Unannounced Primary Inspection

Name of establishment:	**Abbeyview**
Establishment ID No:	**1044**
Date of inspection:	**20 May 2014**
Inspector's name:	**Carmel McKeegan**
Inspection No:	**18086**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of home:	Abbeyview
Address:	48 Newtownards Road Bangor BT20 4BP
Telephone number:	028 91469644
E mail address:	abbeyview@mmcg.co.uk
Registered organisation/ Registered provider / Responsible individual	Maria Mallaband Care Group Ltd Ms Victoria Craddock
Registered manager:	Mrs Eleanor Kerr
Person in charge of the home at the time of inspection:	Mrs Eleanor Kerr
Categories of care:	NH-I, NH-PH, NH-PH(E), NH-TI
Number of registered places:	25
Number of patients / residents (delete as required) accommodated on day of inspection:	21
Scale of charges (per week):	£581.00
Date and type of previous inspection:	4 December 2013, Secondary unannounced inspection
Date and time of inspection:	20 May 2014 10:00 am – 4:00 pm
Name of inspector:	Carmel McKeegan

2.0 Introduction

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

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

3.0 Purpose of the inspection

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

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

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

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

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

4.0 Methods/Process

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

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

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

- analysis of pre-inspection information
- discussion with the registered manager, Mrs Eleanor Kerr

- observation of care delivery and care practices
- discussion with staff
- examination of records
- consultation with patients individually and with others in groups
- tour of the premises
- evaluation and feedback.

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

5.0 Consultation Process

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

Patients	8
Staff	4
Relatives	5
Visiting Professionals	1

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

Issued To	**Number issued**	**Number returned**
Patients / Residents	3	3
Relatives / Representatives	2	2
Staff	8	6

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

Abbeyview Private Nursing home is situated on the Newtownards Road in Bangor, and is close to local facilities including the local health centre.

The nursing home is owned and operated by the Maria Mallaband Care Group Limited.

The current registered manager is Mrs Eleanor Kerr.

This is a purpose built facility providing patient accommodation on two floors. Originally designed to accommodate 22 patients, it was later extended to accommodate 25. All rooms have ensuite facilities. Access to the first floor is via a passenger lift and stairs.

Communal lounge and dining areas are provided are provided on both floors, the main dining room is on the ground floor adjacent to the kitchen. The communal lounge on the first floor has a small dining area contained within.

The home also provides for catering and laundry services on the ground floor. A number of communal sanitary facilities are available throughout the home. The accommodation is bright and spacious and designed to a high standard.

There are adequate car parking spaces at the side and the rear of the premises.

The home is registered to provide care for a maximum of 25 persons under the following categories of care:

<u>Nursing care</u>

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

8.0 Summary of Inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Abbeyview Nursing Home. The inspection was undertaken by Carmel McKeegan on 20 May 2014 from 10:00 am to 4:00 pm.

The inspector was welcomed into the home by Mrs Eleanor Kerr, registered manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Mrs Kerr 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 in May 2014 and the inspector has been able to evidence that the level of compliance achieved with the standards inspected has increased in Section F, Section G and Section I, since the submission of the self-assessment.
The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector met with patients, staff and relatives. The inspector observed care practices, examined a selection of records, issued patient, staff and representative questionnaires and carried out a general inspection of the nursing home environment as part of the inspection process.

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

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

As a result of the previous inspection conducted on 4 December 2013, four requirements and one recommendation were issued.

These were reviewed during this inspection. The inspector evidenced that all four requirements and the recommendation had been fully complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

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

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

Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)

Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria).

Inspection findings

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

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

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

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

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

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

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

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

Review of one patient's care records in relation to wound care indicated that these care records were reviewed each time the dressing was changed and also when the dressing regime was changed or the condition of the wound had deteriorated. Re – assessment of the patient's wound was supported by photography however the most recent photographs were taken in September 2013, it is recommended that wound photographs are updated as the wound presentation changes in order to provide up to date evidence of evaluation.

