Unannounced Care Inspection

Name of Establishment:	**Bethany Care Home**
RQIA Number:	**1061**
Date of Inspection:	**2 February 2015**
Inspector's Name:	**Lyn Buckley**
Inspection ID:	**IN017860**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of establishment:	Bethany Care Home
Address:	69 Osborne Park Belfast BT9 6JP
Telephone number:	0289066 5598
Email address:	bethany.m@fshc.co.uk
Registered organisation/ Registered provider:	Four Seasons Health Care Ltd
Registered manager:	Jennifer Forbes
Person in charge of the home at the time of inspection:	Registered Nurse M Mlauzi (agency nurse)
Categories of care:	NH – I, PH, PH(E) and TI
Number of registered places:	40
Number of patients accommodated on day of Inspection:	38
Scale of charges (per week):	£581- £655
Date and type of previous inspection:	25 & 26 September 2013 Primary unannounced inspection
Date and time of inspection:	2 February 2015 07:00 – 12:00 hours
Name of inspector:	Lyn Buckley

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 on duty
- discussion with patients individually and with others in groups
- review of a sample of staff training records
- review of a sample of staff duty rotas
- review of a sample of care records
- review of a sample of records required to be held in a nursing home
- 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	8
Staff	11
Relatives	0
Visiting Professionals	0

Questionnaires were provided by the inspector 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	5	1
Relatives/Representatives	5	5
Staff	10	10

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 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

Bethany Care Home is situated in a very pleasant residential area of South Belfast and is convenient to two major routes into the city centre, Lisburn Road and Malone Road. The nursing home is owned and operated by Four Seasons Healthcare Ltd. The registered manager is Ms Jennifer Forbes.

The home is a 40-bedded, purpose-built, building which provides accommodation and services on three floors. Bedroom accommodation is provided on the first and second floors and consists of 36 single rooms and two shared bedrooms. Thirteen of the single bedrooms have ensuite facilities. Access to all floors is via a passenger lift and stairs.

Communal lounge and dining areas are provided on the lower ground floor along with catering and laundry services. A number of communal sanitary facilities are available throughout the home.

The home is registered to provide care for a maximum of 40 persons under the following categories of care:

Nursing care (NH)

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

8.0 Executive Summary

The unannounced of Bethany Care Home was undertaken by Lyn Buckley on 2 February 2015 between 07:00 and 12:00 hours. The inspection was facilitated, initially, by the registered nurse in charge of the home. The registered manager, Jennifer Forbes, arrived at the home shortly after the inspection commenced. Ms Forbes was provided with 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 care inspection on 25 &26 September 2013. In addition the inspector also reviewed the competency and capability of registered nurses in charge of the home, in the absence of the registered manager, particularly on night duty. This was in response to information RQIA received on 29 January 2015 from Belfast Health and Social Care Trust's (BHSCT) in respect of a complaint. Refer to sections 9.1 and 11.3.

During the course of the inspection the inspector met and spoke with patients and staff. The inspector observed care practices, examined a selection of records and carried out a general inspection of the nursing home's environment as part of the inspection process.

As a result of the previous inspection one requirement and six recommendations were made. The requirement and four of the recommendations were assessed as compliant. One recommendation is stated for a second time. Due to the timing and focus of this inspection one recommendation is carried forward for review during the next care inspection. Details can be viewed in the section immediately following this summary.

Additional areas also examined included:

- care practices
- fire safety arrangements
- complaints
- patient finance questionnaire
- NMC declaration
- patients' and relatives comments
- staff comments
- staffing
- staff training and competency and capability assessments
- records and record keeping
- environment

Details regarding these areas can been found in section 11.

Conclusion

The inspector can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a good standard. At the commencement of the inspection the majority of patients were in their bedrooms and two patients were having breakfast in the dining room as was their wish. Observations confirmed that patients were not wakened by staff to facilitate the home's routine and that patients were treated with dignity and respect. Good relationships between patients, relatives and staff were evident. Patients spoken with said they felt safe in the home and well cared for.

The home was comfortable and all areas were maintained to a good standard of hygiene and decor.

The management of continence within the home was assessed as compliant.

As a result of this inspection three requirements and four recommendations were made. One recommendation was stated for a second time. One recommendation was carried forward for review during the next care inspection.

