



The Regulation and
Quality Improvement
Authority

Unannounced Secondary Care Inspection

Name of establishment:	Clandeboye
RQIA number:	1072
Date of inspection:	4 November 2014
Inspector's name:	Linda Thompson
Inspection number:	20114

The Regulation And Quality Improvement Authority
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General Information

Name of Home:	Clandeboye
Address:	35 Cardy Close Bangor BT19 1AT
Telephone Number:	028 91271011
E mail Address:	clandeboye@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Health Care Mr James McCall
Registered Manager:	Mrs Joanne Roy
Person in Charge of the Home at the Time of Inspection:	Simona Copcea registered nurse in charge. Joined shortly after commencement by the registered manager.
Categories of Care:	NH - DE
Number of Registered Places:	52
Number of Patients Accommodated on Day of Inspection:	48
Scale of Charges (per week):	£581.00 - £621.00
Date and Type of Previous Inspection:	12 March 2014, Primary Unannounced Inspection
Date and Time of Inspection:	4 November 2014 08.45 – 11.00 hours
Name of Inspector:	Linda Thompson

1.0 Introduction

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

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

1.1 Purpose of the Inspection

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

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

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

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)
- Other published standards which guide best practice may also be referenced during the Inspection process

1.2 Methods/Process

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

- Discussion with the Registered Nurse Manager
- Discussion with staff
- Discussion with patients individually and to others in groups
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- Review of a sample of care plans
- Review of the complaints, accidents and incidents records
- Evaluation and feedback
- Observation during a tour of the premises

1.3 Consultation process

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

Patients	8 individually and to others in small groups
Staff	6
Relatives	0
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	0	0
Relatives / representatives	0	0
Staff	10	10

1.4 Inspection Focus

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

STANDARD 19 - CONTINENCE MANAGEMENT

Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

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

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

2.0 Profile of Service

Clandeboyne Care Home is situated in a residential area on the outskirts of Bangor. It provides single room accommodation for 52 patients. All patient facilities are on the ground floor and easily accessible.

There are two enclosed courtyards and a number of lounges and quiet rooms available throughout the home.

Ample car parking is provided.

The nursing home is owned and operated by Four Seasons Healthcare. Mr James McCall is the responsible person.

The current registered manager is Ms Joanne Roy

The home is registered to provide care for a maximum of 52 persons under the following categories of care:

Nursing care

DE dementia care

The home is divided into two suites;

Stewart Suite which provides care for 33 patients
Dufferin Suite which provides care for 19 patients.

The more physically dependent patients are cared for in the Dufferin Suite.

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) was displayed in the main entrance hall of the home.

3.0 Summary

This summary provides an overview of the services examined during an unannounced secondary care inspection to Clandeboye. The inspection was undertaken by Linda Thompson on 4 November 2014 from 08.45 to 11.00 hours.

The inspector was welcomed into the home by Simona Copcea the registered nurse in charge of the home. The registered manager Ms Joanne Roy joined the inspection shortly afterwards. Ms Roy was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Ms Roy at the conclusion of the inspection.

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

As a result of the previous inspection conducted on 12 March 2014 four recommendations were issued.

These were reviewed during this inspection. The inspector evidenced that all recommendations raised previously have been fully complied with.

Details can be viewed in the section immediately following this summary.

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.

Whilst a high number of patients were unable to clearly verbalise their level of satisfaction with care delivery, the inspector was satisfied that they were content and relaxed in the home setting.

All 10 questionnaires issued to staff were returned to the inspector prior to the conclusion of the inspection. All questionnaires demonstrated positive comments regarding the quality of care delivered in the home.

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

The home was evidenced to be fully compliant with the standard on management of continence.

Nil requirements or recommendations are raised following this inspection.

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 staff who completed questionnaires.