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

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

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

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

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

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

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

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

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

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

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

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

Patient, representatives and staff questionnaires

Some comments received from patients and their representatives:

"I am very happy here; the staff are all very good"
"The food is very good and the staff go out of their way to make sure you are well looked after."
"I have no complaints, all the staff do their very best and work very hard.
"This is a great home with great staff, everyone is so kind, the nurses, the care staff, the cook and the cleaners, I couldn't fault any of them".
"We are always made welcome when we visit, it's like home from home, we are very happy with the care and everything else".

Some comments received from staff:

"Staff work as a team and care is patient centred"
"I thoroughly enjoy my role in Abbeyview. It is a very happy home and I hope I bring fun, stimulation and social inclusion to all the residents"
"Well I find that this home has excellent staff and whatever post you hold you always feel part of the team. So far I have had 3 very happy years here and long may it continue"

A number of additional areas were also examined.

- records required to be held in the nursing home
- guardianship
- Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)
- Patient and staff quality of interactions (QUIS)
- Complaints
- patient finance pre-inspection questionnaire
- NMC declaration
- staffing and staff comments
- comments from representatives/relatives and visiting professionals
- environment

A recommendation is made that the staff duty roster clearly identifies the nurse in charge of the home in the absence of the registered manager.
A recommendation is made that the menu plan should be reviewed to include choices for snacks for patients on therapeutic diets.

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

Conclusion

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

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

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

The inspector would like to thank the patients, the visiting professional, 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 4 December 2013

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1.	13(1)	The registered person must ensure that the management of nutritional risks are appropriately managed. • The home manager should develop a process whereby the assessment of weight loss using the malnutrition universal screening tool (MUST) is considered over the previous 3 and 6 months.	Discussion with the registered manager and review of relevant documentation verified that each patient's nutritional status is monitored at least monthly. The nursing home is participating in a Trust based nutritional research programme, the registered manager stated that the registered nursing staff work closely with the community dietician to monitor the nutritional status of all patients accommodated in the nursing home. Records were available for inspection which enabled the inspector to verify this requirement as compliant	Compliant

2.	15(1)	The registered person must review the appropriateness of the identified person with urgency to ensure that; • The patient's assessed needs can be fully met and that their health and well-being is assured. • Appropriate additional support is provided to meet the patient's needs until transfer to an alternate nursing home registered to support the patients care needs is identified.	The registered manager confirmed that prompt action had been taken which involved the identified person's referring Healthcare Trust. The identified person was transferred to alternate accommodation and the lead inspector had been kept informed throughout the process. This requirement is assessed as compliant.	Compliant

3.	14(5) Reference Article 5 of the European Convention on Human Rights (ECHR)	The registered person must ensure that no patient is subject to restraint unless restraint of the kind deployed is the only practicable means of securing the welfare of that or any other patient and there are exceptional circumstances. • The registered person must review <u>with urgency</u> the current use of key pad egress into and out of the home. The exit point should be changed to a 'push to exit' button device. • All exits from the home must be reviewed and actions taken accordingly.	Discussion with the registered manager and observations of the exit point identified, confirmed that the exit point had been changed to a 'push exit device'. This requirement is assessed as compliant.	Compliant

4.	20(1)(c)(iii)	The registered person must ensure that staff are appropriately trained in; • the management of restraint • the European Convention on Human Rights (ECHR) and the impact that this legislation has upon the day to day life of patients • policy documentation should be updated to reflect and reference this legislation as appropriate.	Discussions with the registered manager and a registered nurse confirmed that training had been provided in the management of restraint and also awareness training on the European Convention of Human Rights. The registered manager confirmed that policy documentation is undergoing review to assess compliance with ECHR. This requirement is assessed as compliant	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1.	32.11	The registered person should ensure that all structural changes such as the instillation of the keypad system are approved by RQIA. Written notification should be forwarded to the estates inspector Mr Colin Muldoon detailing; 1. the reasons for the installation 2. how the system will be managed 3. the impact this system will have upon patients and their representatives.	Discussion with the registered manager confirmed that she is aware of her responsibility to inform RQIA of any structural change. The inspector can confirm that the registered manager provided written notification to RQIA in respect of fitting a 'push exit device' to the exit point identified at the inspection undertaken on 4 December 2013. This requirement is assessed as compliant.	Compliant

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

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

Since the previous care inspection on 4 December 2013, RQIA have received nil notifications of safeguarding of vulnerable adult (SOVA) incidents in respect of Abbeyview Nursing Home.

