Unannounced Care Inspection

Name of Establishment:	**Annadale**
RQIA Number:	**1047**
Date of Inspection:	**10 March 2015**
Inspector's' Names:	**Sharon McKnight & Aveen Donnelly**
Inspection ID:	**18357**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 General Information

Name of Establishment:	Annadale
Address:	11 Annadale Avenue Belfast BT7 3JH
Telephone Number:	02890645900
Email Address:	annadalenursinghome@hotmail.co.uk
Registered Organisation/ Registered Provider:	Annadale Private Nursing Home Ltd
Registered Manager:	Winnie Mashumba
Person in Charge of the Home at the Time of Inspection:	Winnie Mashumba
Categories of Care:	NH-I NH-PH NH-PH(E) NH-TI
Number of Registered Places:	38
Number of Patients Accommodated on Day of Inspection:	35
Scale of Charges (per week):	£650 - £679
Date and Type of Previous Inspection:	29 May 2014 Secondary Unannounced Care Inspection
Date and Time of Inspection:	10 March 2015 10 00 – 15 30
Name of Inspectors:	Sharon McKnight & Aveen Donnelly

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 are required.

This is a report of an inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being 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.

The Regulation and Quality Improvement Authority aims to use inspection to support providers in improving the quality of services, rather than only seeking compliance with regulations and standards. For this reason, annual inspection involves in-depth examination of a limited number of aspects of service provision, rather than a less detailed inspection of all aspects of the service.

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

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

- discussion with the registered manager
- discussion with staff
- discussion with patients individually and to others in groups
- consultation with relatives
- review of a sample of policies and procedures
- review of a sample of staff training records
- review of a sample of care plans
- observation during a tour of the premises
- evaluation and feedback.

5.0 Consultation Process

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

Patients	8 individually and with the majority generally
Staff	8
Relatives	2
Visiting Professionals	0

6.0 Inspection Focus

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible person/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

However, due to workload pressures and contingency measures within the Regulation Directorate, the themes/standards within the self-assessment were not inspected on this occasion.

This inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

Standard 19 - Continence Management

Patients receive individual continence management and support.

The Belfast Health and Social Care Trust Adult Safeguarding Team recently completed a safeguarding investigation and shared the findings with RQIA. The investigation highlighted a number of additional care issues not relating to safeguarding. In order to address these issues RQIA requested that the responsible person, Mr Gage, submit an action plan. The action plan was received by RQIA on 4 March 2015 and the progress made towards addressing the issues was reviewed during this inspection.

The inspector has rated the home's Compliance Level against each criterion 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		
Compliance Statement	**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

Annadale is situated on Annadale Avenue just off the Ormeau Road, Belfast. The nursing home is owned and operated by Annadale Private Nursing Home Ltd. The responsible person is Mr Trevor Gage. The registered manager is Mrs Winnie Mashumba.

The original building was a residential house which has been adapted and extended over a period of time. Accommodation for patients is provided mainly in single rooms, a number of which have en suite facilities and are situated on both floors of the home. Access to the first floor is via a passenger lift and stairs.

The dining room is located on the ground floor adjacent to the kitchen. There are two spacious sitting rooms to the front of the home on the ground floor with other small sitting areas also available. A sun lounge has recently been added to the home.

A number of communal sanitary facilities are available throughout the home.

The laundry is located to the rear of the building.

The home is surrounded by well-maintained mature gardens and there are car parking spaces to the front.

The home is registered to provide care for a maximum of 38 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
TI – Terminal illness

8.0 Executive Summary

The unannounced inspection of Annadale was undertaken by Sharon McKnight and Aveen Donnelly on 10 March 2015 between 10 00 and 15 30 hours. The inspection was facilitated by Mrs Winnie Mashumba, registered manager, who was available for verbal feedback at the conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection which was undertaken on 29 May 2014.

The requirements and recommendations made as a result of the previous inspection were also examined. Observations and discussion demonstrated that the three requirements and one recommendation had been fully complied with. Details can be viewed in the section immediately following this summary.

