Unannounced Primary Care Inspection

Name of establishment: **Bloomfields Private Nursing Home**

RQIA number: **1063**

Date of inspection: **15 October 2014**

Inspector's name: **Donna Rogan**

Inspection number: **IN017177**

The Regulation And Quality Improvement Authority
9th Floor, Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1.0 General information

Name of establishment:	Bloomfields Nursing Home
Address:	115-117 North Road Belfast BT5 5NF
Telephone number:	02890657799
Email address:	Bloomfieldspnh@btinternet.com
Registered organisation/ Registered provider / Responsible individual	Mr Desmond McLaughlin Mrs Jean McLaughlin
Registered manager:	Emma Murphy (acting manager, registration pending)
Person in charge of the home at the time of inspection:	Emma Murphy
Categories of care:	NH- Dementia (DE)
Number of registered places:	30
Number of patients / residents (delete as required) accommodated on day of inspection:	29 1 vacant
Scale of charges (per week):	£605.00
Date and type of previous inspection:	30 May 2013, Primary Unannounced
Date and time of inspection:	15 October 2014 09.30 – 16.30
Name of inspector:	Donna Rogan (accompanied by Cathal Brown)

2.0 Introduction

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

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

3.0 Purpose of the inspection

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

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

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

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

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

4.0 Methods/process

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

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

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

- review of any notifiable events submitted to RQIA, in accordance with Regulation 30 of the Nursing Homes Regulations (NI) 2005, since the previous inspection.
- Analysis of pre-inspection information submitted by the registered person/s.

- Discussion with the acting manager.
- Discussion with Mr McLaughlin, proprietor.
- Discussion with staff.
- Examination of records pertaining to staffing.
- Review of a sample of policies and procedures.
- Review of a sample of staff training records.
- Review of a sample of staff duty rotas.
- Evaluation and feedback.

5.0 Consultation process

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

Patients/Residents	**18**
Staff	**10**
Relatives	**0**
Visiting professionals	**0**

Questionnaires were provided by the inspector, during the inspection, staff to seek their views regarding the quality of the service

Issued to	**Number issued**	**Number returned**
Patients/residents	**0**	**0**
Relatives/representatives	**0**	**0**
Staff	**10**	**3**

6.0 Inspection focus

The theme for the inspection year April 2014 – March 2015 is: 'Nursing Care'

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 regular reviewed. (Standard 5)

Under the 'Nursing Care' theme, inspection will focus on three areas of practice:

- Management of wounds and pressure ulcers (Standard 11).
- Management of nutritional needs of patients and weight loss (Standard 8 & 12).
- Management of dehydration (Standard 12).

Only selected criteria from each of the four standards will be inspected across nine areas and incorporated into the Provider's Self-Assessment.

The inspector will also consider the management of patient's human rights during this inspection.

The inspection theme and focus for the 2014 – 2015 inspection year was outlined by RQIA at the annual Provider Roadshow in February 2014 and the self-assessment was made available on the RQIA website.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

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

7.0 Profile of service

Bloomfields Nursing home is situated on North Road off the Upper Newtonards Road in East Belfast. It is centrally located within the local community and is convenient to public transport facilities, shops and community services.

The nursing home is a purpose built residence, which provides accommodation and services on two floors.

There are two day rooms; one of which is adjacent to the dining room and is situated on the ground floor. A smaller lounge is available on the first floor. Bedroom accommodation is available on both floors. Bath/shower and toilet facilities are also accessible on both floors of the home. A kitchen, laundry area and staff facilities are provided. A designated care park is available.

The home is registered for a total of 30 patients with a diagnosis of dementia and conditions associated with dementia.

The registration certificate for the home reflected the categories of care being provided and was appropriately displayed.

8.0 Summary of inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Bloomfields Private Nursing Home. The inspection was undertaken by Donna Rogan who was accompanied by Cathal Brown (RQIA) on 15 October 2014 from 09 30 to 16 30.

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

The inspector was welcomed into the home by acting nurse manager Emma Murphy. The proprietor of the home Mr Desmond McLaughlin joined the inspection for a brief period in the afternoon. Verbal feedback of the issues identified during the inspection was provided to Ms Murphy at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. This self-assessment was received by RQIA on 1 April 2014 and the inspector has been able to evidence that the level of compliance achieved with the standards inspected was accurately measured by the registered persons. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector met with patients and staff to seek their opinions of the quality of care and service delivered. The inspector also examined the returned questionnaires from staff, observed care practices, examined a selection of records, and carried out a general inspection of the nursing home environment as part of the inspection process.

