Unannounced Care Inspection

Name of Establishment:	**Beechill Care Home**
RQIA Number:	**1058**
Date of Inspection:	**28 January 2015**
Inspector's Name:	**Donna Rogan**
Inspection ID:	**IN020707**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Beechill Care Home
Address:	12 Royal Lodge Road Belfast BT8 4UL
Telephone Number:	028 90 402871
Email Address:	beechill@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Health Care
Registered Manager:	Mr Rosendo Soriano (registration pending)
Person in Charge of the Home at the Time of Inspection:	Mr Rosendo Soriano
Categories of Care:	(NH) (DE)
Number of Registered Places:	34
Number of Patients Accommodated on Day of Inspection:	29 1 in hospital
Scale of Charges (per week):	£550 - £616
Date and Type of Previous Inspection:	27 March 2014 Secondary Unannounced Inspection
Date and Time of Inspection:	28 January 2015 10.30 – 16.30
Name of Inspector:	Donna Rogan

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: amend as relevant

- Discussion with the nurse 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 staff duty rotas.
- Review of a sample of care plans.
- Review of the complaints, accidents and incidents records.
- Observation during a tour of the premises.
- Evaluation and feedback.

5.0 Consultation Process

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

Patients/Residents	**12**
Staff	**8**
Relatives	**3**
Visiting Professionals	**0**

Questionnaires were provided, during the inspection, to patients, their representatives and staff to seek their views regarding the quality of the service.

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**0**	**0**
Relatives/Representatives	**3**	**2**
Staff	**8**	**3**

6.0 Inspection Focus

Prior to the inspection, the responsible person/nurse manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible person/nurse 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 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

Beechill Care Home is owned by Four Seasons Health Care (NI) Ltd. and is situated in a housing development of Royal Lodge on the Old Purdysburn Road, Belfast.

Beechill Care Home is purpose built, two storey home, and is comprised of 26 single and four double bedrooms, sitting rooms, two dining rooms, kitchen, laundry, toilet/washing facilities, staff accommodation and offices.

A passenger lift ensures that facilities are accessible to all patients.

Car parking spaces are available to the front and side of the home.

A garden and an enclosed patio area are available to the rear of the home, providing a safe environment for patients to sit or walk around.

The home is registered to provide nursing care for 34 patients within the category of DE - dementia care. The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) was appropriately displayed in the entrance hall of the home.

8.0 Executive Summary

The unannounced inspection of Beechill Care Home was undertaken by Donna Rogan on 28 January 2015 between 10.30 and 16:30 hours. The inspection was facilitated by Rosendo (Ruben) Soriano, nurse manager, who was also 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 of 27 March 2014.

As a result of the previous inspection four requirements were issued. These were reviewed during this inspection and it was evidenced that all four requirements have been fully complied with. Details of the findings can be viewed in the section immediately following this summary.

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, appropriately dressed in clean matching attire and were relaxed and comfortable in their surroundings.

Assessments and care plans in regard to management of continence in the home were reviewed. Review of four patient's care records evidenced that patients and/or their representatives were informed of changes to patient need and/or condition and the action taken. Nursing staff spoken with on the day of the inspection were knowledgeable regarding the management of urinary catheters and the frequency with which the catheters within the home required to be changed. Discussion with staff and review of training records confirmed that staff were trained and assessed as competent in urinary catheterisation. There was one areas for improvement identified within this theme in relation to updating the policy and procedure in relation to stoma care. A recommendation is made in this regard.

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

Additional Areas Examined

Care Practices
Complaints
Patient Finance Questionnaire
NMC Declaration
Patients/relatives questionnaires and comments
Staff questionnaires and comments
Environment

Details regarding the inspection findings for these areas are available in the main body of the report. Some areas of for improvement were raised with the nurse manager regarding the management of the environment. Issues raised are listed in sectio11.7 of this report. Two requirements are made in this regard.

Conclusion

As a result of this inspection two requirements and one recommendation were made. Details of the requirements and the recommendation made can be found in the quality improvement plan (QIP) of this report.

