areas were also examined.

- Records required to be held in the nursing home
- 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 10 of the report.

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. However, a requirement was made regarding training and care records. A recommendation was also made with regard to further developing the home's record management policy.

There was evidence of an ongoing re-decoration and refurbishment programme to enhance the home's general environment and the home was maintained to an acceptable standard of hygiene. However, a requirement is made with regard to including all areas of the home in the re-decoration and refurbishment programme.

Therefore, three requirements and one recommendation are made as a result of this inspection together with one restated requirement and recommendation. These requirements and recommendations are detailed throughout the report and in the quality improvement plan (QIP).

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

9.0 Follow-up on the requirements and recommendations issued as a result of the previous inspection on 13 August 2013

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	30 (1) (d)	The registered person shall give notice to the Regulation and Improvement Authority without delay of the occurrence of any event in the nursing home which adversely affects the wellbeing or safety of any patient.	The inspector examined a sample of incident / accident records documented in the home. It was identified that notice should have been given to RQIA in accordance with legislation in respect of two of the records examined. This requirement will be stated for a second time and compliance followed up during the next care inspection.	Substantially compliant
2	27 (2)	(b) The registered person shall having regard to the number and needs of patients, ensure that the premises to be used at the nursing home are of sound construction and kept in a good state of repair externally and internally. (d) All parts of the nursing home are kept clean and reasonably decorated. An action plan outlining the works to be undertaken with timescales for completion should be forwarded to the Omagh office of RQIA.	The inspector undertook a tour of the premises and found that the nursing home was cleaned to an acceptable standard. There was evidence of an on-going redecoration and refurbishment programme taking place. Issues identified in relation to the floor covering in the corridor and bedrooms of the dementia nursing unit during the inspection on 13 August 2013 were addressed. There was also evidence that new armchairs were purchased and relatives commented positively in relation to the painting / decorating that took place in the Dennett Unit. The registered manager advised that the redecoration and refurbishment programme is ongoing. Additional environmental issues were	Compliant

			identified by the inspector as cited in section 10 and a separate requirement has been made in this regard.	

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	25.12	It is recommended that details contained in reports of visits undertaken under Regulation 29 be formally discussed during staff meetings /forums.	Six staff confirmed that details contained in reports of visits undertaken under Regulation 29 are formally discussed during staff meetings /forums.	Compliant
2	5.3	It is recommended that the identified patient be repositioned in bed in accordance with the instructions outlined in their care plan.	The inspector cross referenced the care plans with the repositioning charts in relation to three patients who were at risk of developing pressure ulcers. Two of the three care plans examined did not record the frequency that the patient was to be repositioned while in bed. This recommendation has been incorporated into a requirement made in relation to care planning.	Substantially compliant
3	6.2	It is recommended that all entries in care records be dated, timed and signed with the signature accompanied by the designation of the signatory.	A random sample of entries in the care records of three patients evidenced that they were dated, timed and signed with the signature accompanied by the designation of the signatory.	Compliant
4	1.1	It is recommended that systems are put in place for the appropriate labelling of patients clothing	The registered manager and the laundry assistant confirmed the arrangements in place for the labelling of patients' clothing. A random sample of clothing was selected in the laundry and the inspector can confirm that they were appropriately labelled.	Compliant

5	12	It is recommended that the home's menu planner be reviewed and updated in consultation with the patients, their representatives and staff in the home. Patients in the dementia nursing unit should be offered choice for their meals, preferably at the point of service. The menu planner should be adhered to with variations recorded	The registered manager and cook confirmed that the home's menu planner was reviewed and updated in consultation with the patients, their representatives and staff in the home. The inspector viewed the four weekly spring / summer menu plan and cross referenced this with a sample of records of food served. This evidenced that the menu planner was adhered to. The inspector observed the serving of the lunch-time meal in the dementia nursing unit and can confirm that patients were offered a choice of meal.	Compliant
6	E10	It is recommended that one way privacy film be provided on the outside of the patients' bedroom windows to enhance privacy .A suitable alternative may also be considered.	The registered manager advised that a one way privacy film has not been provided on the outside of the patients' bedroom windows. However, Mrs Frobisher stated that as part of the ongoing refurbishment programme that voiles will be put in place instead. This recommendation will be stated for a second time and compliance followed up during the next care inspection.	Moving towards compliance
7	E5	It is recommended that the grounds outside the dementia unit be landscaped.	The inspector can confirm that work has taken place to the grounds outside the dementia unit which has improved the appearance.	Compliant

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

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

There were no outstanding issues regarding safeguarding of vulnerable adults (SOVA) incidents or complaints on the day of inspection.