The inspector spent a period of ten minutes observing staff and patient interaction. Discussions and questionnaires are unlikely to capture the true experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience. These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool was designed to help evaluate the type and quality of communication which takes place in the nursing home.

As a result of the previous inspection conducted on 30 May 2013. Three requirements and eight recommendations were issued. These were reviewed during this inspection and the inspector evidenced that all three requirements have achieved compliance and five of the eight recommendations have been fully complied with. Three are substantially achieved. Details can be viewed in the section immediately following this summary.

Standards inspected:

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

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

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

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

8.1 Inspection findings

8.1.1 Management of nursing care – Standard 5

There was evidence of comprehensive and detailed assessment of patient needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patient need was evidenced to inform the care planning process.

Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis and as and when required. There was also evidence that the referring health and social care trust (HSCT) maintained appropriate reviews of the patient's satisfaction with the placement in the home, the quality of care delivered and the services provided.

There were no requirements or recommendations made in relation to this standard.

Compliance Level: Compliant

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

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

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

There was only one patient identified with a wound in the home. A review of this patient's care record did not evidence good record keeping regarding the management of the wound. The inspector could not evidence the current condition of the wound as there was no further information available following its initial inclusion on a body map. There was no initial wound assessment or on-going wound assessment chart completed. It is required that this care record is updated to urgently reflect the current state of the wound.

A requirement is made in regards to this standard.

Compliance Level: Substantially compliant

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

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

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

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

Patients were observed to be assisted with dignity and respect throughout the meal. The meal served was well presented and appeared appetising.

There were no requirements or recommendations made in regards to this standard.

Compliance Level: Compliant

8.1.4 Management of dehydration – Standard 12 (selected criteria)

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

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

There were no requirements or recommendations made in regards to this standard.

Compliance Level: Compliant

8.4 A number of additional areas were also examined.

- Records required to be held in the nursing home.
- Human Rights Act 1998 and European Convention on Human Rights (ECHR).
- Patient and staff quality of interactions (QUIS).
- Complaints.
- Patient finance pre-inspection questionnaire.
- NMC declaration.
- Staffing and staff comments.
- Review of care records.
- Environment.
- Management and control of infection.

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

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

Overall, areas for improvement were identified in relation to the environment, laundry and management and control of infection.

There were four requirements and one recommendation made as result of this inspection. The requirements made are detailed throughout the report and in the quality improvement plan (QIP).

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

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

9.0 Follow-up on the requirements and recommendations issued as a result of the previous primary unannounced care inspection conducted on 30 May 2013

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
1.	12 (4)(a)-(c)	The registered person must implement a suitable system which ensures that patients' meals are retained at the correct temperature. (This is specific to patients receiving meals on the first floor.)	A heated trolley has been provided for this purpose. On the day of inspection it was observed to be in use. The meals were observed to be served at the correct temperature.	Compliant
2.	16(2)(c)	The registered person must ensure that the decision making in relation to the use of any devices, equipment, treatments or practices viewed as restraint or restrictive to patients, is recorded in individual care records.	The policy on restraint has been revised. A sample of records reviewed evidenced that where restraint is used that the decision making process was recorded in the individual care records.	Compliant
3.	20(1)(c)(i)(iii)	The registered person should ensure that all nursing staff receive training on wound assessment and wound management, and all	The acting manager confirmed that they have received training on wound assessment and wound management. This training has been cascaded to care staff in relation to pressure area care and prevention.	Compliant

		care staff are trained in pressure area care and prevention in accordance with current evidence based practice.		

No	Minimum Standard Ref.	Recommendations	Action taken – as confirmed during this inspection	Inspector's validation of compliance
1.	25.11	The registered person should ensure regulation 29 reports evidence the progress made in addressing action from the previous report, and the identity of the patients is recorded using unique patient identification to ensure patient privacy.	A review of completed regulation 29 reports, evidenced the progress made in addressing action from the previous report was recorded. Patient identity was anonymised by using the unique patient identification. A recommendation is made that the acting manager should sign when the report is made available to them.	Substantially compliant.
2.	25.13	The registered person should ensure the views of patients and or their representatives are sought via satisfaction surveys and the findings are incorporated as part of the next report. The outcome findings from the annual quality report should also be shared during patient, relative and staff meetings.	Customer satisfaction surveys have been completed and a report has been completed alongside an annual quality report which was completed on 18 March 2014. There was a notice displayed on the patient/relatives notice board that they are available to read.	Compliant