The action plan submitted following the safeguarding investigation was also reviewed. It was good to note that the actions to be taken to address the identified issues were progressing and that a number of the actions had been fully addressed. Confirmation was also received from the registered manager that they would continue to progress the identified actions.

Inspection Findings

Review of patients' care records evidenced that continence assessments were undertaken. The outcome of these assessments clearly identified the patients' needs. Assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. Areas for improvement were identified within the care records and two recommendations have been made.

Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available.

Discussion with the registered manager and a review of training records confirmed that staff had attended training in continence care. Staff spoken with were knowledgeable regarding the management of urinary catheters and the frequency with which the catheters required to be changed.

From a review of the available evidence, discussion with relevant staff and observation, the level of compliance with the standard inspected is 'Compliant.'

Additional Areas Examined

- Care Practices
- Complaints
- Patient Finance Questionnaire
- NMC Declaration
- Patients Comments
- Relatives Views
- Staff Comments
- Environment

Areas for improvement were identified in relation to the storage of self-administered medications and the management of patient weights. One requirement and a recommendation have been made. Details regarding the inspection findings for these areas are available in the main body of the report.

Conclusion

The inspectors can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a good standard and patients were observed to be treated by staff with dignity and respect. Good relationships were evident between staff and patients. Patients were well groomed, appropriately dressed and appeared comfortable in their surroundings. Those patients who were unable to verbally express their views were also observed to be well groomed and were relaxed and comfortable in their surroundings.

A total of one requirement and three recommendations were made as a result of this inspection.

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

9.0 Follow-up on the Requirements and Recommendations Issued as a Result of the Previous Unannounced Care Inspection Conducted on 29 May 2014.

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	Regulation 19 (1) (a), schedule3, 2 (k)	The registered person shall ensure that contemporaneous notes of all nursing provided to the patient are maintained. Repositioning charts must be accurately maintained to evidence care delivered.	Repositioning charts were completed on the computerised record system. A review of completed records evidenced that this requirement has been complied with.	Compliant
2.	13 (7)	The registered person must make suitable arrangements to minimise the risk of infections and toxic conditions and the spread of infection between patients and staff by; • ensuring equipment is not stored in bathroom areas • ensuring that in the event of equipment being left in the bathroom such as a hoist, that appropriate decontamination of that equipment is undertaken in line with infection prevention and control evidence based practice and in accordance with the manufacturer's instructions.	There was no inappropriate storage of equipment observed. This requirement is assessed as compliant.	Compliant

3.	16 (2) (b)	The registered person must ensure that the patient's plan is kept under review by: • ensuring that the issues identified in relation to care records are addressed	Care records reviewed contained details of the patient's moving and handling needs and the specific type, if any, of pressure relieving equipment in place. 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.	32.8	Confirm that weighing scales used by patients have been re-checked and if necessary re-calibrated in accordance with the manufacturers' instructions by a suitably qualified person.	Review of service records evidenced that the weighing scales were serviced in July 2014. This recommendation as stated has been complied with. However, new issues in relation to the calibration of weighing scales were identified during this inspection. This is further discussed in section 11.1of this report and forms part of a new recommendation.	Compliant

9.1 Follow-up on any Issues/Concerns Raised with RQIA since the Previous Inspection such as Complaints or Safeguarding Investigations

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

Since the previous inspection on 29 May 2014, RQIA have been notified by the registered manager of referrals in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues. While RQIA are not part of the investigatory process RQIA were kept informed of the investigations by the Belfast Health and Social Care Trust and of the final outcome.

