Unannounced Primary Inspection

Name of establishment:	**Bryansburn**
Establishment ID No:	**1065**
Date of inspection:	**12 June 2014**
Inspector's name:	**Carmel McKeegan**
Inspection No:	**16819**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of home:	Bryansburn
Address:	96-100 Bryansburn Road Bangor BT20 3RG
Telephone number:	028 91275182
E mail address:	bryansburn@burnviewgroup.com
Registered organisation/ Registered provider / Responsible individual	Bryansburn Mr James Kelly & Mrs Briege Kelly
Registered manager:	Mrs Jaya Kuttippurath
Person in charge of the home at the time of inspection:	Mrs Jaya Kuttippurath
Categories of care:	NH-DE
Number of registered places:	35
Number of patients accommodated on day of inspection:	33
Scale of charges (per week):	£581.00
Date and type of previous inspection:	16 May 2013, Primary unannounced inspection
Date and time of inspection:	12 June 2014 10:00 to 16:30
Name of inspector:	Carmel McKeegan

2.0 Introduction

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

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

3.0 Purpose of the inspection

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

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

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

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

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

4.0 Methods/Process

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

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

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

- Review of any notifiable events submitted to RQIA since the previous inspection.
- Analysis of pre-inspection information.
- Discussion with the registered manager, Mrs Jaya Kuttippurath.
- Observation of care delivery and care practices.
- Discussion with staff.
- Examination of records.
- Consultation with patients individually and with others in groups.
- Tour of the premises.
- Evaluation and feedback.

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

5.0 Consultation Process

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

Patients	**6**
Staff	**6**
Relatives	**3**
Visiting Professionals	**0**

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

Issued To	**Number issued**	**Number returned**
Patients / Residents	**5**	**3**
Relatives / Representatives	**5**	**3**
Staff	**5**	**3**

6.0 Inspection Focus

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

Criteria from the following standards are included;

- management of nursing care – Standard 5
- management of wounds and pressure ulcers –Standard 11
- management of nutritional needs and weight Loss – Standard 8 and 12

- management of dehydration – Standard 12

An assessment on the progress of the issues raised during and since the previous inspection was also undertaken.

The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.

The registered persons and the inspector have rated the home's compliance level against each criterion of the standard and also against each standard.

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

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

7.0 Profile of service

Bryansburn Private Nursing Home is situated on the Bryansburn Road in suburbs of Bangor Town. The nursing home is owned and operated by Mr James Kelly and Mrs Breige Kelly. The current registered manager is Mrs Jaya Kuttippurath.

The home provides nursing care for a maximum of 35 patients with dementia. It is a two storey building set in a residential area with car parking to the side of the building.

Each floor has sitting and dining rooms. Bathrooms, shower rooms and toilets are appropriately located throughout the home. Both floors also have storage cupboards, linen cupboards, sluice rooms, clinical rooms and nursing stations.

The 35 individual bedrooms are bright and spacious, each having amenities which provide for independence and privacy.

All rooms are connected to a nurse call system and there is a passenger lift provided. The kitchen and laundry are situated to the rear of the ground floor and the staff dining and changing rooms are on the second floor.

The home is registered to provide care for a maximum of 35 persons under the following category of care:

Nursing care

DE dementia care

8.0 Summary of Inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Bryansburn Nursing Home. The inspection was undertaken by Carmel McKeegan on 12 June 2014 from 10:00 to 16:30.

The inspector was welcomed into the home by Mrs Jaya Kuttippurath registered manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Mrs Kuttippurath at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. This self-assessment was received by the Authority on 10 April 2014. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector met with patients, staff and relatives, who commented positively on the care and services provided by the nursing home. There were no concerns raised with the inspector.

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

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

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

As a result of the previous inspection conducted on 16 May 2013, three recommendations were issued.

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

Standards inspected:

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

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

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

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

Inspection findings

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

The inspector can confirm that at the time of the inspection there was evidence to validate that patients received safe and effective care in Bryansburn Nursing Home.

Review of the admission policy/ procedures identified that further detail should be provided in relation to the admission process for both planned and emergency admissions to the home. A recommendation is made in this regard.

The inspector reviewed three patient's care records which showed that whilst assessment of need was undertaken for each patient at the time of admission, areas for improvement were identified as follows;

- One patient's care records did not have specific validated risk assessments undertaken on the day of admission to the home.
- One patient's wound management care plan did not show that the mattress recommended by the Tissue Viability Nurse had been provided.
- Three validated assessments in place had not been signed or dated by the author.