3.	16.3 16.9	The registered person should ensure that four house- keeping staff should receive safe guarding training commensurate with their role and responsibility in the home.	A review of safe guarding training evidenced that house-keeping staff were included in mandatory training. The inspector spoke with the house-keeping staff on duty and they were able to demonstrate knowledge of the action to take should they observe potential abuse.	Compliant
4.	10.7	The registered person should ensure that any revision to, or the introduction of new, policies and procedures are ratified by the responsible individual. In addition the use the use of sensor alarm mats should be included the home's restraint policy.	A review of a sample of policies and procedures evidenced that policies and procedures were ratified by the responsible individual. A review of the revised restraint policy evidenced that the use of sensor alarm mats was included.	Compliant
5.	5.2	The registered person should ensure all nursing records are consistently completed in accordance with guidance provided by the nursing regulatory body. (NMC)	A review of nursing records evidenced that records were generally being maintained in keeping with the NMC guidance. However improvements are required to be made in relation to one patient's care records, in relation to wound care management. A requirement is made in this regard.	Substantially compliant

6.	5.4 5.6	The registered person should ensure that patient daily notes are developed to ensure they are effective in recording a contemporaneous note of all nursing provided to the patient, including a record of their condition.	A review of four patient care record evidenced that patient daily notes were being recorded in relation to the daily care patients were receiving. However one care record is required to be reviewed in relation to a wound of one patient identified. There was no evidence in the care record that the wound had been redressed by care staff from 7 October 2014 to 1510/14. There was no up to date description of the current condition of the wound. The care plan did not state how often the wound was to be redressed. A requirement is made in this regard.	Substantially compliant
7.	5.7	The registered person should ensure that an effective system to audit care records including an action plan to act on the audit findings is effectively implemented.	The acting manager has commenced an auditing process, this includes an effective system to audit care records including an action plan to act on the audit findings.	Compliant
8.	12.1	The registered person should ensure that effective systems are in place to ensure patients are offered hand hygiene prior to the serving of meals.	Throughout the inspection the inspector observed patients being offered hand hygiene. This included prior to the serving of meals.	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 the remit of RQIA to investigate complaints made by or on 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 have been notifications to RQIA regarding incidents since the previous inspection. The incidents were being managed in accordance with best practice guidelines and The Nursing Home Regulations (Northern Ireland) 2005.

10.0 Additional areas examined

10.1 Records required to be held in the nursing home

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

10.2 Patients/residents under guardianship

There were no patients currently under guardianship resident at the time of inspection in the home.

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

The inspector discussed the Human Rights Act and Human Rights Legislation with the acting manager and two of the registered nurses. All three were knowledgeable regarding Human Rights Act 1998.

10.4 Quality of interaction schedule (QUIS)

The inspector undertook a period of observation in the home which lasted for approximately 10 minutes.

The inspector observed the interactions between patient and staff during the serving of lunch in both dining rooms.

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

Positive interactions	10
Basic care interactions	0
Neutral interactions	1
Negative interactions	0

The inspector evidenced that the quality of interactions between staff and patients/residents was positive.

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

10.5 Complaints

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

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

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

10.6 Patient finance questionnaire

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

10.7 NMC declaration

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

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

10.8 Questionnaire findings

10.8.1 Staffing/staff comments

Discussion with the acting manager and a number of staff and review of a sample of staff duty rosters evidenced that the registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients currently in the home. The care and ancillary staffing levels were found to be satisfactory.

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

During the inspection the inspector spoke with ten staff. The inspector was able to speak to a number of these staff individually and in private. On the day of inspection, four staff completed questionnaires. The following are examples of staff comments during the inspection and in questionnaires;

"I enjoy working in the home as all members of staff work as a team and it is a friendly home to work in"
"I have always believed that the care delivered in the home is of a high standard. The home has a good level of staff who work to the best of their ability"
"Care in the home is of a high standard, I am very happy here"
"Everything is good"
"We all work as a team"

10.8.2 Patients' comments

During the inspection the inspectors spoke with 18 patients individually and with a number in groups. Those patients who could communicate with the inspector expressed satisfaction with the care they were receiving. There were no negative comments verbalised.

The following are examples of patients' comments made to the inspector;

"I happy"
"The food is good"
"I've no complaints"

10.8.3 Patient representative/relatives' comments

There were no patients' relatives or representatives available to speak with on the day of inspection.

10.9 Review of care records

The inspector examined four patient care records as part of the inspection process to validate the provider's self-assessment. Three care records were evidenced to be maintained to an acceptable standard.