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

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

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	18 (2) (n) (i)	The registered manager must ensure that the activity programme includes group and individual activities that are planned and provided with regard to the needs of patients and in a manner that produces positive outcomes for patients.	Since the previous inspection a new activity person has been employed and provides activities on a daily basis from 10.30 to 15.30 from Monday to Friday. Following a review of the activity programme and discussion with activity therapist, patients, relatives and staff, it was confirmed that the activities are provided in a manner that produces positive outcomes for patients.	Compliant
2	12 (1) (b)	Ensure all necessary patients' details are obtained either prior to or on admission in order to provide a baseline and to inform the plan of care. Ensure that registered nurses record the appropriate information at the time of admission to ensure their nursing needs are met in a timely and appropriate manner in keeping with best practice.	A review of four patients' care records evidenced that patients' details are obtained prior to and on admission. The information received provided a baseline in order to inform the plan of care. All relevant information was observed to be provided at the time of admission. Care plans were observed to be appropriately drawn up to address their nursing needs following admission to the home.	Compliant

		Ensure that registered nurses include details such as the patients' weights and the condition of patients' skin and clinical observations.	In the four care records examined details of the patients' weights, the condition of their skin and their clinical observations were included in the admission notes.	
3	16 (1)	Ensure that a written nursing plan is prepared by a nurse in consultation with the patient or patients' representatives as to how the patients' needs in respect of his health and welfare are to be met.	A review of four patients' care records evidenced that they included details as to how the patients' needs in respect of their health and welfare were to be met. All four care records were prepared by a registered nurse.	Compliant
4	27	Ensure privacy screens are provided in the identified double bedrooms.	Privacy screens were observed to be provided in the identified screens. The nurse manager informed the inspector that this is kept under review.	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.

There are currently no ongoing safeguarding issues in the home.

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 bladder and bowel continence assessments were undertaken. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. The continence assessment in use was regularly revised. The assessment viewed by the inspector evidenced the decision making processes used to identify the continence needs of the individual. There was evidence in four patients' care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. 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 general practitioners as appropriate. Review of four 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. The care plans reviewed addressed the patients' assessed needs in regard to continence management. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	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 and procedures were in place; • Continence management / incontinence management. • Stoma care. • Catheter care. However the policy and procedure regarding stoma care in place had not been reviewed since September 2009 and is required to be reviewed and updated to reflect current practices in the home. A recommendation is made in this regard. The following guideline documents were in place: • RCN continence care guidelines. • British Geriatrics Society Continence Care in Residential and Nursing Homes. • NICE guidelines on the management of urinary incontinence. • NICE guidelines on the management of faecal incontinence. Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	Substantially 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:	
There were information leaflets available in the front foyer in an accessible format regarding the promotion of continence management.	Compliant
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 nurse manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the nurse manager and a review of the staff training records revealed that registered nurses in the home were deemed competent in female catheterisation, male catheterisation, suprapubic catheterisation and the management of stoma appliances. Care staff completed training in continence care as part of their induction. There are currently no patients in the home requiring catheter or stoma care. The promotion of continence and the management of incontinence are completed by all staff at the time of induction. The review of one staff induction training record evidenced this training had been completed and had been validated by the registered manager. Regular audits of the management of continence products are undertaken by the registered nursing staff. The nurse manager informed the inspector that a continence link nurse will be appointed in the home following training on the 18 February 2015.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

During the inspection staff were noted to treat the patients with dignity and respect. Good relationships were evident between patients and staff.

Patients were well presented with their clothing suitable for the season. Staff were observed to respond to patients' requests promptly. The demeanour of patients indicated that they were relaxed in their surroundings.

The activities in the home were reviewed and the inspector observed the overall management of activities to be well improved from the previous inspection. Relatives spoken with stated that they were appropriate to the needs of patients and were well organised and in the main carried out as planned. This is to be commended on this occasion.

The lunch time meal was observed to be very appetising, choices were offered and staff were observed to be attentive to patients needs throughout the dining experience. All staff including nursing staff were observed to assist with the serving of meals.

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 pro-actively managed.

The inspector discussed the management of complaints with the nurse manager and reviewed the complaint record. This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements.

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).

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

11.5 Patients/Residents and Relatives Comments

During the inspection the inspector spoke with twelve patients individually and to others in groups. Most patients were unable to express their views verbally. However, these patients indicated by positive gestures that they were happy living in the home. Where communicated examples of patients' comments were as follows:

“I’m ok”
“I am good”
“I like the food”

The nurse manager stated that no patients in the home would be able to effectively complete patient questionnaires, therefore none were issued or returned. There were no issues raised verbally or indicated by gestures by patients during the inspection.

Three questionnaires were issued to relatives during the inspection for completion. Two were returned. One did not contain any comments. One was completed and all comments made regarding care and services provided were positive. The following comments were made by three relatives visiting on the day of inspection;

“My mother has been here for three years and I am very satisfied with the new management arrangements”
“This is a great home, and I am confident my relative is receiving the best care possible”
“I have no worries or complaints.