Aside from these issues, the inspector was able to verify in other records reviewed that a variety of risk assessments were also used to supplement the general assessment tool. The assessment of patient need was evidenced to inform the care planning process. Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis plus as required. One requirement and two recommendations are made to address the deficits identified.

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.

A recommendation is made that the Patient Guide document is further developed to outline the role and function of the named nurse within Bryansburn Nursing Home.

Review of the 'Writing Care Plan Policy' identified that further information was needed in relation to the role and function of the named nurse in the care planning process and person centred care. A recommendation is made in this regard.

Compliance Level: Substantially compliant

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

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

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

As previously stated one patient's care plan is required to be updated to show that the mattress recommended by the Tissue Viability Nurse had been provided for the patient.

A recommendation is made that the wound management policy is further developed to state the notification procedure of pressure ulcers, grade 2 and above to RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. The policy also should be localised and refer only to this nursing home.

Review of the 'Pressure Sore Risk Assessment Policy' revealed that the policy should be updated to ensure that a pressure risk assessment is undertaken for each patient on the day of admission to the nursing home. The policy should also outline the registered nurses responsibility of the follow on care where a patient is identified to be at risk of developing a pressure sore. A recommendation is made in this regard.

Compliance Level: Substantively compliant

- **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.

A four week rotational menu plan was in place, it is recommended that the four week menu plan is further developed to show the choices for snacks available for all patients, including those on therapeutic diets.

Review of the Nutritional Assessment Policy' revealed that the policy should be updated to reference the Malnutrition Universal Screening Tool (MUST), which was seen to be the nutritional risk assessment tool applied in patients' care records. A recommendation is made in this regard.

Compliance Level: Substantively compliant

Management of dehydration – Standard 12 (selected criteria)

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

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

Review of a sample of fluid intake charts for three patients revealed that there was evidence that the patients were offered fluids on a regular basis throughout the day and also during the night time period.

The fluid intake charts for patients recorded the total fluid intake for patients over 24 hours, an effective reconciliation of the total fluid intake against the fluid target was established, with a record of reconciliation of fluid intake in the daily progress notes.

Compliance Level: Compliant

Patient, representatives and staff questionnaires

Some comments received from patients and their representatives:

"The staff are all very good, they look after us all very well"
"I think this is a good nursing home"
"The food is very good, and the staff are always about to help us"
"I am very grateful for the wonderful care provided in this nursing home, my xxxxxxx has settled in so well, all the staff are professional, patient and kind"
"As a family we are very pleased with the care and attention offered to all the patients, I have no concerns and, if I did, I would speak with the manager"

Some comments received from staff:

"I think this is a very good home and residents are well cared for"
"The quality of care in the home is very good and staff treat the patients very well"
"Everybody works well as a team"
"I am very happy with the standard of care provided in the home,"

A number of additional areas were also examined.

- Records required to be held in the nursing home.
- Guardianship.
- Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS).
- Patient and staff quality of interactions (QUIS).
- Complaints.
- Patient finance pre-inspection questionnaire.
- NMC declaration.
- Staffing and staff comments.
- Comments from representatives/relatives.
- Environment.

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

Conclusion

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

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

Therefore, one requirement and eight recommendations are made. These requirements and recommendations are detailed throughout the report and in the quality improvement plan (QIP).

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

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

9.0 Follow-up on the requirements and recommendations issued as a result of the previous inspection on 16 May 2013

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1.	16	The induction programme for all staff should be further developed to provide written evidence that awareness raising and training on the recognition, recording and reporting of abuse has taken place.	The inspector was able to verify that the induction programme included written evidence that awareness raising and training on the recognition, recording and reporting of abuse has taken place. This recommendation is assessed as compliant	Compliant
2.	15	The policy and procedure in place for the management of restraint should be further developed to provide specific guidance for staff on the types of restraint used in the nursing home.	The inspector was able to verify that the 'Restraint Policy' included provide specific guidance for staff on the types of restraint used in the nursing home. This recommendation is assessed as compliant	Compliant

3.	5	Patients assessed by the Braden Scale as at risk should have a record in the daily progress report in relation to their skin integrity to evidence that regular skin checks are being monitored by the registered nurse and ensure that any identified change in the patient's skin condition is communicated at daily staff handover reports.	Review of three patient's daily progress records confirmed that detail of skin integrity had been assessed and consistently recorded. This recommendation is assessed as compliant.	Compliant

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

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

Since the previous care inspection on 16 May 2013, RQIA have received nil notifications of safeguarding of vulnerable adult (SOVA) incidents in respect of Bryansburn Nursing Home.