Wound care records were examined for one patient. The inspector assessed the record as requiring to be updated to accurately reflect the current state of one identified wound. The record required to be updated to evidence that the wound was being managed in keeping with best practice and records were reflective of the care delivery. The acting manager agreed to address this issue without delay. A requirement is made in this regard.

10.10 Environment

The home was well presented, and the environment was welcoming clean and free from malodours. The following areas were discussed with the acting manager and are required to be addressed;

- A variation in the change of use of a bathroom to a store room should be forwarded to RQIA without delay. Any change of use of rooms should be forwarded to RQIA prior to the changes being completed.
- Due to their being continuous faults with the washing machine in the laundry a contingency plan should be put in place for all staff to follow should the washing machine cease to work. A copy of the plan should be forwarded to RQIA.
- Replace the carpet in the identified bedroom.
- Items should not be stored under the identified stairwell in the interests of fire Safety.

10.11 Management and control of infection

There have been a number of infection control audits carried out and they are usually completed monthly. However on the day of inspection a number of infection control issues were identified. The acting manager agreed to address the following issues;

- Soiled and infected linen should be stored in separate coloured bags.
- All prescribed creams and lotions should be clearly labelled with the name of the patient for whom they are prescribed.
- Ensure toothbrushes are appropriately cleaned and stored after use.
- Where toothmugs/denture pots are used in double bedrooms they should be clearly labelled with the patients' identity.
- Pressure relieving equipment should not be used as crash/fallout mats.

11.0 Quality Improvement Plan

The details of the quality improvement plan appended to this report were discussed with Emma Murphy, acting manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider / manager is required to record comments on the quality improvement plan.

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

Enquiries relating to this report should be addressed to:

Donna Rogan
The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
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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 a pre-assessment is carried out by the Home Manager, this along with the information received from family and care management team. On admission the admitting nurse will have already received pre-admission findings and have individual care file ready. The nurse admitting carries out a visual check assessment in the following areas: Nutrition (MUST), Pain (Abbey Pain Scale), Pressure (Braden), Mobility/Falls (therapy risk assessment), Moving & Handling and bedrail assessments.	Compliant

A full body map is completed, if wounds are identified a full wound assessment is carried out. At risk residents will have individualised care plans and will be referred to appropriate members of the multi-disciplinary team for further treatment / advice.	

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**
There is a policy on named nurse concept which outlines responsibilities of named nurse. A plan of care is agreed with the resident / representative in discussion with and taking into account advice and directions for other professionals e.g. Tissue Viability, GP and Dieticians. All referrals are dated and followed up to reduce delays.	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**
All residents are re-assessed as needed, especially regarding wound care following other professionals advice. Daily notes aare recorded twice. All residents have monthly assessment reviews or earlier as stated in care plan.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All care delivered is supported by research based evidence, with regular updates on changes sent by Belfast H&SCT and Public Health. Bloomfields operates Braden Score to assess pressure ulcer risk. Repositioning and wound care / observation sheets are completed for those affected. Treatment plan is drawn up in conjunction with TVN and relevant professional bodies. Residents at risk are on air flow mattresses. NICE Guidelines on file for prevention of pressure ulcers. NICE Clinical Guidelines and Public Health on Nutritional Guidelines for Nursing Homes 2014. One copy at main reception (in residents weights folder) second retained in Kitchen.	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**
There is a policy on record keeping held within the Policy file. All trained staff have copies and are aware of NMC guidelines on record keeping. Residents NOK are encouraged to take part / read and sign completed care plans for their loved ones. Nutritional charts and FBC are retained and completed following all meal / drink servings. Any actions relating to under-nourishment or over-eating are recorded and referrals are made encouraging outside professional bodies to record written report at back of residents notes (multi-disciplinary notes).	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All care plans are updated at least monthly by the named nurse, reviews are also room numbered in diary to remind staff the monthly review is due on that day. Any changes to the residents needs are agreed and documented accordingly. The care plan is adjusted to reflect change. Daily records and entries are recorded at least twice daily withhin the Home.	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**
Residents will normally be seen by their Care Manager from local Trust on the day of their reviews with family present. Care review forms are pre-written normally by the named nurse prior to care review date and time. Any changes are recorded on the communication sheets and relevant changes are made to the residents care plan to reflect changing needs.	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**
There is a 3 week rotational menu in place with choices for residents. At times due to level of dementia a resident may refuse the choices available that day, so staff would be quick to request cook in the kitchen to make an alternative meal. Any resident with particular instructions / requirements regarding their diets are recorded in the care plans and this information is used at hand-over times, especially meal-times to remind staff again, any special diets / preferences, etc. are given to the Cook for his attention.	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All nurses have attended SALT Swallowing Awareness Study Days at some stage. When SALT make assessments the nurse will take on and follow the instructions, then instruct junior staff to the specific techniques. One trained member of staff is always available within the main dining area at meal times to reduce risk of choking. All staff have attended first aid training which including choking.	Substantially compliant

11.7 - early detection of discolouration of potential pressure points is observed and acted upon, notifying GP, Care Manager, RQIA, TVN and Next of Kin.	