Following discussion with the registered manager RQIA were satisfied that SOVA issues were dealt with in the appropriate manner and in accordance with regional guidelines and legislative requirements.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of four patients' care records evidenced that continence assessments were undertaken. The outcome of these assessments clearly identified the patients' needs. The type of continence products that patients' required was not identified in the patients' care records and there was no reference to the patients' normal bowel pattern. A recommendation has been made. Assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. Review of the evaluation of care plans evidenced that some nurses were recording a meaningful evaluation including the care delivered and the patient's condition since the previous review. However, some care plan evaluations stated "no change". It is recommended that care plan evaluations include a meaningful statement of the patient's condition, including any changes, since the previous review. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. The management of urinary catheters was reviewed. The frequency with which catheters were required to be changed was recorded in the care plan. Care records evidenced that catheters were changed regularly and in accordance with the recommended frequency. Review of patient's care records evidenced that patients and/or their representatives were informed of changes to their needs and/or conditions and the action taken. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The following policies were in place: • continence management • catheter care The following best practice guidance were available in the home: • NICE Guidelines - "Urinary Continence: The Management of Urinary Incontinence in Women." • RCN Guidance – "Catheter Care: RCN Guidance For Nurses." • RCN Guidance – "Improving Continence Care for Patients."	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not applicable	Not applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the registered manager and a review of training records confirmed that staff had attended training in continence care. The registered manager evidenced that a number of registered nurses were deemed competent in female catheterisation. The registered manager also confirmed that training in male catheterisation is provided by the local health care trust with competencies assessed by the continence link nurse from the trust. Staff spoken with were knowledgeable regarding the management of urinary catheters and the frequency with which the catheters required to be changed. There were no patients resident in the home at the time of this inspection who had a stoma appliance.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

Staff were observed treating patients with dignity and respect. Good relationships were evident between patients and staff. A review of bed side charts evidenced that those patients who were being nursed in bed, were attended by staff on a regular basis.

The monitoring and management of patient weights was discussed with the registered nurses. Nurses were knowledgeable of the patients who had lost weight and verbally confirmed that referrals had been made to the relevant healthcare professionals. However the care records of one patient did not contain any evidence that a referral had been made. Another care record evidenced that a referral had been made in December 2014. However at the time of this inspection the patient had not been reviewed and there was no evidence that staff had followed up the referral. This was discussed with the registered manager at the conclusion of the inspection who agreed to follow up the referral. A recommendation has been made to ensure that referrals to healthcare professionals are recorded in the individual patients care records and that staff follow up referrals in a timely manner.

Whilst reviewing care records it was identified that there were significant variations in some of the weights recorded. For example one patient's records included a weight gain of 8.5 kg in one month, another patient's records evidenced a loss of 7.6 kg in one month. This matter was discussed with the registered nurses on duty who attributed the significant variations to errors with the weighing scales. However the care records did not contain any evidence of the patient's weights being rechecked or any action which had been taken to address calibration issues of the weighing scales. A recommendation has been made to ensure that when a significant variation to patient's weights is identified appropriate action is taken in a timely manner with records retained. Weighing scales must be regularly calibrated and records maintained.

Following observations made the storage arrangements of medicines for patients who choose to self-administer their medications was discussed with the registered nurses and registered manager. It is required that all medicines are stored in a secure place. Secure storage should support the patients' wishes to self-administer their medicines. A requirement has been made.

11.2 Complaints

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 managed.

11.3 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.

11.4 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) and that the registration status of all nursing staff was checked at the time of expiry.

11.5 Patients' Comments

The inspectors spoke with eight patients individually and with the majority of others in smaller groups. Patient spoken with confirmed that staff were polite and respectful; that they could call for help if required; that they were satisfied with the standard of care and the facilities and services provided in the home. Patients were aware of who to speak to if they had concerns and wanted to make a complaint.

There were no issues or concerns raised with the inspectors about care delivery in the home.

11.5 Relatives' Views

Two relatives, spoken with commented positively regarding the attitude of staff and the care their loved one received. They confirmed that the staff in the home kept them informed of any changes to their relatives' condition and consulted with relevant healthcare professionals in a timely way. Relatives spoken with were aware of the complaints procedure and who they would speak with if they had concerns.

There were no issues or concerns raised by relatives about care delivery in the home.

11.6 Staff Comments

The inspectors spoke with eight staff. Staff spoken with commented positively in regard to the care delivery in the home, management and the support and training available. Staff were knowledgeable regarding individual patient need. Discussion took place regarding who staff would speak to if they had any concerns. Staff were fully aware of the line management structure within the home.