10.0 Inspection Findings

Section A

Standard 5.1

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

Standard 5.2

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

Standard 8.1

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

Standard 11.1

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

Inspection Findings:

Policies and procedures relating to patients' admissions were available in the home. It is recommended that the 'Admission Policy' is further developed to include the following;

- The role, function and arrangement of the pre-admission procedure.
- The arrangements to ensure referral forms providing all necessary information, including risk assessments relating to the patient, are provided from the referring Health and Social Care (HSC) Trust prior to admission.
- The arrangements to provide confirmation to the prospective patient that the home is suitable to meet their needs.
- The arrangements to respond to any unplanned admission.
- The arrangements to respond to self-referred patients.
- Detail of the specific clinical risk assessments to be undertaken on the day of admission.
- The policy should be localised as the existing policy refers to 'locating a General Practitioner (GP) in the Carrickfergus area'.
- Admission policies and procedures should be reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing

Homes Minimum Standards (2008) and NMC professional guidance.

The inspector reviewed three patients' care records which evidenced that two patients' individual needs were established on the day of admission to the nursing home through pre-admission assessments and information received from the care management team for the relevant Trust. One patient did not have the Braden scale, MUST, continence, falls risk assessment or safe moving and handling assessment completed on the day of admission to the nursing home, a recommendation is made in this regard.

Two patient's nursing assessment of the patient's activities of daily living had not been signed or dated. A recommendation is made in this regard. Also one patient's assessment of daily living activities had not been updated since 12 March 2013, this assessment should be updated at least annually or more frequently as the patient's needs change. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 15 (2) (b) the patient's need is revised at any time when it is necessary to do so, and in any case not less than annually.

Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure ulcer/wound and if required, the specific care plans regarding the management of the pressure ulcer/wound.

Review of three patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 11 days of patient's admission to the home.

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

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

Section B

Standard 5.3

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

Standard 11.2

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

Standard 11.3

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

Standard 11.8

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

Standard 8.3

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

The inspector observed that a named nurse system was operational in the home. The roles and responsibilities of named nurse were not outlined in the patient's guide. It is recommended the patient's guide is further developed to inlcuded the roles and responsibilities of named nurse so that prospective patients and their representative are informed and understand the function of the named nurse.

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

Patients' care records revealed that the pressure relieving equipment in place on the patients' beds and when sitting out of bed was

addressed in each patients' care plans on pressure area care and prevention.

The inspector was also able to confirm that;

- Pain assessments and care plans on pain management were in place for these patients.
- A body mapping chart was completed for each patient on admission. This chart was reviewed and updated when any changes occurred to the patient's skin condition.
- A care plan was in place which specified the pressure relieving equipment in place on the patient's bed and also when sitting out of bed.
- The type of mattress in use was based on the outcome of the pressure risk assessment. The specialist mattresses in use were being safely used and records were available to reflect they were appropriately maintained.
- A daily repositioning and skin inspection chart was in place patients assessed as being at risk of developing pressure ulcers and also for the patient with a wound. Review of a sample of these charts revealed that patients' skin condition was inspected for evidence of change at each positional change. It was also revealed that patients were repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention.

Review of the 'Pressure Sore Risk Assessment Policy' stated that the initial pressure risk assessment is completed within 10 days of admission, it is recommended that this policy is updated to ensure that a pressure risk assessment is undertaken on the day of admission to the nursing home. The policy should also outline the registered nurses responsibility of the follow on care where a patient is identified to be at risk of developing a pressure sore.

Discussion with the registered manager and two registered nurses and review of three patients' care records confirmed that where a patient was assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention plan and treatment programme. Discussions with registered nursing staff confirmed that pressure ulcers were graded using an evidenced based classification system.

The registered manager and registered nurses confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local HSC Trust. Staff spoken with were knowledgeable regarding the referral process. Discussion with two

registered nurses evidenced that they were knowledgeable of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

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

A process was in place to ensure that each patient's weight was recorded on admission and on at least a monthly basis or more often if required.

