Announced Primary Inspection

Name of Establishment:	**Lough Neagh**
Establishment ID No:	**1757**
Date of Inspection:	**28 July 2014**
Inspector's Name:	**Heather Moore**
Inspection No:	**16509**

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

Name of Home:	Lough Neagh
Address:	23 Maghery Road Portadown BT62 1SZ
Telephone Number:	028 3885 2600
E mail Address:	loughneaghnursinghome@hotmail.co.uk
Registered Organisation/ Registered Provider:	Mr Cathal & Mrs Marie Quinn
Registered Manager:	Mrs Bernadette Burke
Person in Charge of the Home at the time of Inspection:	Mrs Bernadette Burke
Registered Categories of Care and number of places:	NH-DE NH-I NH-LD RC-PH 26
Number of Patients/Residents Accommodated on Day of Inspection **Scale of charges(per week)**	24-Patients 2- Residents £581.00 Nursing £461.00 Residential
Date and time of this inspection:	28 July 2014: 08.15 hours-14.45 hours
Date and type of previous inspection:	11 December 2013 Secondary Unannounced

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

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

4.0 Methods/Process

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

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

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

- Review of any notifiable events submitted to RQIA since the previous inspection
- Analysis of pre-inspection information

- Discussion with the registered manager
- Examination of records
- Consultation with patients/residents individually and with others in groups.
- Consultation with patient's relatives/representatives.
- Observation of care practices and care delivery
- Tour of the premises
- Evaluation and feedback.

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

5.0 Consultation Process

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

Patients/residents	**6**
Staff	**8**
Relatives	**2**
Visiting Professionals	**0**

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

Issued To	**Number issued**	**Number returned**
Patients /residents	**8**	**8**
Relatives / Representatives	**1**	**1**
Staff	**8**	**8**

6.0 Inspection Focus

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

The criteria from the following standards are included;

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

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

The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.
The table below sets out the definitions that RQIA has used to categorise the service's performance:

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

7.0 Profile of Service

Lough Neagh was initially registered by the current owners in 1995. The nursing home is owned and operated by Mr Cathal and Mrs Quinn. Mrs Bernadette Burke is currently the registered manager.

The home is registered to provide nursing care in the old and infirm, learning disability, dementia nursing and physical disability categories of care. The home is also registered to provide residential care for two residents.

The facility is located in Milltown on the outskirts of Maghery overlooking Lough Neagh. The home comprises of 20 single and three double bedrooms, a sitting/dining room (ground floor), two sitting rooms and a dining room (first floor), a kitchen, laundry, toilet/washing facilities, staff accommodation and offices.

The grounds around the home are landscaped and there is an enclosed garden outside the Dementia Unit, which is commendable.

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

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

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (announced) to Lough Neagh. The inspection was undertaken by Heather Moore on 28 July 2014 from 08.15 hours to 14.45 hours.

The inspector was welcomed into the home by Mrs Bernadette Burke, Registered Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection were given to the registered manager, Ms Eileen Quinn Senior Manager and Mrs Quinn Registered Provider 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 by the RQIA. 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, residents, staff and two visiting relatives. The inspector observed care practices, examined a selection of records and carried out a general inspection of the nursing home environment as part of the inspection process.

Questionnaires were issued to patients, staff and relatives during the inspection. 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 is designed to help evaluate the type and quality of communication which takes place in the nursing home. A description of the coding categories of the Quality of Interaction Tool is appended to the report at Appendix Two.

As a result of the previous inspection conducted on 11 December 2013, two recommendations were issued. These recommendations were reviewed during the inspection. The inspector evidenced that the two recommendations had been fully complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

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

Standard 8: Nutritional needs of patients are met. (Selected criteria)

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

8.1 Inspection Findings

8.1.1 Management of Nursing Care – Standard 5

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

There was evidence of comprehensive and detailed assessment of patient's needs from date of admission. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patients' needs was evidenced to inform the care planning process. Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis plus as required.

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

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

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

On the day of inspection there were no patients in the home with wounds/pressure ulcers. There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment. Care plans for the management of risks of pressure ulcers were maintained to a professional standard.