Provider's Overall Assessment of the Nursing Home's Compliance Level Against Standard 5	**Compliance Level**
	Compliant

Appendix 2

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

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

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

References

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

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

Quality Improvement Plan

Primary Unannounced Care Inspection

Bloomfields Private Nursing Home

15 October 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Emma Murphy, acting 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	25 (b)	The registered person shall ensure all nursing records are consistently completed in accordance with guidance provided by the nursing regulatory body. (Nursing and Midwifery Council)	One	The Nurse Manager and Sister will regularly audit all nursing records. Training and supervision is ongoing in this area.	From the date of inspection
2	15 (2)	The registered person shall ensure that patient daily notes are developed to ensure they are effective in recording a contemporaneous note of all nursing provided to the patient, including a record of their condition. The identified care record should be updated to ensure the management of wound care is recorded in keeping with best practice guidelines. A regular audit of wounds/pressure ulcers should be conducted by the acting manager to ensure staff are recording wound care/pressure ulcers in accordance with best practice. Records of the audits should be maintained. **Ref previous requirements and 8.1.2**	One	The process of regular auditing will highlight any areas which may require attention. Identified areas will be addressed by the Nurse Manager through training of staff and supervision sessions. New wound care file is in place to keep accurate and up to date records on all wounds in the Home. All wounds will have an initial wound chart, ongoing wound chart and care plan in place including any guidelines from T.V.N. or other members of the multi disciplinary team. The Nurse Manager will carry out regular audits on all wound and records of all wounds on a regular basis.	From the date of inspection

3	27	The registered persons shall ensure the following issues are addressed; A variation in the change of use of a bathroom to a store room should be forwarded to RQIA without delay. Any change of use of rooms should be forwarded to RQIA prior to the changes being completed. Due to their being continuous faults reported with the washing machine in the laundry a contingency plan should be put in place for all staff to follow should the washing machine cease to work. A copy of the plan should be forwarded to RQIA. Replace the carpet in the identified bedroom. Items should not be stored under the identified stairwell in the interests of fire safety. **Ref 10.10 Environment**	One	The variation in the change of use of the bathroom to a store room will be addressed in the New Year when the extension to the Home is taking place. There was a report and form 1a sent to the RQIA about the washing machine. The Policy has been updated and a contingency plan is in place from 16th October 2014. No further faults with laundry equipment which is regularly serviced. Carpet in identified bedroom will be replaced in early 2015. All items have been removed from under identified stairwells and stored in more appropriate areas. New storage to be provided with extension.	From the date of inspection
4	13 (7)	The registered persons shall ensure the following issues are addressed in relation to the management of infection control; Soiled and infected linen should be stored in separate coloured bags. All prescribed creams and lotions should be clearly labelled with the name of the patient	One	Soiled linen is being placed in green bags and infected linen in red bags so staff can easily identify the difference. All creams and lotions remain in original packaging with the name of the patient and instructions for use clearly	From the date of inspection

		for whom they are prescribed. Ensure toothbrushes are appropriately cleaned after use. Where toothmugs/denture pots are used in double bedrooms they should be clearly labelled with the patients' identity. Pressure relieving equipment should not be used as crash/fallout mats. **Ref 10.11 Management and control of infection**		marked. All staff have recently received supervision in use of creams and emollients. All residents have received new toothbrushes. Staff aware to cleanse toothbrushes well after use.Denture pots provided for all residents who require them and these are also clearly labelled. All toiletries belonging to residents in double bedrooms are clearly labelled with the residents identity. Only crash mats are now being used not pressure relieving equipment.	

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	25.12	The acting manager should sign when the Regulation 29 report is made available to them. **Ref previous recommendations**	One	The Regulation 29 Report is signed and dated when received by the Nurse Manager. Any issues identified are actioned immediately.	From the date of inspection

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Emma Murphy
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Desmond McLaughlin

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	Donna Rogan	05/01/15
Further information requested from provider			