The inspector would like to thank the patients, relatives, registered manager and staff for their assistance and co-operation throughout the inspection process. The inspector would also like to thank those 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	15 (2) (a) and (b)	The registered person shall ensure that the assessment of the patient's needs is – (a) kept under review; and (b) revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually. Nursing staff must ensure that where risk is assessed as being present a corresponding care plan is written and implemented.	The inspector reviewed three patient care records and records pertaining to staff supervision which evidenced that this requirement had been addressed.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	5.4	It is recommended reassessment is an on-going process that is carried out daily and at, agreed time intervals as recorded in nursing care records. This recommendation is in relation to pain management and the use of analgesia.	Review of care records and discussion with patients confirmed that this recommendation had been addressed.	Compliant
2	11.6	It is recommended information on skin care and prevention of skin damage is available in an accessible format for patients, and their representatives.	Leaflets had been available in the foyer of the home but had recently 'run out'. The registered manager confirmed that more were ordered. Based on discussion with the registered manager the inspector is satisfied that this recommendation had been addressed.	Compliant
3	5.3	It is recommended staff seek advice in relation to aids which minimise the risk of friction.	The inspector observed that 'slide sheets' were available throughout the home. The registered manager confirmed that each patient had their own slide sheet.	Compliant

4	5.3	It is recommended staff complete all sections detailed on the repositioning record, for example, the condition of the pressure relieving mattress.	The registered manager confirmed and evidenced that they had raised this issue with staff following the previous inspection. However, review of two repositioning records evidenced that staff did not complete all sections as listed. For example details of the frequency of repositioning were blank. The registered manager agreed that this recommendation needed to be reiterated with staff. Therefore this recommendation is stated for a second time.	Moving toward compliance.
5	5.3	It is recommended a care plan and a corresponding dressing plan is drawn up where nursing staff provide wound/ulcer management.	Review of care records evidenced that this recommendation was addressed.	Compliant

6	12.1	It is recommended the daily routine is reviewed in respect of the length of time patients wait at the dining table prior to meals being served.	Due to the timing of this inspection the preparation and serving of the lunchtime meal was not observed. Patients spoken with informed the inspector that they enjoyed the meal time experience. Discussion with the registered manager confirmed that some patients choose to arrive early at the dining tables and others assisted by staff were provided with a drink and made comfortable. This recommendation is carried forward for review during the next care inspection.	Not assessed on this occasion.

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 in September 2013, RQIA have been notified of ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues. Following a recent SOVA allegation the registered manager, in keeping with regional adult protection policy/procedures, reported the allegation to the BHSCT's safeguarding team. The allegation was then investigated under the direction of the Trust's safeguarding team. Confirmation that the case had been closed was received by the registered manager on 22 January 2015.

On 29 January 2015 RQIA received information from the BHSCT in respect of a complainant alleging poor levels of registered nurses' competency and capabilities, particularly on night duty. RQIA had also received information from the registered manager in respect of this complaint on 28 January 2015. Following discussion with senior management, in RQIA, the decision was made to review this issue during the schedule unannounced care inspection. Refer to section 11.

Following discussion and review of records pertaining to SOVA and complaints management, the inspector was satisfied that the registered manager had dealt with the issues appropriately 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 three patients' care records evidenced that bladder and bowel continence assessments were undertaken for all patients at the time of admission to the home. As required, a more detailed assessment was undertaken. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patient care plans on continence/incontinence care. Care plans were reviewed on at least a monthly basis and had been discussed with the patient and/or their representative. Discussion with staff and observation evidenced that there were adequate stocks of continence products available. Products were stored centrally and dispersed to patients' bedrooms as required. Discussion with the registered manager confirmed that registered nurses could refer patients to specialist healthcare workers, such as the stoma nurse or continence product advisors.	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 inspector reviewed records in respect of staff awareness and knowledge of continence/incontinence, management of bowel and bladder complications. The registered manager and staff spoken with confirmed that staff were 'working through' Four Seasons Health Care's bowel management and caring for a patient with a urinary catheter work books. These booklets were comprehensive and provided staff with background anatomy and physiology and how and why incontinence or complications arise and their management. There was information available on the management of urinary catheters, specific products and appliances. Staff also had access to the organisation's intranet policies, procedure and professional guidance.	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 assessed on this occasion.	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 staff and review of records confirmed that staff received training during induction in relation to continence/incontinence and the management and use of products and aids. Additional training had been provided to registered nurses in relation to male urinary catheterisation and a specific procedure required for a specified assessed need. Discussion with the registered manager and nursing staff revealed that the registered nurses employed by the home were deemed competent in female and male urinary catheterisation. Discussion with registered nurses and review of care records evidenced that staff were knowledgeable on the management of a stoma.	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