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

8.1.3 Management of Nutritional Needs, Weight Loss and Dehydration 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 GPs, speech and language therapists and/or dieticians being made as required. The inspector also observed the serving of the lunch meal and can confirm that the patients were offered a choice of meal and that the meal service was well delivered. Patients were observed to be assisted with dignity and respect throughout the meal.

The inspector also examined the management of dehydration during the inspection. The home was evidenced to identify fluid requirements for patients and records were maintained of the fluid intake of those patients assessed at risk of dehydration.

However inspection of one identified patient's care record confirmed that the patient's daily fluid target was not discussed nor recorded in the patient's care plan. A recommendation is made in this regard.

Patients were observed to be able to access fluids with ease throughout the inspection.

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

8.2 Patients, their representatives and staff questionnaires

Some comments received from patients and their representatives;

- "I am always offered a choice of food and drink."
- "I am happy here."
- "I always have access to my buzzer."
- "I have no complaints."
- "I am able to get pain relief when I need it."

- "It is a great relief to know that my daughter is so well looked after, my wife and I will always be eternally grateful to the management and to all the staff."

Some comments received from staff;

- "The quality of care in the home is very good and staff treat the patients very well."
- "In my opinion the staff here are all very caring."
- "I enjoy working here and caring for the patients."
- "I like to see the patients enjoying their meals."
- "I feel that we provide a high quality of care to each of our patients."
- "I think the home is a good quality nursing home and I would recommend this home to my family and friends."

8.3 A number of additional areas were also examined;

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

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

Conclusion

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

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

One recommendation is made. This recommendation is addressed in the report and in the quality improvement plan. (QIP)

The inspector would like to thank the patients, residents, registered providers, senior manager, registered manager, the visiting relatives, 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.

10.0 Inspection Findings

10.1 Nursing Care - Standard 5

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' /residents' individual needs were established on the day of admission to the nursing home through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks. 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. Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, pain, infection control, Bristol stool chart and continence were also completed on admission. Review of three patients' care records evidenced that a comprehensive holistic assessment of the patient's and residents' care needs were completed within11 days of patient's admission to the home. Review of three patients' care records and discussion with patients and two visiting relatives evidenced that patients/residents as appropriate and their representatives were involved in discussions regarding the agreeing and planning of nursing interventions. Records also evedenced discussion with patients and or their representatives following changes to plans of care. This is in keeping with the DHSSPS Minimum Standards and the Human Rights Act 1998. Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. A policy and procedure relating to nursing records management was available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

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

Review of three patients' care records revealed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient. These statements reflected nutritional management intervention for patients as required. Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patients' status or to indicate communication with other professionals/representatives concerning the patients. Entries were noted to be timed and signed with the signature accompanied by the designation of the signatory.

Prior to the inspection a patient's 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 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.

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

10.2 Management of Wounds and Pressure Ulcers- Standard 11

Inspection Findings:

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

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

Discussion with the registered manager and registered nurse 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 manager informed the inspector that there were currently no patients in the home who required wound management for wounds/pressure ulcers. The inspector reviewed two patients' care records who were assessed as being at risk of developing pressure ulcers/wounds:

- Body mapping charts were completed for these patients on admission. These charts were reviewed and updated when any changes occurred to the patients' skin condition
- Care plans were in place which specified the pressure relieving equipment in place on the patients' beds and also when sitting out of bed
- The type of mattresses in use was based on the outcome of the pressure risk assessments. The specialist mattresses in use were being safely used and the registered manager informed the inspector that these mattresses were serviced on an annual or more often basis
- A daily repositioning and skin inspection chart was in place for one of these patients. This chart was recorded appropriately.

The registered manager and registered nurse 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 the registered nurse evidenced that they were knowledgeable of the action to take to meet the patient's needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

The patients' weights were recorded on admission and on at least a monthly basis or more often if required.

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

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 nurse was 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.

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

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.

Discussion with the registered manager, registered nurse, care staff and review of the staff training records revealed that staff were trained in wound management and pressure area care and prevention.

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

10.3 Management of Nutritional Needs, Weight Loss and Dehydration- Standard 8 &12

Inspection Findings:

The inspector confirmed the guidance documents were available in the home;

- The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.