There was evidence to verify that patients' nutritional status was also reviewed on at least a monthly basis or more often if required. Daily records were maintained regarding the patient's daily food and fluid intake

Policies and procedures were in place for staff on making referrals to the dietician. These included indicators of the action to be taken and by whom. The 'Nutritional Assessment Policy' stated that the homes uses the 'Prideaux Score', it is recommended that this policy is updated to reference the Malnutrition Universal Screening Tool (MUST), which was seen to be included in patients' care records.

All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment.

Review of care records for three patients evidenced that where the need was identified patients had been referred for a dietetic assessment and/or to the to the speech and language therapist in a timely manner.

Policies and procedures were in place for staff on making referrals to the dietician. These included indicators of the action to be taken and by whom. All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment, however as the home is participating in the Nutritional Research Project being undertaken by the Southern Eastern Healthcare Trust, the community dietician visits the nursing home on a monthly basis and can accept referrals directly which provides dietetic assessment in a timely manner.

Discussion with the registered manager, registered nurses, care staff and review of the 2014 staff training matrix revealed that a high percentage of staff had already undertaken training in pressure area care and prevention, the management of nutrition and wound management. The registered manager confirmed that system was in place to ensure that new staff and those who had not yet attended mandatory training would be provided training later this year.

Patients' moving and handling needs were assessed and addressed in their care plans. There was evidence that manual handling aids were used to minimise risk of friction. Staff consulted confirmed there was sufficient nursing equipment available to move and handle patients'

appropriately.

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

Section C

Standard 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Homes Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**
Review of three patients' care records evidenced that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care including wound care for each patient. Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. Review of one patient's care records in relation to wound care indicated that these care records were reviewed each time the dressing was changed and also when the dressing regime was changed or the condition of the wound had deteriorated. Review of care records also evidenced that nutritional care plans for patients were reviewed monthly or more often as deemed appropriate. The evaluation process included the effectiveness of any prescribed treatments, for example prescribed analgesia. Discussion with one registered nurse and review of governance documents evidenced that a number of care records were audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

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

Section D

Standard 5.5

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

Standard 11.4

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

Standard 8.4

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

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

The inspector examined three patients' care records which evidenced the completion of validated assessment tools such as;

- The Roper, Logan and Tierney assessment of activities of daily living.
- Braden pressure risk assessment tool.
- Nutritional risk assessment such as Malnutrition Universal Screening Tool (MUST)

As previously stated in Section A, it is recommended that specific clinical risk assessments should be undertaken on the day of admission to the nursing home.

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

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

Discussion with the registered manager and registered nurses confirmed that they had a good awareness of these guidelines. Review of

patients' care records evidenced that registered nurses implemented and applied this knowledge.

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

Six staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held at each nurse's station for easy access by staff. Staff were observed maintaining a contemporaneous record of patient's food and fluid intake throughout the day. This is good practice.

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

Section E

Standard 5.6

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

Standard 12.11

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

Standard 12.12

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

A policy and procedure relating to nursing records management was available in the home. It is recommended that the 'Writing Care Plans Policy' is further developed to include the role and responsibility of the named nurse in developing care records and ensuring that the outcome of care is monitored, reviewed, evaluated and recorded in accordance with The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

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

A review of the training records confirmed that staff had received training on the importance of record keeping commensurate with their roles and responsibilities in the home.

Review of three patients' care records revealed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient. These statements reflected wound and nutritional management intervention for patients as required.

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

In general entries were noted to be timed and signed with the signature accompanied by the designation of the signatory. As previously

stated in Section A, a recommendation is made to ensure the patient's assessment of daily living activities is dated and signed to show when the initial nursing assessment had been undertaken and also to ensure that this assessment is reviewed no less than annually.

The inspector reviewed a record of the meals provided for patients. Records were maintained in sufficient detail to enable the inspector to judge that the diet for each patient was satisfactory.

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

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

Review of a sample of fluid intake charts for three patients revealed that there was evidence that the patients were offered fluids on a regular basis throughout the day and also during the night time period.

The fluid intake charts for patients recorded the total fluid intake for patients over 24 hours, an effective reconciliation of the total fluid intake against the fluid target was established, with a record of reconciliation of fluid intake in the daily progress notes.

Staff spoken with were evidenced to be knowledgeable regarding patients' nutritional needs.