At the commencement of the inspection, 07:00 hours, the majority of patients were in their bedrooms and two patients were having breakfast in the dining room as was their wish. Discussion with staff and observations confirmed that patients were not wakened by staff to facilitate the home's routine. Night staff were assisting patients as required. Nurse call bells were answered promptly.

Day staff arrived early to receive a handover report from night staff. Staff on night duty confirmed that two staff remained 'on the floor' until the handover report was finished and day staff came on duty. However, the inspector observed that the handover report did not finish until after 08:00hours and that the agency staff member on the first floor had left the floor at 08:00 hours. Day duty staff did not arrive on this floor until 08:17 hours.

In addition the inspector observed that two patients, on the first floor, had activated their nurse call bells at 08:05 hours. The first staff member onto this floor at 08:17 hours was observed to enter a patient's bedroom but did not respond to the nurse call in the bedroom opposite which was clearly indicated by the light above the bedroom door. A second staff member did attend to the nurse call at 08:18 hours. This delay of 12 minutes was concerning and was discussed with the registered manager. A recommendation is made that the registered manager reviews how staff manage calls for assistance during the handover report and especially if the report does not finish on time.

During the inspection staff were observed to treat the patients with dignity and respect. Staff, before entering a bedroom, would knock the door, if closed; say good morning; identify who they were and ask for permission to enter. Good relationships were evident between patients and staff.

Staff were observed to move and handled patients appropriately.

Patients seated in the lounge areas after breakfast were well presented with their clothing suitable for the season. The demeanour of patients indicated that they were relaxed in their surroundings and those patients who spoke with the inspector confirmed that they felt safe and well cared for.

11.2 Fire safety arrangements

On gaining entry to the home at 07:00 hours the inspector spoke with two registered nurses. The nurse in charge of the home was identified as the registered nurse from a nursing agency and the second nurse was an employee of the home. The inspector then asked what action would be taken in the event of the fire alarm sounding. Both registered nurses were able to verbalise the correct procedure to follow and confirmed that they had been made aware of this as part of their induction to the home. However, when the inspector asked to be shown where the fire panel was located, neither registered nurse knew its' location. Eventually the second registered nurse advised the inspector of the panel's location but this was approximately 10 minutes after the question was asked. This was concerning.

Both registered nurses acknowledged and took responsibility for their lack of knowledge.

Discussion took place regarding this deficit in knowledge and the risks for patients and staff. The inspector advised that further discussion would take place with the home's registered manager and that the agency nurse should also report to their line manager.

The inspector also observed three bedroom doors to be propped or wedged open despite being fitted with hold open devices linked to the fire system. The kitchen door was also wedged open and the kitchen left unattended, by the night staff.

When the registered manager came on duty the inspector discussed the concerns regarding the knowledge of the registered nurse left in charge of the home and fire safety and prevention measures undertaken over the night duty period.

The registered manager confirmed that

- staff employed by the home were required to complete mandatory fire safety training on at least an annual basis. This was delivered through e-learning modules and the compliance levels for fire safety e-learning module were 90%
- agency staff employed by the home were required to complete a home induction record when they first worked in the home. This induction included a section on the fire safety procedures to be followed.

Urgent action requirements were made following feedback to the registered manager and confirmed by email on 3 February 2015.

- any registered nurse who takes charge of the home in the absence of the manager must know the procedures to be followed in the event of the fire alarm sounding. In particular the location of the fire panel and how to interpret it

- reasonable precautions, such as ensuring fire doors are not propped/wedged open or restricted from closing (by equipment), when the fire alarm sounds should be part of the routine checks carried out in relation to the fire safety precautions and prevention measures

- the practice of wedging open the kitchen door must be review and where possible eliminated.

11.3 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 registered manager and reviewed the complaint record. This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements.

Refer also to section 9.1.

11.4 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.

11.5 NMC Declaration

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

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

The inspector reviewed NMC registration checks for three randomly selected registered nurses which evidenced that checks were carried out at the time of renewal of registration.