10.0 Additional areas examined

10.1 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.

A policy relating to nursing records management was available in the home. This requires further development to fully reflect relevant legislation, standards and professional guidance. A recommendation made in this regard was discussed with the registered manager.

10.2 Patients/residents under guardianship

The registered manager confirmed that there were no patients subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) Order 1986 accommodated in the home at the time of the inspection.

10.3 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 manager, three registered nurses and three care assistants. The registered manager and registered nurses demonstrated an awareness of the details outlined in these documents and all care staff spoken with demonstrated an awareness of the practical application of the legislation commensurate with their role.

The inspector can confirm that copies of these documents were available in the home. The registered manager informed the inspector that staff were made aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patients care and accompanying records through training provided.

The inspector also discussed the Deprivation of Liberty Safeguards (DOLs) with the registered manager and registered nurses including the recording of best interest decisions on behalf of patients. A copy of DOLS was also available in the home.

10.4 Quality of interaction schedule (QUIS)

The inspector undertook a period of observation in the home observing the lunch meal being served in the dining room which lasted for approximately thirty minutes. Care practices were also observed by the inspector while undertaking a tour of the home.

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	29
Basic care interactions	
Neutral interactions	
Negative interactions	

The inspector evidenced that the quality of interactions between staff and patients were positive.

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

10.5 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 one complaint was received by the home in the past year.

The inspector reviewed the complaints records. The registered manager confirmed that only one complaint was received since the last care inspection.

10.6 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 and further clarification provided by the registered manager on the day of inspection indicated that patients' monies were being managed in accordance with legislation and best practice guidance.

10.7 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.

10.8 Questionnaire findings

10.8.1 Staffing/staff comments

Discussion with the registered manager and a number of staff 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.

Staff were provided with a variety of relevant training including mandatory training since the previous inspection. However, further to discussion with staff and review of the record of training, discussion took place with the registered manager regarding the provision of further training / updates in relation to the following:

- record keeping (all staff commensurate with role)
- dysphagia (all staff commensurate with role)
- management of nutrition (all staff commensurate with role)
- Prevention of pressure ulcers (care staff)
- Wound care (registered nurses)

A requirement is made in this regard.

During the inspection, the inspector spoke with ten staff and eleven staff completed questionnaires. Registered nurses and care staff spoken with and observed while undertaking care practices demonstrated a good awareness of patients' individual needs and how their human rights are safeguarded and actively promoted within the context of services delivered by the home.

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

"The quality of care is good here, residents seem happy and are given choice and various activities"
" I enjoy working in Melmount Manor and I feel the level of care is excellent"
"Excellent care standards, staff morale good"
"Quality of care is excellent"
"I enjoy my work"
"Staff spend time with the residents on a 1-1 basis even though this is a busy unit. It is nice to see that the home has moved on as regards training and other areas"
"An excellent manager who is supportive in all areas"

One registered nurse felt that the size and geographical layout of the dementia unit was not conducive to the management of patients with dementia. This comment was discussed with the registered manager who advised that the company are currently reviewing the layout of the unit to promote a more person centred environment.

10.8.2 Patients' comments

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

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

"It is like a holiday home, all is 100%"
"very happy"
"couldn't be better, very content and happy here"
"food is lovely, staff are very good, very polite"
"staff all excellent, food very good"

Patients who were unable to verbally express their views were observed to be well groomed, appropriately dressed and appeared relaxed and comfortable in their surroundings.

10.8.3 Patient representative/relatives' comments

During the inspection the inspector spoke with seven representatives / relatives / visitors using the questionnaire framework to ascertain their views. The following are examples of relatives' comments during inspection;

" excellent care, manager and every one of the staff are lovely and friendly"
"very clean , no smells"
"family are invited to the entertainment and parties"
"care is great, very happy with the redecoration"
"activities every day, my relative is very content"
"staff fantastic and go out of their way to help"

One relative mentioned that they would like the opportunity to review their relative's food preferences, and another relative made reference to a specific aspect of personal hygiene they wish to be monitored more closely. These comments were discussed with the registered manager who agreed that they would be incorporated into the care planning process.