4.0 Follow-Up on Previous Issues

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1.	28.1	It is recommended evidence is present in the induction training records of staff that the registered manager has signed and validated the competency of the staff member.	The inspector can confirm that induction records are appropriately maintained.	Compliant
2.	28.4	It is recommended that all staff complete the eLearning module on the deprivation of liberty.	The inspector can confirm that staff are encouraged to access the e learning and that formal face to face training is scheduled for staff this month.	Compliant
3.	11.4	<p>It is recommended that evidence is present in wound care documentation of the grade of any pressure ulcer, as assessed by nursing staff. A validated tool should be used, for example the European Pressure Ulcer Advisory Panel (EPUAP).</p> <p>It is also recommendation that skin information leaflets are available in the home and given to patients and representatives, as required, in the event of wound care management.</p>	<p>The inspector examined two care records in respect of wound care and can confirm that both were appropriately managed.</p> <p>Information leaflets are provided at the entrance of the home.</p>	Compliant

4.	5.6	It is recommended that evidence is present in patients' progress notes of the status of any wound, following treatment.	The inspector can confirm that daily progress records include an evaluation of wound progress.	Complaint
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4.0 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.

There have been a number of notifications to RQIA regarding safeguarding of vulnerable adults (SOVA) incidents since the previous inspection. The incidents are being managed in accordance with the regional adult protection policy by the safeguarding team within the South Eastern Health and Social Care Trust.

5.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support.	
Criterion Assessed:	COMPLIANCE LEVEL
<p>19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.</p>	
Inspection Findings:	
<p>Review of two patients' care records evidenced that bladder and bowel continence assessments were undertaken for both patients. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care.</p> <p>There was evidence in the patient's care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate.</p> <p>The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate.</p> <p>Review of both 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.</p> <p>The care plans reviewed addressed the patients' assessed needs in regard to continence management.</p> <p>Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.</p>	<p>Compliant</p>

<p>Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.</p>	<p>COMPLIANCE LEVEL</p>
<p>Inspection Findings:</p> <p>The inspector can confirm that the following policies and procedures were in place;</p> <ul style="list-style-type: none"> • continence management / incontinence management • stoma care • catheter care <p>The inspector can also confirm that the following guideline documents were in place:</p> <ul style="list-style-type: none"> • RCN continence care guidelines • British Geriatrics Society Continence Care in Residential and Nursing Homes • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence <p>Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.</p>	<p>Compliant</p>

STANDARD 19 - CONTINENCE MANAGEMENT
Patients receive individual continence management and support.

Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	COMPLIANCE LEVEL
Inspection Findings: Not applicable	Not applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	COMPLIANCE LEVEL
Inspection Findings: Discussion with the registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the manager revealed that all the registered nurses in the home were deemed competent in male/female catheterisation and the management of stoma appliances. Training for all grades of staff in the home was evidenced to be well maintained and records demonstrated the use of a reflective learning tool. The management of this training is commended.	Compliant

Inspector's overall assessment of the nursing home's compliance level against the standard assessed	Compliant
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6.0 Additional Areas Examined

6.1 Care Practices

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

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

6.2 Patients' Views

During the inspection the inspector spoke to 8 patients individually and to others in groups. These patients expressed high levels of satisfaction with the standard of care, facilities and services provided in the home. A high number of patients were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients' comments were as follows:

"I am very happy with everything here."
"The girls in green are 110% perfect"
"There are a great bunch of girls here"
"Food is very good."

6.3 Staffing/Staff Views

The inspector examined duty rotas spanning a three week period. Review of duty rotas indicated that the staffing arrangement met RQIA's recommended minimum staffing guidance for nursing homes for the number of patients currently accommodated.

During the inspection the inspector spoke to six staff. The inspector also issued 10 questionnaires which were all returned prior to the conclusion of the inspection.

Examples of staff comments were as follows;

"I am very happy working in the home."
"This is a good home we work well as a team."
"The patients and residents are well cared for."
"As a carer I believe the home provides a fantastic care environment for all residents. All residents are treated as individuals and we strive to meet their needs and keep them happy on a daily basis"

6.4 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a high standard of hygiene. There were no malodours evidenced throughout the home.