10.0 Inspection Findings

Section A

Standard 5.1

- **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment**

Standard 5.2

- **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission**

Standard 8.1

- **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent**

Standard 11.1

- **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.**

Inspection Findings:

Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

The inspector reviewed three patients' care records which evidenced that patients' individual needs were established on the day of admission to the nursing home through pre-admission assessments and information received from the care management team for the relevant Trust. It is recommended that any documents from the referring Healthcare Trust are dated and signed when received.

Two patient's care records evidenced that validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, moving and handling, bed rail and continence were completed on admission. One patient's care records did not have the MUST, continence assessment or bed rail assessment completed at the time of this inspection, nor was the body mapping skin assessment record completed. This patient had been admitted four days prior to this inspection. It is recommended that specific validated assessment tools are completed on the day of admission in order to establish the patient's current needs and base line observations for

example; the patient's weight. The specific risk assessments to be completed on the day of admission to the home are outlined in the Guidance for Nursing Homes on RQIA web site.

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.

Review of two patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 11 days of patient's admission to the home. As previously stated one patient had been admitted four days prior to this inspection, the inspector observed that this patient's care plan had commenced.

In discussion with the registered manager she demonstrated a good awareness of the patient who required wound management intervention for a wound and the number and progress of patients who were assessed as being at risk of weight loss and dehydration.

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

Section B

Standard 5.3

- **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.**

Standard 11.2

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

Standard 11.3

- **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.**

Standard 11.8

- **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration**

Standard 8.3

- **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.**

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

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

Patients' care records revealed that the pressure relieving equipment in place on the patients' beds and when sitting out of bed was addressed in each patients' care plans on pressure area care and prevention. And the inspector was able to confirm that pain assessments

were appropriately used for these patients in conjunction with care plans on pain management which were also in place for these patients.

The inspector reviewed one patient's care records that required wound management for a wound. Review of this patient's care records revealed the following;

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

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

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

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

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

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

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

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

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

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

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

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

Discussion with the registered manager, one registered nurse, care staff and review of completed staff questionnaires revealed that registered nursing staff had attended in wound management and pressure area care and care assistant staff were provided training in pressure area care and prevention in response to a requirement which had been raised at the care inspection undertaken on 13 June 2013.

The registered manager confirmed that as part of the research programme ongoing in the nursing home, all staff have been trained in the management of nutrition. The registered manager informed the inspector that one registered nurse had attended a 'swallowing awareness course, provided by the Department of Speech and Language Therapy Community Services. This nurse has in shared her learning with other staff within the nursing home. The registered manager stated that further training will be facilitated later in the year and is incorporated into the staff training and development plan for 2014.

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

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

Section C

Standard 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Homes Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**
Review of three patients' care records evidenced that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care including wound care for each patient. Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. Review of one patient's care records in relation to wound care indicated that these care records were reviewed each time the dressing was changed and also when the dressing regime was changed or the condition of the wound had deteriorated. Re –assessment of the patient's wound was supported by photography however the most recent photographs were taken in September 2013, it is recommended that wound photographs are updated as the wound presentation changes in order to provide up to date evidence of evaluation. Review of care records also evidenced that nutritional care plans for patients were reviewed monthly or more often as deemed appropriate. The evaluation process included the effectiveness of any prescribed treatments, for example prescribed analgesia. Discussion with the registered manager and review of governance documents evidenced that a system was in place to ensure care records were audited on at least monthly basis. Records were available to show that each week day a wound, weight loss/ nutrition care plan was reviewed by the home manager, this is part of the governance arrangements for the nursing home and is incorporated into the 'Daily High Risk Checks' which is the registered manager's responsibility. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