11.6 Patients and relatives comments

During the inspection the inspector spoke with eight patients individually. Some patients said that they would prefer to be at home but that they were treated with respect, that staff were kind and attentive and they felt safe and cared for.

One patient questionnaire was completed with the inspector, all comments were positive. The patient commented, 'I have a lovely room…it [the bedroom] is kept really clean'.

There were no expressions of dissatisfaction made to the inspector during this inspection.

The inspector spoke briefly with one visitor who took a questionnaire. Five relative/visitor questionnaires were distributed and returned. Comments recorded in the main were positive regarding care received, communication, staff attitude and staff knowledge. Two respondents indicated that they felt the home was under staff and that 'very often' some staff ['agency staff at night'] did not know the needs of their loved one.

One relative commented 'I have been very impressed with the professional attitude of all the staff at Bethany'.

11.7 Staff Comments

During the inspection the inspector spoke with 11 staff and 10 staff completed and returned questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training as required to fulfil their role and function in the home.

Five of the returned questionnaires indicated that staff were 'dissatisfied' in respect of having time to listen and talk with patients. This response was in the main attributed to staffing levels. Refer to section below for details regarding staffing.

However, additional comments recorded by the same staff included:
'Friendly staff, hardworking team'

'We strive to care for each resident the way we would like to be cared for'
'… Our residents depend on the staff…'
'The staff…are caring, loving people who want nothing but the best for our residents…'

11.8 Staffing

The inspector discussed the planned staffing levels for the home and reviewed the nursing and care staff duty rotas for week commencing 26 January 2015. The registered manager confirmed that staffing levels were kept under review to ensure the assessed needs of patients were met.

Staffing levels were observed to meet the needs of the patients during the inspection**.**

11.9 Staff training and competency and capability assessments

When the registered manager came on duty the inspector discussed her concerns regarding the knowledge of the registered nurse left in charge of the home and fire safety and preventions measure over the night duty period. Refer to section 11.2.

The registered manager confirmed that any agency member of staff employed was required to complete an induction on their first shift in the home. The inspector reviewed two records which confirmed this. The record did cover the action to be taken in the event of a fire/fire alarm occurring. However, as evidenced, the registered nurse in charge of the home was not aware of the location of the fire panel and was therefore not competent or capable to act in the event of a fire/fire alarm placing patients and other staff on duty at risk. A requirement has been made in relation to the competency and capability of any registered nurse in charge of the home in the absence of the registered manager. Refer to section 11.2.

The inspector reviewed three randomly selected competency and capability assessments for the registered nurse left in charge of the home in the absence of the registered manager. The records selected were for employees of the home. Each record had been completed in full and signed by the registered nurse and the registered manager declaring competence to fulfil this role.

A system was in place whereby the registered manager reviewed each assessment on an annual basis.

Registered nurses spoken with demonstrated their knowledge regarding

- the care and management of enteral feeding systems
- cardio pulmonary resuscitation (CPR)/basic life support
- management of urinary catheters and incontinence
- the procedure to follow in the event of a fire/fire if they were the designated nurse in charge of the home.

The registered manager confirmed that update training in the management of enteral feeding system had been arranged for 13 February 2015.

Mandatory training was provided through an e-learning programme for all staff employed. The inspector confirmed that the registered manager proactively managed compliance with training requirements.

11.10 Records and record keeping

The inspector examined three patient care records in relation to the assessment, care planning and review of continence/incontinence. Generally care records were maintained to a good standard.

One area identified for improvement, in all three records, was in relation to the management of bowels.

Care staff recorded their observations using the Bristol Stool Chart. However, this record was inconsistent with gaps in recording evident. The evaluation of care delivery recorded on; at least, a daily basis by registered nurses did not provide any information regarding bowel management. A recommendation is made that staff should accurately and consistently record bowel patterns to enable registered nurses to assess needs and to take appropriate action as required.

11.11 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 good standard of hygiene.

The inspector observed that housekeeping staff had stored clinical waste bags outside the lounge dining room on the lower ground floor. Staff confirmed that they would usually wait to remove these bags until they had completed the cleaning of this floor. The inspector advised that clinical waste bags should be removed to the outdoor bin as soon as possible and that storing them outside the lounge/dining room and especially on a carpeted floor would contaminate the area. The housekeeper readily agreed to remove the bags immediately and was observed to do so.