Quality Improvement Plan

Where the inspection resulted in no recommendations or requirements being made the provider/manger is asked to sign the appropriate page confirming they are assured about the factual accuracy of the content of the report.

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

Enquiries relating to this report should be addressed to:

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Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
<p>Criterion 5.1</p> <ul style="list-style-type: none"> • 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. <p>Criterion 5.2</p> <ul style="list-style-type: none"> • A comprehensive, holistic assessment of the patient’s care needs using validated assessment tools is completed within 11 days of admission. <p>Criterion 8.1</p> <ul style="list-style-type: none"> • Nutritional screening is carried out with patients on admission, using a validated tool such as the ‘Malnutrition Universal Screening Tool (MUST)’ or equivalent. <p>Criterion 11.1</p> <ul style="list-style-type: none"> • 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 : Regulations 12(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
<p>Prior to admission to the home, the Home Manager or a designated representative from the home carries out a pre admission assessment. Information gleaned from the resident/representative (where possible), the care records and information from the Care Management Team informs this assessment. Risk assessments such as the Braden Tool are carried out, if possible, at this stage. Following a review of all information a decision is made in regard to the home's ability to meet the needs of the resident. If the admission is an emergency admission and a pre admission is not possible in the resident's current location then - a pre admission assessment is completed over the telephone with written comprehensive, multidisciplinary information regarding the resident being faxed or left into the home. Only when the Manager is satisfied that the home can meet the residents needs will the admission take place.</p> <p>On admission to the home an identified nurse completes initial assessments using a patient centred approach. The nurse communicates with the resident and/or representative, refers to the pre admission assessment and to information received from the care management team to assist her/him in this process.</p> <p>There are two documents completed within twelve hours of admission - an Admission Assessment which includes photography consent, record of personal effects and a record of 'My Preferences' and a Needs Assessment which includes 16 areas of need - the additional comments section within each of the 16 sections includes additional necessary information that is required to formulate a person centred plan of care for the Resident.</p> <p>In addition to these two documents, the nurse completes risk assessments immediately on admission. These include a skin assessment using the Braden Tool, a body map, an initial wound assessment (if required), a moving and handling assessment, a falls risk assessment, bed rail assessment, a pain assessment and nutritional assessments including the MUST tool, FSHC nutritional and oral assessment. Other risk assessments that are completed within seven days of admission are a continence assessment and a bowel assessment,</p> <p>Following discussion with the resident/representative, and using the nurse's clinical judgement, a plan of care is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations. This can be evidenced in the care plan and consent forms.</p> <p>The Home Manager and Regional Manager will complete audits on a regular basis to quality assure this process</p>	<p>Compliant</p>

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.	
<p>Criterion 5.3</p> <ul style="list-style-type: none"> • 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. <p>Criterion 11.2</p> <ul style="list-style-type: none"> • There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability. <p>Criterion 11.3</p> <ul style="list-style-type: none"> • 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. <p>Criterion 11.8</p> <ul style="list-style-type: none"> • 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. <p>Criterion 8.3</p> <ul style="list-style-type: none"> • 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 : Regulations 13 (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
<p>A named nurse completes a comprehensive and holistic assessment of the resident's care needs using the assessment tools as cited in section A, within 7 days of admission. The named nurse devises care plans to meet identified needs and in consultation with the resident/representative. The care plans demonstrate the promotion of maximum independence and focuses on what the resident can do for themselves as well as what assistance is required. Any recommendations made by other members of the multidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable.</p> <p>Registered nurses in the home are fully aware of the process of referral to a TVN when necessary. There are referral forms held in a designated file in the nurse's office, the Tissue Viability Nurse's details are also held in this file - name, address and telephone no. Once the form has been sent it, is then followed up by a telephone call to the TVN where advice can be given prior to their visit. Referrals are also made via this process in relation to residents who have lower limb or foot ulceration to either the TVN or a podiatrist. If necessary, a further referral is made to a vascular surgeon by the G.P, TVN or podiatrist.</p> <p>Where a resident is assessed as being 'at risk' of developing pressure ulcers, a Pressure Ulcer Management and Treatment plan is commenced. A care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. The care plan will give due consideration to advice received from other multidisciplinary members. The treatment plan is agreed with the resident/representative, Care Management and relevant members of the MDT. The Regional Manager is informed via a monthly report and during the Reg 29 visit.</p> <p>The Registered Nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Dietician referral forms are held within the home. These forms can be completed by staff in the home and faxed directly to the dietician for referral. The dietician is also available over the telephone for advice until she is able to visit the resident. All advice, treatment or recommendations are recorded on the MDT form with a subsequent care plan being compiled or current care plan being updated to reflect the advice and recommendations. The care plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in the home and other members of the MDT are kept informed of any changes.</p>	<p>Compliant</p>