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

Section D

Standard 5.5

- **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.**

Standard 11.4

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

Standard 8.4

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

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

As previously stated the inspector examined three patients' care records which evidenced that validated assessment tools such as the Roper, Logan and Tierney assessment of activities of daily living , the Braden pressure risk assessment tool and the Nutritional risk assessment such as Malnutrition Universal Screening Tool (MUST) had been completed for two patients. One patient's care records did not have the MUST, continence assessment or bed rail assessment completed at the time of this inspection, nor was the body mapping skin assessment record completed. This patient had been admitted four days prior to this inspection. . The registered manager stated that nursing staff may have assumed that the Community Dietician would complete the MUST as part of the ongoing research project. The MUST is an essential risk assessment that should be completed on the day of admission to the nursing home, in order to establish the patient's specific and immediate nutritional needs.

It is recommended that specific validated assessment tools are completed on the day of admission in order to establish the patient's current needs and base line observations for example; the patient's weight.

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

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

- RCN/NMC guidance for practitioners.

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

Discussion with the registered manager, registered nurses and review of governance documents evidenced that the quality of pressure ulcer/wound management was audited each time dressings were changed and discussed at each hand over report. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process. Registered nursing staff were found to be knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care.

Three staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held at each patient's bed side for easy access by staff. This is commendable practice.

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

Section E

Standard 5.6

- **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.**

Standard 12.11

- **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.**

Standard 12.12

- **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.**
  Where a patient is eating excessively, a similar record is kept
  All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.

A policy and procedure relating to nursing records management was available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

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

Discussion with the registered manager and a registered nurse indicated that staff had received training on the importance of record keeping commensurate with their roles and responsibilities in the home.

Review of three patients' care records revealed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient. These statements reflected wound and nutritional management intervention for patients as required. Entries were noted to be timed and signed with the signature accompanied by the designation of the signatory.

Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patients' status or to indicate communication with other professionals/representatives concerning the patients.

The inspector reviewed a record of the meals provided for patients. Records were maintained in sufficient detail to enable the inspector to

judge that the diet for each patient was satisfactory.

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

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

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

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

The fluid intake records reviewed evidenced the following;

- the total fluid intake for patients over 24 hours
- an effective reconciliation of the total fluid intake against the fluid target established
- action to be taken if targets were not being achieved
- a record of reconciliation of fluid intake in the daily progress notes

This is an example of good record keeping and is to be commended.

As previously stated, the home was involved in the nutritional research project, the Dietician working with the nursing home provided training in the management of nutrition for all staff.

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

Section F

Standard 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.**
Please refer to criterion examined in Section E. In addition the review of three patients' care records evidenced that consultation with the patient and/or their representative had taken place in relation to the planning of the patient's care. This is in keeping with the DHSSPS Minimum Standards and the Human Rights Act 1998.

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

Section G

Standard 5.8
- **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate**

Standard 5.9
- **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.**

Prior to the inspection a patients' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that all the patients in the home had been subject to a care review by the care management team of the referring HSC Trust between 1 April 2013 and 31 March 2014.

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

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

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

Section H

Standard 12.1
- **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.**
  Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.

Standard 12.3
- **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.**
  A choice is also offered to those on therapeutic or specific diets.

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

The four weekly menu planner was displayed at the main reception to the nursing home. 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 the 1 January 2014. The inspector was unable to ascertain the menu on the day of the inspection, the menu board in the main dining room remained blank throughout the inspection. The registered manager stated that the cook updates the daily menu board, however on the day of this inspection the cook was occupied in the kitchen as two of the main electrical appliances were showing a fault, engineers were observed to arrive promptly to deal with the situation. The inspector spoke with several patients in the dining room who were aware of the mid-day meal choices available. One patient informed the inspector that staff are very willing to provide whatever meal choices and accompaniments patients need and provided an example of their personal experience. Patient's comments indicated that they were satisfied with meal choices provided in Abbeyview.

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

Staff spoken with were knowledgeable regarding the individual dietary needs of patients to include their likes and dislikes. Discussion with staff and review of the record of the patient's meals confirmed that patients were offered choice prior to their meals.