There were no issues or concerns raised by staff about care delivery in the home.

11.7 Environment

The inspectors undertook a tour of the premises and viewed the majority of the patients' bedrooms, bathrooms, shower and toilet facilities and communal areas. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was appropriately heated throughout.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Winnie Mashumba, 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:

Sharon McKnight
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Appendix 1

<table>
<tr><th>Section A</th><th></th></tr>
<tr><td>Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</td><td></td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>The registered manager or trained member of staff carries out a pre-admission assessment for all planned admissions using the Caresys Initial care needs assessments tool. Assessments obtained from the care manager or social worker and information given by the staff looking after the prospective resident informs this process. Where a pre-admission assessment is not possible, a trained nurse from the home does a telephone assessment with the health care</td><td>Compliant</td></tr>
</table>

professional responsible for the care of the prospective client and records this. A comprehensive, holistic assessment of the patient's care needs is completed within seven days of admission. An initial care plan would have been devised at the time of assessment by the Caresys initial assessment tool. The admitting nurse then reviews this care plan at the time of admission and adjusts the care plan accordingly. We only carry out pre-admission assessments when we have a room ready to offer. This room should have been shown and accepted by the prospective resident's representative and admission is anticipated within a few days of the assessment so that the assessments will be relevant at the time of admission and minimal changes will be expected. We use the Malnutrition Universal Screening Tool and the Caresys Nutritional risk assessment. We use the Braden on pre-admission assessment and on arrival to the home tool for pressure ulcer risk assessment and management strategies are based on the Braden Score. We also use the Abbey pain chart where required.	

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 care plans and agrees on nursing interventions to meet identified assessed needs with individual residents and their representatives. We prioritise the promotion of independence aim to rehabilitate our residents as much as attainable. The registered nurses in the home are aware of the referral arrangements to other relevant health professional to seek their expertise, support and advice on tissue viability matters. This is done through call management in the Belfast Health and Social Care Trust. Once a resident is assessed to be at risk of developing pressure ulcers, prevention and treatment programme is drawn up and agreed with the relevant health care professionals to meet the resident's identified needs. Recommendations from other healthcare professionals such as tissue viability nurses, Speech and Language therapists and dieticians are kept on each resident's file and recorded in the resident's care plan and these recommendations are adhered to. Each resident has a diary kept on the system to indicate contact with other health care professionals and allow for follow up. This information is carried through at handover.	Compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Re-assessment of care needs is an on-going process and it is carried out daily and reflected on the resident's daily notes and monthly care plan reviews. All residents have an annual care review meeting with their care manager, their representatives and a member of staff from the care home which ascertains and verifies that their care needs are met. Care Managers check and go through care plans and assessments kept in the home in finer detail and any issues are discussed. They also check that these are up to date and relevant.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All residents have a Braden assessment on admission and it is reviewed monthly or sooner if required in instances where the resident's condition deteriorates. Nursing interventions are put in place taking into account the level of risk. We use the EUPAP pressure ulcer grading system and treatment is implemented in consultation with the Tissue Viability Nurses. The position of the wound is also marked on the body map Any skin damage of Grade 2 upwards is notified to the RQIA and the Trust. The progress of the wound is monitored and recorded. Nice guidelines and the RCN Clinical Practice Guidelines are used as reference to support nursing interventions activities and procedures implemented in the management of the pressure ulcers. We appreciate the role nutrition plays in the prevention of pressure sores and management of pressure sores and healing promotion. We use the 2014 Nutritional Guidelines and menu checklists as references in menu planning daily meal preparation. We are proud of the standard of meals we serve our residents. Our residents always respond very positively to our annual feedback questionnaires regarding meals. All our food is prepared on the premises using the best available fresh ingredients. We currently do not have	Compliant

any residents with pressure ulcers in the home.	

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**
A record of meals provided and amount taken by each resident is kept. All residents are assessed using the MUST tool. Interventions are agreed and implemented after consulting with the Dietician where a resident's BMI is less than 18.5 or above 30. Where a resident chooses not to eat a record is also kept of any alternatives offered and outcomes.	Compliant

Record keeping training is offered to trained nurses. Contemporaneous records are kept in line with the NMC guidelines. The nurse in charge is informed of instances where a resident chooses not to eat or eats excessively and referrals are made to the Dietician where necessary and recommendations are recorded in the resident's care plan and followed through.	