As previously stated staff had attended training in the management of nutrition with further dates provided to ensure all staff attend mandatory training and training relevant to their responsibilities.

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

Section F

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

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

Section G

Standard 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate** **Standard 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.**
Prior to the inspection a patients' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that all the patients in the home had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014. The registered manager informed the inspector that patients' care reviews were held post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff preferably the patient's named nurse attends each care review. A copy of the minutes of the most recent care review was held in the patient's care record file. The inspector viewed the minutes of three care management care reviews which evidenced that, where appropriate patients and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended, an updated assessment of the patient's needs and a record of issues discussed. Care plans were evidenced to be updated post care review to reflect recommendations made where applicable.

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

Section H

Standard 12.1

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

Standard 12.3

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

A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. As previously stated in Section B, the 'Nutritional Assessment Policy' should be updated to reference the Malnutrition Universal Screening Tool (MUST), which was seen to be included in patients' care records.

There was a four weekly menu planner in place. The registered manager informed the Inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home. The current menu planner was dated to show when the menu had been revised.

Review of the menu planner showed that only one option was recorded for mid-day meals, discussion with the registered manager, the cook and five staff members indicated that patients are provided with several choices at each meal time. Nursing staff and care staff stated that through person centred care planning and discussions with the patient's representatives, a record is established of each patient's previous and current dietary and culinary preferences and requirements; therefore they can provide an alternative choice should the planned menu conflict with any patient's preference.

During the inspection, the inspector observed patients being consulted with regarding their meals and drinks, different meals and food combinations were provided for some patients, other patients appeared satisfied with the planned meal for that day. The inspector was also able to verify that an accurate record was kept of the meal each patient was provided and of what each patient consumed.

A recommendation is made that the menu plan be further developed to include choices for snacks for all patients, including those on therapeutic diets.

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

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

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

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

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

Section I

Standard 8.6
- **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.**

Standard 12.5
- **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.**

Standard 12.10
- **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:**
  - **risks when patients are eating and drinking are managed**
  - **required assistance is provided**
  - **necessary aids and equipment are available for use.**

Standard 11.7
- **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.**

The inspector discussed the needs of the patients with the registered manager. It was determined that a number of patients had swallowing difficulties.

The registered manager confirmed that staff had attended training in dysphagia awareness during the previous three years and further training was planned for 2014. All staff had attended training in first aid during the previous 12 months.

Review of one patient's care record evidenced that the care plan fully reflected the instructions of a recent speech and language swallow assessment.

Discussion with registered manager confirmed that meals were served at appropriate intervals throughout the day and in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.
The registered manager confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning afternoon and at supper times. As previously stated, in Section H, snack choices should be included in the menu planner.

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

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

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

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

Discussion with the registered nurses clearly evidenced their knowledge in the assessment, management and treatment of wounds. Review of the template used to undertake competency and capability assessments for the registered nurses revealed that pressure ulcer/wound care was addressed.

A 'Wound Care Policy' was in pace to guide registered nurses of the role and responsibility in wound management. It is recommended that the policy is updated as the policy makes reference to another nursing home. The policy should also state the notification procedure of pressure ulcers, grade 2 and above to RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005**.**

The inspector reviewed one patient's care plan who was receiving treatment for a wound. The inspector was able to evidence that a pain assessment and pain management care plan was in place for this patient. The wound management care plan was not easily allocated, and was eventually found with the initial wound assessment, ongoing wound observation chart and Tissue Viability referral records all kept in one single poly pocket. The TVN had recommended that the patient's mattress be upgraded, the patient's care plan did not evidence that this recommendation had been completed. The inspector trawled through the patient's daily progress record that stated that the patient's mattress was delivered and put in place for the patient. It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, regulation 15 (2) (b) that the patient's care plan is updated to evidence each that each recommendation made by the Tissue Viability Nurse is undertaken, reviewed and evaluated.

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

11.0 Additional Areas Examined

11.1 Records required to be held in the nursing home

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

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

11.2 Patients/residents under Guardianship

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

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

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

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

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

The registered manager informed the inspector that these documents will be discussed with staff during staff meetings and that staff will be made aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patients care and accompanying records.