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

As previously stated under Section B &E, review of care records for one patient evidenced that the patient was referred for a dietetic assessment in a timely manner. This patient was also referred to the speech and language therapist. The patient's care plan had been reviewed and updated to reflect and address the dietician's and also the speech and language therapist's recommendations.

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

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

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

Section I

Standard 8.6
• **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.**
Standard 12.5
• **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.**
Standard 12.10
• **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:**
  • **risks when patients are eating and drinking are managed**
  • **required assistance is provided**
  • **necessary aids and equipment are available for use.**
Standard 11.7
• **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.**

The inspector discussed the needs of the patients with the registered manager. It was determined that a number of patients had swallowing difficulties. The registered manager confirmed that as part of the research programme ongoing in the nursing home, all staff have been trained in the management of nutrition. The registered manager informed the inspector that one registered nurse had attended a 'swallowing awareness course, provided by the Department of Speech and Language Therapy Community Services. This nurse has in shared her learning with other staff within the nursing home. The registered manager stated that further training in the use of food thickening agents will be facilitated later in the year and is incorporated into the staff training and development plan for 2014. Review of the training matrix confirmed that all staff had attended training in first aid during the previous 12 months, which included management of the choking patient. Patient's care records reviewed verified that these care plans fully reflected the instructions of a recent speech and language swallow assessments. 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 the serving of midmorning and mid-afternoon beverages and snacks and was able to confirm that a suitable range of snacks were provided and offered to patients and also those visiting in the nursing home.

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

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Six staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held in a care folder in each patient's bedroom for easy access by staff. This is commendable practice.

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

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

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

11.0 Additional Areas Examined

11.1 Records required to be held in the nursing home

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

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

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

11.2 Patients/residents under Guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) Order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection.

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

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

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

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

The registered manager informed the inspector that these documents were discussed with staff during a Human Rights awareness session and during staff meetings and 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.

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.

11.4 Quality of interaction schedule (QUIS)

The inspector undertook two periods of observation in the home which lasted for approximately 20 minutes each.

The inspector observed the lunch meal being served in the dining room and in the interactions between patient and staff in upstairs sitting room. The inspector also observed the mid-afternoon drinks and snacks being served on the ground floor and on the first floor.

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

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

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

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

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

Staff and relative interactions showed that staff had developed professional relationships with relatives, conversations centred on the patient and any changes in their health and wellbeing since the relative's previous visit.
The registered manager was a visual presence throughout the home and was observed greeting all relatives and visitors to the home.

There were no negative interactions were observed.

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

11.5 Complaints

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

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

The registered manager informed the inspector that lessons learnt from investigations were acted upon.

11.6 Patient finance questionnaire

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

11.7 NMC declaration

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

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

11.8 Questionnaire findings

Staffing/Staff Comments

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

The inspector spoke with the activity therapist who informed the inspector that she very much enjoys providing activities to patients. The activity therapist appeared highly motivated to provide meaningful activities for patients and she informed the inspector how she customises the activity programme to meet the individual needs of the patients.

Staff were provided with a variety of relevant training including mandatory training since the previous inspection.

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

"Staff work as a team and care is patient centred"
"I thoroughly enjoy my role in Abbey view. It is a very happy home and I hope I bring fun, stimulation and social inclusion to all the residents"
"Well, I find that this home has excellent staff and whatever post you hold you always feel part of the team. So far I have had 3 very happy years here and long may it continue"
"In Abbeyview we all as a team try our best at all times we like to sit with the residents and chat about olden days. I like hearing stories about their lives and enjoy a sing song with them".
"I had a good and thorough induction; I felt it prepared me for the job responsibilities"
"We all try and do our best, sometimes we can't spend as much time with the residents, but we do try".

Patients' comments

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

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

"I am very happy here; the staff are all very good"
"The food is very good and the staff go out of their way to make sure you are well looked after."
"I have no complaints, all the staff do their very best and work very hard.
"This is a great home with great staff, everyone is so kind, the nurses, the care staff, the cook and the cleaners, I couldn't fault any of them".