During feedback this was discussed with the registered manager who agreed to look at this issue in relation to infection prevention and control measures. A recommendation is made.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with the registered manager, Jennifer Forbes, 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 designated representative from the home carries out a pre admission assessment. Information from the resident/representative (where possible), the nurse, the care records and information from the Care Management Team informs this assessment. Risk assessments such as the Braden Tool are documented in the pre admission documentation if available 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	Substantially Compliant

completed either over the telephone or immediately on admission with written comprehensive, multidisciplinary information regarding the resident being faxed or left into the home. On admission to the home an identified nurse completes initial assessments using a patient centred approach. The nurse communicates with the resident and/or representative, refers to the pre admission assessment and to information received from the care management team to assist her/him in this process. There are two documents completed within twelve hours of admission - an Admission Assessment which includes photography consent, record of personal effects and a Needs Assessment which includes 16 areas of need - the additional comments section within each of the 16 sections includes additional necessary information that is required to formulate a person centred plan of care for the Resident. In addition to these two documents, the nurse completes risk assessments immediately on admission. These include a skin assessment using the Braden Tool, a body map, an initial wound assessment (if required), a moving and handling assessment, a falls risk assessment, bed rail assessment (if required), a pain assessment and nutritional assessments including the MUST tool, FSHC nutritional and oral assessment. Other risk assessments that are completed within seven days of admission are a continence assessment and a bowel assessment unless there is evidence for immediate assessments requiring completion. Following discussion with the resident/representative, and using the nurse's clinical judgement, a plan of care is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations. This can be evidenced in the care plan and consent forms. The Home Manager and Regional Manager will 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 and holistic assessment of the resident's care needs using the assessment tools as cited in section A, between 7 and 11 days of admission. The named nurse devises care plans to meet identified needs and in consultation with the resident/representative. The care plans demonstrate the promotion of maximum independence and focuses on what the resident can do for themselves as well as what assistance is required. Any recommendations made by other members of the mutidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable. Registered nurses in the home are fully aware of the process of referral to a TVN when necessary. The nurse makes a telephone call to call management who in turn contacts the nursing home support team to make them aware of the referral. 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 from the relevant trust. If necessary, a further referral is made to a vascular surgeon by the G.P, TVN or podiatrist. Where a resident is assessed as being 'at risk' of developing pressure ulcers, a Pressure Ulcer Management and Treatment plan is commenced. A care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. 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 Registered Nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Referrals are made through call management or the GP. All advice, treatment or recommendations are recorded on the FSHC MDT form and advice sheet from the MDT member 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.	Substantially 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**
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 and are re written on a yearly basis. The plan of care dictates the frequency of review and re assessment. The resident is assessed on an on-going 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.	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 system. 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 on-going 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 on-going basis. Staff also refer to FSHC policies and procedures in relation to nutritional care, diabetic care, care of subcutaneous fluids and care of percutaneous endoscopic gastrostomy (PEG).	Substantially Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
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 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/Deputy, these are given to the named nurse to addresss any deficits and are then reaudited.	Substantially Complaint

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 at least monthly or more frequent 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.	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. The care manager is contacted if the minutes have not been received into the home. 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 on-going basis. The care plan reflects type of diet, any special dietary needs, and 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 reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives - residents meetings, one to one meetings and food questionnaires. 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 in the form of a diet notification form which informs the kitchen of each resident's specific dietary needs.	Substantially Compliant

Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything 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. Daily menus are on display on each dining room table, with the 3 week menu displayed in a menu display folder in the foyer of the home.	

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
All nurses have completed an eating and swallowing competency. Four nurses have attended PEG feeding training in May 2013. All instructions from speech and language therapy and other members of the multi disciplinary team, are transcribed in a care plan for all staff to adhere to. There is an evidence folder available in the nurses station and the kitchen with relevant research in regards to caring for residents with dysphagia.. Breakfast is served in a patient cantered manner and is available when the residents request. Lunch is served at 12.45pm, evening meal at 5pm and supper at 8.30pm, however if the resident chooses not to eat at these times a meal is provided at a time of their choice. Hot and cold drinks and snacks are available on request and at customary intervals and fresh drinking water is available at all times. Each resident has an eating and drinking care plan, a diet notification sheet and a food questionnaire detailing likes and dislikes completed. Allocation of staff is done on a daily basis to ensure that there are adequate numbers of staff in the dining room and also for assisting those in their bedrooms at meal times. Any required special aids are provided. Nurses have completed the E Learning module on pressure area care. They also complete a wound competency and supervision practice. The home has good support from the nursing home support team with regards to wound care.	Substantially Compliant

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Secondary Unannounced Care Inspection

Bethany Care Home

2 February 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 registered manager either during or after the inspection visit.