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 delivered is monitored and recorded on a day to day basis. All care records are recorded on Caresys which is a computerised care delivery programme. Care records are maintained as per NMC guidelines. References literature such as the NIPEC Evidence Care: Improving Record Keeping Practice and RCN guidance are available to the staff. Each resident has an annual Care Review Meeting that is attended by their next of kin or representative, Care Manager, and a trained nurse from the home. Care outcomes are discussed and agreed. If no issues are raised another care review meeting is arranged in another year and if there is issues raised the review is scheduled sooner. We also keep the resident's representative and Care manager informed of any changes or concerns with the resident. . There are instances where difficulties are experienced with some trusts in carrying out care reviews timely. In such cases we contact the care managers to arrange the reviews. If we still have difficulties with this we would arrange a meeting with the family and the resident as a stop gap measure to determine that we are meeting their care needs and that they are happy with the care provided until the Trust arranges one.	Compliant

Random audit of daily notes are carried out. Record keeping forms part of the performance appraisal for nurses.	

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 ● **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** ● **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Residents are encouraged to attend the annual care review meeting with their representatives. The registered nurses in the home complete an assessment for the care manager prior to the meeting giving information on events of the past year such as weight loss or gain, dental visits, hospitalises, falls and all other relevant information. The care manager chairs the meeting and takes minutes of the meeting. She seeks the input of the family or representative of the resident, the resident themselves and that of the nursing home staff. A copy of the minutes is sent to the home and the outcomes are recorded. We do appreciate the difficulty some trust have in carrying out care reviews timely. In such cases we contact the care managers to arrange the reviews. If we still have difficulties with this we would arrange a meeting with the family as a measure to determine that we are meeting the care needs and that they are happy with the care provided.	Compliant

<table>
<tr><td>Section H</td><td></td></tr>
<tr><td>Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</td><td></td></tr>
<tr><td>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)</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>Residents are provided a nutritious varied diet which is reviewed at the start of each season. A 3 weekly menu is on display at any given time. The Chef uses the Nutritional guidelines and menu checklist for residential and nursing homes 2014 to plan the menus. There is always an alternative on the menu to accommodate individual preferences and the same applies for those on therapeutic or specific diets. If a resident does not like any of the choices the Chef does his best to provide what they like. Menu choices are offered in advance of the meal to allow the Chef to prepare special requests.
We appreciate that most of our residents look forward to a good meal and we do our best to provide the best produce we can find. All food is prepared fresh on the premises. Dietary needs that are identified by the other professionals such as the Speech and Language therapist and Dietician are taken into consideration when planning menus. We also carry out annual satisfaction surveys to ensure that our residents are happy with the meals provided.</td><td>Compliant</td></tr>
</table>

<table>
<tr><th>Section I</th><th></th></tr>
<tr><td>Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</td><td></td></tr>
<tr><td>Criterion 8.6
● Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.
Criterion 12.5
● Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.
Criterion 12.10
● Staff are aware of any matters concerning patients’ eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:
o risks when patients are eating and drinking are managed
o required assistance is provided
o necessary aids and equipment are available for use.
Criterion 11.7
● Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>If any resident is experiencing any swallowing difficulties a referral is made to the Speech and Language Therapist for an assessment and guidance. Once advice is given it is recorded in the resident's care plan and communicated to all staff using the communication book and handover reports. A copy of the recommendations is kept on file. Residents have 3 main meals a day. Breakfast consists of a selection of cereals, porridge, fruit selection, scrambled eggs, baked</td><td>Compliant</td></tr>
</table>