The inspector also discussed the Deprivation of Liberty Safeguards (DOLs) with the registered manager and registered nurses including the recording of best interest decisions on behalf of patients. A copy of DOLS was also available in the home**.**

11.4 Quality of interaction schedule (QUIS)

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

The inspector observed the lunch meal being served in the dining room and in the interactions between patient and staff in upstairs sitting room. The inspector also observed care practices in one of the sitting rooms following the lunch meal.

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

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

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

Staff were observed preparing and seating patients for their meal in a caring, sensitive and unhurried manner. Staff were seen to speak directly to each patient, making eye contact and actively communicating with each person. Care staff were also noted assisting patients with their meals, staff sat down beside the patient they were assisting and were fully engaged in the activity of providing the patient's meal, offering encouragement and prompting as appropriate.

The inspector evidenced that the quality of interactions between staff and patients was positive. Staff were polite and courteous when speaking with patients, conversation was relaxed and respectful.

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

11.5 Complaints

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

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

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

11.6 Patient finance questionnaire

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

11.7 NMC declaration

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

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

11.8 Questionnaire findings

Staffing/Staff Comments

Discussion with the registered manager and a number of staff and review of a sample of staff duty rosters evidenced that the registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients currently in the home. The ancillary staffing levels were found to be satisfactory. In addition to the staff on duty an activity therapist is employed in the nursing home. This is considered good practice and is to be commended.

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

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

"I think this is a very good home and residents are well cared for"
"The quality of care in the home is very good and staff treat the patients very well"
"Everybody works well as a team"
"I am very happy with the standard of care provided in the home,"

Patients' comments

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

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

"The staff are all very good, they look after us all very well"
"I think this is a good nursing home"
"The food is very good, and the staff are always about to help us"

Patient Representative/relatives' comments

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

"I am very grateful for the wonderful care provided in this nursing home, my xxxxxxx has settled in so well, all the staff are professional, patient and kind"
"As a family we are very pleased with the care and attention offered to all the patients, I have no concerns and, if I did, I would speak with the manager"

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Jaya Kuttippurath, registered manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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

Enquiries relating to this report should be addressed to:

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

_____ _____

Carmel McKeegan **Date**
Inspector/Quality Reviewer (Bank)

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**
On admission the staff nurse carries out all initial risk assessments using validated assessment tools such as Braden scale, MUST tool, Manual Handling assessment tool, Fall risk assessment tool and Bed rail risk assessment tools. Taking into consideration of pre admission assessment, information received from the care management team and the intial risk assessment carried out by the staff nurse person centred care plans are completed within 11 days of admission.	Compliant

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
A comprehensive holistic assessment of the patients care needs using validated tools are completed within 11 days of admission. A named nurse has been assigned to discuss, plan and agree nursing interventions to meet the identified assessed needs with the patient's representatives and the multidisciplinary team	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 nurse manager or a designated deputy completes the pre admission assessment and the staff nurse continues the process on admission. There is ongoing reassessments and the care plans are evaluated atleast once a month or more frequently as needed.	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 nursing interventions, activities and procedures are supported by research evidence and guidelines provided by the professional bodies and national standard setting organisations.The staff use validated tools like EPUAP, Crest guidelines,Northern Ireland wound formulary to grade and assess skin damage. The staff also use up to date nutritional guidelines and MUST tool to meet the nutritional requirements of patients.	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 in relation to each patient are kept adhering to NMC guidelines. Food and fluid charts are in place for patients and advices form multi disciplinary team are taken into consideration. The staff have also received training on nutrition and the nursing home is presently involved in a nutrition project conducted by the SEHCT.	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**
The outcome of the care delivered is recorded in progress notes on a daily basis. The patients and relatives are involved in the care as much as possible and the care has been evaluated on a regular basis	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**
The HSC trust arrange care review meetings initially within 6 weeks of placement and one annually. However if the situation warrants additional care review meetings are held as needed. The patient and relatives are encouraged as much as possible to attend the meetings.	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**
Menus are planned by the cook manager taking into consideration of MDT advices. The menus are rotated weekly and the patients are consulted for their likes and dislikes.	Substantially compliant

Section I

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

Criterion 8.6

- **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.**

Criterion 12.5

- **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.**

Criterion 12.10

- **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:**
  - **risks when patients are eating and drinking are managed**
  - **required assistance is provided**
  - **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**
The patients are referred to SLT by the nurses when the patient present with swallowing difficulties. Their recommendations are used to plan care interventions and recorded in care plans. The cook manager is also informed of the changes to the diet. The home has a named wound care nurse who also deliver wound care training. The wound care link nurse from the HSC trust is also consulted for advices on wound care products and dressings.	Compliant

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.