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

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

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

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

Statutory Requirements

This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Nursing Homes Regulations (NI) 2005

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	20(3)	Any registered nurse who takes charge of the home in the absence of the manager must know the procedures to be followed in the event of the fire alarm sounding. In particular the location of the fire panel and how to interpret it **Ref: Section 11 (11.2) and (11.9)**	One	Supervision has taken place with all staff in relation to fire procedures in particular the location of the fire paneland how to interpret it. Also included in the supervision is information of emergency contingency plan for the home, zones within the home, role of the nurse in charge andfire evacuation mattresses. This supervision has been carried out with all trained staff from agencies who work in the home and will be carried out with agency care assistants if any are required to work in the home.	Urgent action required.
2	27(4)	Reasonable precautions, such as ensuring fire doors are not propped/wedged open or restricted from closing (by equipment), when the fire alarm sounds should be part of the routine checks carried out in relation to the fire safety precautions and prevention measures. **Ref: Section 11 (11.2)**	One	Supervision has taken place with all staff including agency in relation to the wedging/propping open of fire doors and also the importance of not having fire doors blocked by equipment. During the estates inspection on 30th September 2014 E learning stats for fire awareness where 75% these have now increased	Urgent action required.

				to 83% and the manager will aim for 100% by 13th April 2015 as some new staff have commenced working in the home and are currently on induction. This module includes the propping/wedging of fire doors. Door retaining units have been requested for any doors which do not already have them.	
3	27(4)	The practice of wedging open the kitchen door must be review and where possible eliminated. **Ref: section 11 (11.2)**	One	All kitchen staff have been informed that the kitchen door must be kept closed at all times until the door retaining unit has been fitted. They have also been informed to keep the equipment switched off ie gas and door closed when kitchen is unoccupied.	Urgent action required.

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.3	Staff must complete all sections detailed on the repositioning record, for example, the condition of the pressure relieving mattress. **Ref: Section 9 (recommendation 4)**	Two	Supervision has been carried out on how to complete a repositioning chart for all staff responsible for completing these charts. Correct completion will be monitored by the home manager.	By end of March 2015.
2	12.1	**Carried forward for review during the next inspection.** It is recommended the daily routine is reviewed in respect of the length of time patients wait at the dining table prior to meals being served. **Ref: Section 9 (recommendation 6)**	One	Lunch time begins with the soup starter at 12.30pm for those residents who wish to have soup. These residents are brought to the dining room from approx 12.15pm. The main meal is served at 12.45pm and the remaining residents are brought to the lounge at approx 12.30. Therefore the length of time waitning is 15 minutes and during this time they are given a clothes protector to wear if they choose to wear one and also are given the drink of their choice.	By end of March 2015.
3	25.2	The registered manager should review how staff manage calls for assistance during the handover report and especially if the report does not finish on time.	One	Supervision has been carried out with staff in regards to time management of the handover.Systems have been put in place to ensure that there	By the end of March 2015.

		Ref: Section 11 (11.1)		are staff on the floors to supervise at all times.	

4	5.6	Staff should accurately and consistently record bowel patterns to enable registered nurses to assess needs and to take appropriate action as required. **Ref: Section 11 (11.10)**	One	All staff have had supervision carried out in relation to the recording of bowel patterns. All care staff have been informed of the importance of reporting bowel patterns to the nurse in charge so as they can monitor if any interventions may be required.	By the end of March 2015.
5	34	The registered manager should review adherence to infection prevention and control measure, particularly in relation to the prompt removal of clinical waste. **Ref: Section 11 (11.11)**	One	All staff have had supervision carried out in relation to infection control and preventiion with particular attention in relation to the prompt removal of clinical waste.	By the end of March 2015.

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	Jenny Forbes
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall Jim McCall 8/3/15

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

Quality Improvement Plan

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	x	Sharon McKnight	8-04-15
Further information requested from provider			