Patient Representative/relatives' comments

During the inspection the inspector spoke with five representatives/relatives/visitors. In addition, on the day of inspection, two representatives/relatives competed and returned questionnaires.
The following are examples of relatives' comments during inspection and in questionnaires;

"We are always made welcome when we visit, it's like home from home, we are very happy with the care and everything else".
"It's like home from home, they all know me and I know most of the staff, we have absolutely no complaints"
"This is a very good home, the staff always have time to speak to you no matter how busy they are, and we are kept informed about any change at all".

Professionals' Comments

One professional visited the home during the inspection. This professional expressed high levels of satisfaction with the quality of care, facilities and services provided in the home and was satisfied that recommendations made regarding patient care and treatments were acted upon.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Eleanor Kerr, 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:

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

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
A comprehensive pre admission assessment is carried out on every resident before admission, person centered care planning using validated assessment tools is implemented, nutritional screening, pressure ulcer risk assessment which includes nutritional,pain and continence assessments is also carried out. As much information as practiable is gleaned before admission and expanded on following admission in a holistic fashion	Substantially 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 nuse is allocated to each resident and her remit will include planning and agreeing nursing interventions agreed with the resident or their representative if they lack capasity or the ability to consent.Abbeyview works closely with trust personel regarding tissue viability and plans are drawn up in conjunction with the relevant health care professionals if necessary to include podiatry and nutritional needs NB we are currently taking part in Trust lead	Substantially compliant

research in to nutritional needs and monthly statics and virtual ward round are taking place for all our residents	
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**
A daily record of any changes in health status of our residents is implemented and hand over reports are held on three different occasions	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**
Our practice in Abbeyiew is underpinned by up to date training both in house and Trust based, trained staff attend outside training and are up to date practioners, working closely with the allocated Trust tissue viability healthcare representative an appropriate treatment plan will be implemented. We have a Trust based research programme regarding nutritional guidelines on going at present in Abbeyview	Substantially 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**
Conteporaneous records are kept of all nursing interventions and reflect outcomes.All oral intake is documented in detail to enable a judgement to be made regarding the suitability of food ingested, wether under or over eating occurs record are kept in each instance. Dietary advice is sought and freely available to us in Abbeyview due to on going resesarch by the Trust in the home	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**
Care delivery s monitored and recorded on a daily basis and audits are completed on an on going basis, residents or their representatives are involved and any changes in nursing interventions discussed	Substantially compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Any resident who has the capasity and the ability to consent is actively involved in reviews and any changes discusse with them or their representatives and any new goals identified	Substantially 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**
A varied and nutritious diet is provided to our residents here in Abbeyview, all guidance documentation is readily available in each residents personal care charts which are kept in their individual rooms for the guidance of staff. Choice is always given and alternative meals provided to all residents	Substantially compliant

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

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.

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Primary Inspection

Abbeyview

20 May 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 Eleanor Kerr, 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.

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.	5.3	Specific validated risk assessment tools should be completed on the day of admission in order to establish the patient's current needs and base line observations. **Ref: Section A**	One	Nurses reminded of the company policy and RQIA guidelines regarding essential specific risk assessments on admission. This will be audited going forward	From the date of this inspection
2.	3.4	Any documents from the referring Healthcare Trust should be dated and signed when received by the nursing home. **Ref: Section A**	One	This has been implemented	From the date of this inspection
3.	5.7	Wound photographs should be updated as the wound presentation changes in order to provide an up to date evidence of evaluation. **Ref: Section C**	One	This has been implemented and up to date photographs have been taken	From the date of this inspection
4.	12.3	The menu plan should be reviewed to include choices for snacks for patients on therapeutic diets. **Ref: Section H**	One	The menu plan is currently under review to incorporate snacks for residents on theraputic diets	30 June 2014

5.	30.7	The staff duty roster should clearly identify the nurse in charge of the home in the absence of the registered manager. **Ref: Section 11.8**	One	This has been implemented	From the date of this inspection

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

Name of Registered Manager Completing Qip	Eleanor M Kerr
Name of Responsible Person / Identified Responsible Person Approving Qip	Maddaar

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	✓	L Thomps	1/9/14
Further information requested from provider			