A relative also mentioned that more chairs are needed for visitors while in the sitting room, this was brought to the registered manager's attention who advised the inspector that additional chairs were on order.

10.8.4 Environment

The inspector undertook a general inspection of the home which included viewing 38 bedrooms, communal sitting and dining areas and bathroom / toilet facilities. There was evidence of an extensive ongoing refurbishment and redecoration programme which mainly focused on the Dennett Suite. It was agreed that the following would also be addressed:

- Staining of floor around toilet bowl and malodour in en-suite bedroom in Dennett suite
- Toilet bowl and flooring needs replaced in one communal toilet (mal-odour present) in Dennett unit
- Furnishings in smoking room need replaced. This room also needs painted.
- Pillows not suitable for use need to be replaced throughout the home.

- Damage to doors and architraves needs repaired and redecorated (Mourne and Foyle)
- Some armchairs need replaced as fabric very worn (Mourne and Foyle)

A requirement is made in this regard.

11.0 Quality improvement plan

The details of the quality improvement plan appended to this report were discussed with Mrs A Frobisher, 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:

Loretto Fegan
The Regulation and Quality Improvement Authority
Hilltop
Tyrone and Fermanagh Hospital
Omagh
Co Tyrone
BT70 0NS

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**
Prior to admission each patient is assessed by a nurse using validated assessment tools recording all the information and in conjuction with the information received from the care manangement team draws up a care plan to meet the immediate care needs of the patient as per company policy and minimum standards of the RQIA. Over the period of the first 11 days from admission a holistic assessment is carried out using as per policy and RQIA minimum standards using validated assessment tools. The MUST nurtrition screening tool is used to assess any nutritional needs or risks.The Baden scale assessment is used to assess any pressure care needs or risks along side this are assessments of continience needs,nutritional needs, pain assessment (the abbey pain assessment and Dis Dat assessments) are used as appropriate where possible prior to admission as well,in order to have the appropriate pressure reliving equipment in place. In the event of an ulcer we use the EPUAP grading tool and Nice guidelines (2005) Wound assessments are ongoing and any changes are recorded on a daily basis or when dressings are changed as directed by the careplan.	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**
A named nusre is responsible for discussing, planning and agreeing nursing interventions to meet the indentified assessed needs with the individual patients' and their representatives. Each nursing care plan clearly demonstrates the promotion of maximum independence and rehabilatation according to each individuals optimum level. Where appropriate the nurse takes into account the recommendations from relevant health professionals. There are in place referral arrangements to obtain advice and support from the Tissue Viability Nurse when required.	Compliant

Where it is identified that a patient is "at risk" of developing pressure ulcers, a documented pressure ulcer prevention and treartment programme that meets that individuals needs and comfort is drawn up in conjuction with the relevant professions. Within the home there are referral arrangements to relevent professionals who have the knowlegde and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration. There are referral arrangements within the home for the dietician to assess the needs of individual patient's nutritional requirements and draw up a nutritional treatment plan, each nutritional plan is developed taking into account the reccommendations from the dietician and these plans are ahered to. GPs will prescribe suppliments if it is likely they are required while waiting for the Dieticians consultation and directions.	

<table>
<tr><th colspan="2">Section C</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>Re-assessment is a continuous process that is carried out daily and at identified agreed time intervals as recorded in the patients' nursing care plan.</td><td>Compliant</td></tr>
</table>

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All nursing interventions, activities and procedures are supported by research,NMC guidelines, RQIA guidance, national and local trust standards and other professional bodies. The adapted EPUAP grading tool is used to screen patients who have skin damage and with the advice/recommendations of the TVN where appropriate an appropriate treatment plan is implemented. The most recent nutrional guidelines are used by staff on a daily basis.	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
Contemporaneous nursing records, in accordance with NMC guidelines and home policies, are kept of all nursing interventions, activities and procedures that are carried out for each patient including the octcome for the patient are kept. Individual records are kept of the meals provided to each individual patient in sufficient detail to enable any person inspecting it to establish wheter the diet is a satisfactory diet for each patient. Where a patient's care plan requires or when a patient is unable to, or chooses not eat a meal, a record is kept of the food or fluids that patient did consume. Where a patient is eating excessively a record is kept of all food and fluids consumed. Any changes in the intake of food or fluid is brought to the attention of the nurse in charge in order they can discuss this with the patient where appropriate and make a referral to the appropriate health professional which may be the GP the diettician or both.Detailed records are kept of any such referrals and the recommendations made and actions. taken.	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**
The outcome of care delivered is monitored on a daily basis and is subject to to additional documented review at an agreed interval and evaluations using benchmarks where appropriate. This involves the patient or their representative where ever possible.Care delivered is also reviewed as part of the care management of patient's with their care manager and representative and other professionals as appropriate.	Compliant