There were no issues raised by relatives or their representatives during the inspection.

11.6 Questionnaire Findings/Staff Comments

During the inspection the inspector spoke with eight staff. The inspector was able to speak to a number of these staff both individually and in private. Eight staff questionnaires were issued during the inspection, three staff returned the questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

The following comments were made during the inspection and returned in the staff questionnaires;

“All staff work well together this is a great home”
“Beechill is always kept clean and smelling good”
“Residents look really happy and comfortable with the activities in the home”
“The care at Beechill, is very satisfactory, this is because we are small and work well as a team”

There were no issues raised by staff to the inspector during the inspection.

11.7 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients’ bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a high standard of hygiene.

Since the previous inspection there have been a number of rooms which management have changed from their original use. The changes have enhanced the function and operational management of services in the home. However, whilst there has been some discussion with RQIA regarding the proposed changes, it is a requirement that any proposed changes to the

use of rooms should be forwarded to RQIA prior to alterations being made. RQIA can confirm that since the inspection that the required applications have been received and are currently being processed. A requirement is made that the manager ensures that any future proposed changes are forwarded to RQIA before the works are commenced.

The following issues are required to be addressed following this inspection;

- The work to the patient's day room on the first floor is required to be repainted.
- The new nurse station on the first floor is required to be redecorated.
- New sink unit us required in the identified patient's bedroom.
- The new hairdressing room is required to have the holes in the walls repaired and it required to be repainted.
- All areas in the staffroom kitchen and female and male changing rooms are required to be totally cleaned and redecorated.
- Fire doors are not to be wedged open.
- The microwave in the staff kitchen should be thoroughly cleaned or replaced.

12.0 Quality Improvement Plan

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

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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**
Prior to admission to the Home, the Home manager or a nominated representative from the home carries out a pre admission assessment. Information gleaned from the resident / representative, the care records and the information from the Care Management team informs this assessment. Risk assessments such as the Braden Tool are carried out, if possible, at this stage. Following a review of all information a decision is made in regard to the home's ability to meet the needs of the resident. If the admission is an emergency admission and a pre admission is not possible in the resident's current location then a pre admission assessment is completed over the telephone with written	Compliant

comprehensive multidisciplinary information regarding the resident being faxed or left in the home. Only when the manager is satisfied that the home can meet the resident's needs will the admission take place. On admission to the home an identified nurse completes initial assessments using a patient centred approach, the admission and needs assessments. Also on admission risk assessments are completed, such as the Braden tool, a body map, manual handling assessment, a falls risk assessment, a pain assessment, nutritional assessments including the MUST tool, nutritional and oral assessments. Continence and bowel assessments are also completed following admission. A plan of care is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations The home and regional manager complete audits on a regular basis to quality assure this process	

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 completes a comprehensive assessment of the resident's care needs using the assessment tools as discussed in section A. Care plans are devised to meet identified needs and in consultation with the resident / representative. Any recommendations made by the multidisciplinary team are included in the care plan.	Substantially compliant

Registered nurses in the home are fully aware of the process of referral to a TVN when necessary. The staff use the call management system to make a telephone call to the TVN where advice can be given prior to their visit. Referrals are also made via this process in relation to residents who have lower limb or foot ulceration to either the TVN or a podiatrist. Where a resident is assessed as being 'at risk' of developing pressure ulcers, a care plan will be devised to include skin care, frequency of repositioning and any pressure relieving equipment used. The care plan will give due consideration to advice received from other multidisciplinary members. The treatment plan is agreed with the resident/representative, Care Management and relevant members of the MDT. The Regional Manager is informed via a monthly report and during the Reg 29 visit. The Registered Nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Dietician referral is completed via the GP. The dietician is also available over the telephone for advice until she is able to visit the resident. All advice, treatment or recommendations are recorded on the MDT form with a subsequent care plan being compiled or current care plan being updated to reflect the advice and recommendations. The care plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in the home and other members of the MDT are kept informed of any changes.	

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**
The Needs Assessment, risk assessments and care plans are reviewed and evaluated at a minimum of once a month or more often if there is a change in the resident's condition. The plan of care dictates the frequency of review and re assessment, with the agreed time interval recorded on the plan of care. The resident is assessed on an ongoing daily basis with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the Home Manager's attention. The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.	Substantially 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**
The home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to. The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading sysytem. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime or if the condition of the pressure ulcer changes. There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', ' PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in	Substantially compliant

relation to nutritional care, diabetic care, care of subcuteanous fluids and care of percutaneous endoscopic gastrostomy (PEG)..	