The **Regulation** and **Quality Improvement Authority**

Quality Improvement Plan

Unannounced Primary Inspection

Bryansburn

12 June 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Jaya Kuttippurath, 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	15 (2) (b)	Patient's needs should be revised at any time when it is necessary to do so, and in any case not less than annually; The patient's assessment of need in relation daily living activities should be reviewed at least annually or as the patient's needs change. The patient's care plan should be updated to evidence any recommendation made by the Tissue Viability Nurse's is undertaken. **Ref; Section A and I**	One	The patient's assessment of need in relation daily living activities are now reviewed annually or as the patients need change. The patients care plans are updated with recommendations made by TVN.	From the date of this inspection

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.	26.2	The admission policy should be updated to include to include the following; • The role, function and arrangement of the pre-admission procedure. • The arrangements to ensure referral forms providing all necessary information, including risk assessments relating to the patient, are provided from the referring Health and Social Care (HSC) Trust prior to admission. • The arrangements to provide confirmation to the prospective patient that the home is suitable to meet their needs. • The arrangements to respond to any unplanned admission. • The arrangements to respond to self-referred patients. • Detail of the specific clinical risk assessments to be undertaken on the day of admission. • The policy should be localised as the existing policy refers to 'locating a General Practitioner (GP) in the Carrickfergus area'. • Admission policies and procedures should be reflective of The Nursing Homes Regulations (Northern Ireland)	One	The admission policy has been renewed to include all listed by RQIA.	31 August 2014

		2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.			
2.	6.2	Records should be signed and dated by the author. **Ref; Section A**	One	The staff have been advised of the same and the nurse manager continue to monitor the progress.	From the date of this inspection
3.	5.1	Specific validated risk assessment tools should be completed on the day of admission in order to establish the patient's current needs and base line observations. **Ref; Section A and D**	One	This is ongoing practice.	From the date of this inspection
4.	3.1	The patient's guide should be further developed to outline the role and function of the named nurse process within the nursing home. **Ref; Section B**	One	The patient's guide have been developed to include the role and function of the named nurse	31 August 2014
5.	6.2	The 'Pressure Sore Risk Assessment Policy' should be updated to ensure that a pressure risk assessment is undertaken on the day of admission to the nursing home. The policy should also outline the registered nurses responsibility of the follow on care where a patient is identified to be at risk of developing a pressure sore. **Ref; Section B**	One	The pressure sore risk assessment policy have been updated to incorporate the same.	31 August 2014

6.	6.2	The 'Nutritional Assessment Policy' should be updated to reference the Malnutrition Universal Screening Tool (MUST), which was seen to be the nutritional risk assessment tool applied in patients' care records. **Ref; Section B**	One	Nutritional Assessment policy has been updated as suggested by RQIA.	31 August 2014
7.	6.2	The 'Writing Care Plans Policy' should be further developed to include the role and responsibility of the named nurse in developing care records and ensuring that the outcome of care is monitored, reviewed, evaluated and recorded in accordance with The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance. **Ref; Section E**	One	The writing care plans policy has been revised to include the role and responsibilities of the named nurse.	31 August 2014
8.	12.13	It is recommended that the four week menu plan be further developed to include choices for snacks for all patients, including those on therapeutic diets. **Ref; Section H**	One	The four week menu has been further developed to include choice for snacks.	31 August 2014

9.	6.2	The 'Wound Care Policy' should be updated as the policy makes reference to another nursing home. The policy should also state the notification procedure of pressure ulcers, grade 2 and above to RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. **Ref; Section I**	One	The wound care policy has been updated to reflect the name of the current nursing home. It also states the protocol to report grading of pressure sore to RQIA.	31 August 2014

The registered provider/manager is required to detail the action taken, or to be taken, in response to the issue(s) raised in the Quality Improvement Plan. The Quality Improvement Plan is then to be signed below by the registered provider and registered manager and returned to:

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

Signed: B Kelly

Name: BRIEGE KELLY
Registered Provider

Date 12/09/14

Signed:

Name: Jaya Shree Kuttappurath
Registered Manager

Date 12.09.2014

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	✓	Linda Thomas	22/9/14
Further information requested from provider			