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

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

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

Review of a sample of fluid balance charts confirmed that these charts were recorded appropriately, however inspection of one identified patient's care plan confirmed that the patient's fluid target was not recorded and information pertaining to the action to be taken if the patient's daily fluid target was not achieved was not recorded in the care plan. A recommendation is made in this regard.

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

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

There was a four weekly menu planner in place. The registered manager informed the inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home. The current menu planner was implemented on 01 April 2014. 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 patients' meals confirmed that patients were offered choice prior to their meals.

Policies and procedures were in place for staff on making referrals to the dietician and other relevant professionals including the speech and language therapist (SALT). These included indicators of the action to be taken and by whom.

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

Review of two patients' care records evidenced that these patients were referred for dietetic assessments in a timely manner. The patients' care plans on eating and drinking addressed the dietician's instructions. Review of one patient's care records revealed that this patient was referred to a speech and language therapist and this professional's recommendations were addressed in the patient's care plan on eating and drinking.

The inspector discussed the needs of the patients with the registered manager. It was determined that a number of patients had swallowing difficulties. There were two patients in the home who had enteral feeding systems in place.

Discussion with the registered manager, a number of staff and review of the staff training records revealed that staff knowledge and skills in the following areas require to be updated:

- Nutritional awareness
- Preparation and presentation of pureed meals
- Fortification of foods
- Dysphagia awareness
- Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes
- Enteral feeding systems including the use of specific pump equipment.

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

The registered manager confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and

choices were offered midmorning afternoon and at supper times.

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

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

On the day of the inspection, the inspector observed the lunch meal. Observation confirmed that meals were served promptly and assistance required by patients 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.

11.0 Additional Areas Examined

11.1 Documents required to be held in the Nursing Home

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

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

11.2 Patients under guardianship

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

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

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

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

11.4 Quality of interaction schedule (QUIS)

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

The inspector observed the patients' lunch meal which was served in the dining rooms.

The observation tool used to record these observations uses a simple coding system to record interactions between staff, patients and visitors.

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

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

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

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

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

Overall the periods of observations were positive.

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 there were no complaints recorded since the previous inspection.

11.6 Patient Finance Questionnaire

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

11.7 NMC declaration

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

The evidence provided in the returned proforma indicated that all nurses, including the manager were registered with the NMC.

11.8 Staffing /Staff Comments/Staff Training

On the day of inspection registered nurses and care staff, staffing levels were satisfactory however the inspector examined a sample of staff duty rosters from the previous weeks.

Inspection confirmed that registered nurses and care staff, staffing levels for day and night duty were in accordance with the RQIA's recommended minimum staffing guidelines however examination of registered nurses staffing levels.

Examples of staff comments were for as follows:

- “The quality of care in the home is very good and staff treat the patients very well.”
- “In my opinion the staff here are all very caring.”
- “I enjoy working here and caring for the patients.”
- “I like to see the patients enjoying their meals.”
- “I feel that we provide a high quality of care to each of our patients.”
- “I think the home is a good quality nursing home and I would recommend this home to my family and friends.”

11.9 Patients’ Comments

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

Examples of their comments were as follows:

- “I am always offered a choice of food and drink.”
- “I am happy here.”
- “I always have access to my buzzer.”
- “I have no complaints.”
- “I am able to get pain relief when I need it.”
- “It is a great relief to know that my daughter is so well looked after, my wife and I will always be eternally grateful to the management and to all the staff.”

11.10 Relatives’ Comments

The inspector spoke to two relatives and one relative completed a questionnaire.

An example of the relative’s comments is:

- “We cannot speak highly enough of the standard of care in the home, we will be eternally grateful to the management and staff for the care that is provided to our relative.”