beans, bacon and egg made to the resident's specifications, tea and toast and a selection of fruit juices. Residents have a plenty of variety to choose from and the Chefs try their very best to meet these choices. Lunch is served between 12:30 and 13:30hours. Residents have a 3 course menu at lunchtime and they are offered options for every course. The other main meal is served at tea time. Hot drinks and snacks are served at 11am, 3pm, and 7pm and between 8pm and 11pm. Fresh water and drinks are available throughout the day. Tea is also offered at any time on request. We have a tea and coffee making facility for visitors to the home. Members of staff stay with the residents during meal times to assist those residents who need help and at least one trained member of staff is in the Dining room to deal with any emergencies that may arise. Meal times are protected to allow residents to eat in private and without interference. We facilitate resident's choice in choosing where they would like to have their meal for example some prefer to the meals brought to their rooms and others choose to stay in the lounges. Feeding cups, plate guides and straws are available to the residents. Special cutlery where applicable is available to residents as recommended. Nursing staff have attended the wound management and dressing selection training arranged by the Trust. This training has been very vital in providing the nurses with the expertise and skills required in wound management which include wound assessment choosing and applying wound care products and dressing. They also have the support of the tissue viability nurses where expert advice is required.	

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

Quality Improvement Plan

Unannounced Care Inspection

Annadale

10 March 2015

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 Winnie Mashumba either during or after the inspection visit.

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

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

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

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

Statutory Requirements **This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Nursing Homes Regulations (NI) 2005**					
No.	**Regulation Reference**	**Requirements**	**Number Of Times Stated**	**Details Of Action Taken By Registered Person(S)**	**Timescale**
1	13(4(a)	All medicines must be stored in a secure place. Arrangements to ensure that medicines are securely stored should support the patients' wishes to self-administer their medicines. **Ref section 11,11.2**	One	The resident in question was admitted for respite care. She was provided with a lockable cupboard to store her medicines but chose to keep these by the window where they sat during the day and then moved to the cupboard at night. A risk assessment was in place but was not asked for or looked at by the Inspector on the day of inspection. The resident acknowledged that the policy of the home in relation to storage of self administered medicines had been explained to her and she chose not to comply. The only option was to have these kept on the medicines trolley which would have infringed on the resident's right to indepence and choice. The resident sat in a big chair that blocked access to the medicines to anyone coming into the room.	By the end of April 2015.

				Resident was immobile and used the commode in the room therefore would not have left the room at all during her stay with us and this was her choice. The resident was always fully alert and aware of who was in and out of her room and it was only staff responsible for caring or providing a service to the resident who would have entered the room. There were no other residents or service users that would have gone into the room. The only visitor the resident had was her main carer at home who was fully aware of the medicines. There were no controlled drugs stored in the room. The resident was discharged home. We have no other residents who self administer. We have robust policies and procedures on self administration of medicines and we appreciate the uniqueness of this case in terms of prohibitive practice that would have hindered on the	

				rehabilitation of the named resident and the danger of infringing on the resident's rights.	

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	19.1	Care records should be further developed to include: • The specific type of continence products that patients' required • the patients' normal bowel pattern. **Ref section 10, 19.1**	One	Continence products used by each resident and their normal bowel patterns have been added to care plans.	By the end of April 2015.
2	5.7	Care plan evaluations should include a meaningful statement of the patient's condition, including any changes, since the previous review. **Ref section 10, 19.1**	One	This was communicated to all nurses at the computer records training update held on 24/03/2015 and they have effected this in their reviews.	By the end of April 2015.
3	12.12	The management of patients weights should be reviewed and the following issues addressed: • Referrals to healthcare professionals should be recorded in the individual patients care records • staff should follow up referrals in a timely manner • when a significant variation to patient's weights are recorded	One	Staff were reminded to record the professional referrals in the given section on the computer at the update training held on the 24th of March 2015. -They were also reminded to follow up on referrals however some of the healthcare professional teams have a waiting period of up to 6 months which is beyond our	By the end of April 2015.

		appropriate action is taken at the time of recording • Weighing scales should be regularly calibrated and records maintained. **Ref section 11, 11.2**		control. -Weighing scales are now being calibrated every month.	

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Winn Mashumba
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Trevor Gage

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Aveen Donnelly	12 June 2015
Further information requested from provider			