<table>
<tr><th colspan="2">Section G</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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)</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>Patient's are encouraged and faciltated to participate in all aspects of reviewing the outcomes of their care and to attend and or contribute to formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.
The outcomes of all reviews are subject to minutes and are recorded, including any changes that have be made to the nursing care plan with the agreement of the patient and representative.Patients and representatives are regularily updated on progress made.</td><td>Provider to complete</td></tr>
</table>

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Patients are provided with a nutritious, varied and seasonal diet which meets their individual and recorded dietary needs and preferences.Full account is taken of the most recent relevant documents/guidance provided by dieticians,and other professionals and disciplines. The menu either offers patients a choice of meal at each meal time and if this is not to their liking an alternative will be provided. The same provision is made for patients' on theraputic or specific diets. Meals can be made available at any time of the day to accommodate patients' outings or appointments. Snacks and drinks are available at all times including throughout the night.	Compliant

<table>
<tr><th colspan="2">Section I</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>All nurses in the home have up to date skills and knowlegde in the managing feeding techniques for patients who have swallowing difficulties, and ensuring that instructions drawn up by the speech and language therapist are adhered to.
Meals in the home are served at conventional time, hot and cold drinks and snacks are served at customary intervals and are available at all times as is fresh drinking water.
Staff are aware of any matters concerning patients' eating and drinking needs as detailed in each individual care plan and there</td><td>Compliant</td></tr>
</table>

are adequate numbers of staff available when meals are being served to ensure risks when patients are eating and drinking are mananged, to ensure assisstance is provided as care planned ans that all necessary aids and equipment are available for use. Where a patient requires wound care, nurses have the expertise aand skills in wound care management that includes the ability to carry out a wound assessment and apply wound care products and dressings. The nurses' have the confidence of the TVN and the local GPs in providing excellent care.	

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	**COMPLIANCE LEVEL**
	Provider to complete

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

Primary Announced Inspection

Melmount Manor Care Centre

13 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 A Frobisher, registered manager either during or after the inspection visit.

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

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

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

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

Statutory Requirements **This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on the HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and the Nursing Homes Regulations (NI) 2005**					
No.	**Regulation Reference**	**Requirements**	**Number of Times Stated**	**Details Of Action Taken By Registered Person(S)**	**Timescale**
1	30 (1) (d)	The registered person shall give notice to the Regulation and Improvement Authority without delay of the occurrence of any event in the nursing home which adversely affects the wellbeing or safety of any patient. **Ref: Section 9, Follow up on previous issue**	Two	All staff responsible for sending notification to the RQIA have been directed to so in a timely manner.	From the date of previous inspection
2	16 (2) (b)	The registered person must ensure that the patient's nursing care plan is kept under review **Ref: Section 8.1.1, 8.1.2, 8.1.4 & 10.8.3**	One	There is now in place a robust audit programme for patients care plans.	From the date of inspection
3	27 (2) (b& d)	The registered person shall having regard to the number and needs of patients, ensure that the premises to be used at the nursing home are of sound construction and kept in a good state of repair externally and internally. All parts of the nursing home are kept clean and reasonably decorated. **Ref: Section 10.8.1**	One	The rolling programme of refurbishment and decoration of the home continues and includes the areas referred to in the report.	By 31 December 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		It is recommended that one way privacy film be provided on the outside of the patients' bedroom windows to enhance privacy .A suitable alternative may also be considered. **Ref: Section 9, Follow up on previous issue**	Two	Windows have been measured and blinds ordered to address the issue of privacy in the bedrooms.	30 Nov 2014
2	26.1 & 26.2	It is recommended that the nursing records management policy is further developed to fully reflect relevant legislation, standards and professional guidance. **Ref: Section 10.1**	One	The policy is under review by the Bussiness support Manager and the nurse consultant.	30 September 2014

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	L Fegan	17/10/14
Further information requested from provider			