11.11 Environment

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

The premises presented as warm, generally clean and comfortable.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Bernadette Burke Registered Manager, Ms Eileen Quinn Senior Manager, and Mrs Marie Quinn Registered Provider as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

Heather Moore
The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
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**
The Nurse Manager or Senior Manager carries out a preadmission assessment on all patients prior to admission to the Lough Neagh Private Nursing Home. Information received from the care management team informs this assessment. This initial assessment of need uses the Roper, Logan and Tierney model of nursing care, and validated assessment tools such as MUST tool and Braden scale. The patient's holistic assessment of needs is completed within 11 days using validated assessment tools.	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 nurse discusses, plans and agrees on a plan of care to meet the patient's care needs. This assessment of need reflects promotion of maximum independence and evidence based best practice. Patient's who are at risk of	Compliant

developing pressure ulcers are asssessed using validated tools in the assessment, prevention and treatment of pressure ulcers and in the promotion of comfort. Referrals where indicated using validated assessment and screening tools are made to the TVN and professional advice is reflected in the care plan. The MUST tool is used to assess patients at risk of nutritional impairment and referrals where indicated are made to the GP and dietician. A care plan is then developed and reviewed that takes into account the advice of the multi-disciplinary healthcare professionals.	
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**
Care plans are reviewed by the named nurse at least monthly and where there are changes in the patient's care needs. The care plans are audited monthly by the Nurse Manager.	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**
Evidence based nursing practice is used within the home. This practice is informed by guidelines published by, for example NICE, GAIN, DHSS, RQIA, RCN and relevant local and regional policies and guidelines. Staff have access to current published guidelines including up to date nutritional guidelines. A validated pressure ulcer screening tool is used to screen patient's who have skin damage. Staff are trained in wound care awareness and in the prevention and treatment of pressure ulcers. Lough Neagh Nursing Home participates in quality improvement programmes which include SHSCT Care Home Managers meetings and the Nursing Home Quality and Safety Collaborative in promoting excellence in care. Monthly audits are used to collect patient skin care data.	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**
Daily records and outcomes are kept of all interventions, activities and procedures as carried out on patients. A detailed record is kept of the meals provided for each patient. And, where indicated by a patient's needs, a record is kept of all food and fluids consumed. Dietician referrals are made as indicated by the patient's needs and the care plan is updated.	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**
Roper, Logan and Tierney model of nursing care is used within Lough Neagh Nursing Home. Care plans are reviewed at least monthly and where there are changes. Benchmarks in care, as appropriate are used with the involvement of	Compliant

patients and or their representatives. All patients are care managed and reviewed accordingly.	
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**
Patients and or their representatives are invited to participate in the care management review. A copy of the review minutes are kept in the patient's folder and where there are changes these are included in the patient's care plan.	Compliant
Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary**	

needs and preferences. **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Menus are planned as per nutritional guidelines and with the advice of community dieticians to ensure patient's individual needs are catered for. Choices in menus are provided for all patients and this includes patients on therapeutic diets.	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:** ○ **risks when patients are eating and drinking are managed**	

○ **required assistance is provided** ○ **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**
Staff are trained in caring for patients with swallow difficulties and in the MUST tool. Copies of SLT guidance are kept in the patients care plan and patient's food record folder. Meals are provided for patients at conventional times. Hot and cold drinks and snacks are available at customary intervals. Fresh drinking water is available at all times. Staff assisting patients to eat and drink are knowledgeable in the individual patient needs and associated risk factors. Appropriately trained staff are on duty at all times to manage risks and provide patient assistance where necessary. Necessary aids and equipment are available to staff as required.	Compliant

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

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Announced Primary Inspection

Lough Neagh

28 July 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 Bernadette Burke Registered Manager, Ms Eileen Quinn Senior Manager** and **Mrs Marie Quinn Registered Provider** 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
		No requirements were made as a result of this inspection.			

Recommendations

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

No.	Minimum Standard Reference	Recommendation	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	12.10	It is recommended that patients' recommended daily fluid targets and the action to be taken if these targets are not being achieved be recorded in patients' care plans on eating and drinking.	One	completed.	From the date of this inspection

The registered provider / manager is required to detail the action taken, or to be taken, in response to the issue(s) raised in the Quality Improvement Plan. The Quality Improvement Plan is then to be signed below by the registered provider and registered manager and returned to:

The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS

Signed: [signature] **Signed:** [signature]

Name: CATHAL QUINN **Name:** B. BURKE
Registered Provider **Registered Manager**

Date 8/9/14 **Date** 8/9/14

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	✓	[signature]	19/9/14
Further information requested from provider			