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**
Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are comtemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines - Record keeping:Guidance for nurses and midwives. Records of the meals provided for each resident at each mealtime are recorded on a daily menu choice form. The Catering Manager also keeps records of the food served and include any specialist dietary needs. Residents who are assessed as being 'at risk' of malnutrition, dehyration or eating excessively have all their food and fluids recorded in detail on a daily basis using a FSHC food record booklet or fluid record booklet. These charts are	Substantially compliant

recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. The nurse utilises the information contained in these charts in their daily evaluation. Any deficits are identified with appropriate action being taken and with referrals made to the relevant MDT member as necessary. Any changes to the resident's plan of care is discussed with them and/or their representative. Care records are audited on a regular basis by the Manager with an action plan compiled to address any deficits or areas for improvement ..	

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care delivered is monitored and recorded on a daily basis on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan of care or more frequently if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their represenatatives are involved in the evaluation process.	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**
Care Management Reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the resident's file. Any recommendations made are actioned by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals.	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**
The home follows FSHC policy and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs on admission and review on an ongoing basis. The care plan reflects type of diet, any special dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if necessary. The home has a 3 week menu which is usually reviewed on a 6 monthly basis taking into account seasonal foods. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied. Copies of instructions and recommendations from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs. Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything	Substantially compliant

from the daily menu an alternative meal of their choice is provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments, sauces and fluids are available at each meal..	

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**
Training on dysphagia and the correct use of food thickeners has taken place for the care and catering staff on 17/06/14, 2/10/14 and 15/10/14. The Speech and Language therapist and dietician also give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document - 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for feeding, equipment to use and assistance required. Special diets are displayed on a white board in the kitchen. Meals are served at the following times:-	Substantially compliant

Breakfast - 9am-10.30am Morning tea - 11am Lunch - 12.30pm-1.30pm Afternoon tea - 3pm Evening tea - 4.40pm - 5.40pm Supper - 7.30pm-8pm There are variations to the above if a resident requests to have their meals outside of these times. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. There are foods available outside of these times for those resident's who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedrooms, these are replenished on a regular basis. Any matters concerning a resident's eating and drinking are detailed on each individual care plan - including for eg. likes and dislikes, type of diet, consistency of fluid, any special equipment required and if assistance is required. A diet notification form is completed for each resident with a copy given to the kitchen and one held in the care file. Meals are not served unless a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Appropriate aids such as plate guards and specialised cutlery are available as necessary and as indicated in the plan of care. Each nurse has completed an education e-learning module on pressure area care. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the home have a competency assessment completed. Competency assessments have a quality assurance element built into the process.	

Provider's Overall Assessment Of The Nursing Home's Compliance Level Against Standard 5	Compliance Level
	Substantially compliant

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Secondary Unannounced Care Inspection

Beechill Care Home

28 January 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 Rosendo Soriano, manager during 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	32 (h)	The nurse manager shall ensure that any future proposed changes or variations to the home are forwarded to RQIA for approval before the works are completed. **Ref 11.7**	One	The Nurse Manager will ensure in the future any proposed changes or variations to the home will be forwarded to RQIA for approval before the commencement of works.	From the date of inspection
2	27	Ensure the following issues are addressed; The work to the patient's day room on the first floor is required to be repainted. The new nurse station on the first floor is required to be redecorated. New sink unit us required in the identified patient's bedroom. The new hairdressing room is required to have the holes in the walls repaired and it required to be repainted. All areas in the staffroom kitchen and female and male changing rooms are required to be totally cleaned and redecorated. Fire doors are not to be wedged open. The microwave in the staff kitchen should be thoroughly cleaned/replaced. **Ref 11.7**	One	 This has been repainted on 10th February 2015 This has been painted and redecorated. New sink unit was installed in the identified patient's bedroom. The holes in the walls of the hairdressing room have been repaired and repainted. Staff room, kitchen, male and female changing rooms have been repainted, cleaned and redecorated. Fire doors are no longer wedged open. The identified microwave has been replaced with a new one.	One month

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	19.2	The policy and procedure regarding the management of stoma care should be reviewed and reissued. **Ref 19.2**	One	Policy and procedure regarding management of stoma care is currently being reviewed.	One 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	Rosendo Soriano
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	yes		1/4/15
Further information requested from provider			