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 <ul style="list-style-type: none"> • 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
<p>The Needs Assessment, risk assessments and care plans are reviewed and evaluated at a minimum of once a month or more often if there is a change in the resident's condition. The plan of care dictates the frequency of review and re assessment, with the agreed time interval recorded on the plan of care.</p> <p>The resident is assessed on an ongoing daily basis with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the Home Manager's attention.</p> <p>The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.</p>	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.	
<p>Criterion 5.5</p> <ul style="list-style-type: none"> • All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. <p>Criterion 11.4</p> <ul style="list-style-type: none"> • A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented. <p>Criterion 8.4</p> <ul style="list-style-type: none"> • There are up to date nutritional guidelines that are in use by staff on a daily basis. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)</p>	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
<p>The home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to.</p> <p>The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading system. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime or if the condition of the pressure ulcer changes.</p> <p>There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', ' PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in relation to nutritional care, diabetic care, care of subcutaneous fluids and care of percutaneous endoscopic gastrostomy (PEG)..</p>	<p>Compliant</p>

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 and 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
<p>Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are contemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines - Record keeping:Guidance for nurses and midwives.</p> <p>Records of the meals provided for each resident at each mealtime are recorded on a daily menu choice form. The Catering Manager also keeps records of the food served and include any specialist dietary needs.</p> <p>Residents who are assessed as being 'at risk' of malnutrition, dehydration or eating excessively have all their food and fluids recorded in detail on a daily basis using a FSHC food record booklet or fluid record booklet. These charts are recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. The nurse utilises the information contained in these charts in their daily evaluation. Any deficits are identified with appropriate action being taken and with referrals made to the relevant MDT member as necessary. Any changes to the resident's plan of care is discussed with them and/or their representative.</p> <p>Care records are audited on a regular basis by the Manager with an action plan compiled to address any deficits or areas for improvement - this is discussed during supervision sessions with each nurse as necessary.</p>	<p>Compliant</p>

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 <ul style="list-style-type: none"> The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives. 	
Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
The outcome of care delivered is monitored and recorded on a daily basis on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan of care or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their representatives are involved in the evaluation process.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
<p>Criterion 5.8</p> <ul style="list-style-type: none"> 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. <p>Criterion 5.9</p> <ul style="list-style-type: none"> 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. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)</p>	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
<p>Care Management Reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the resident's file.</p> <p>Any recommendations made are actioned by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals.</p>	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
<p>The home follows FSHC policy and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs on admission and review on an ongoing basis. The care plan reflects type of diet, any special dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if necessary.</p> <p>The home has a 4 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives - residents meetings, one to one meetings and food questionnaires. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied.</p> <p>Copies of instructions and recommendations from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs.</p> <p>Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything from the daily menu an alternative meal of their choice is provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room, with the 4 week menu displayed in a menu display folder and on the wall outside the kitchen.</p>	<p>Compliant</p>

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
<p>Registered nurses have received training on dysphagia and enteral feeding techniques (PEG) on 10/9/13. Further training on dysphagia and feeding techniques is arranged for all care and kitchen staff on 29/4/14, 13/6/14 and 11/9/14. The Speech and Language therapist and dietician also give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document - 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for feeding, equipment to use and assistance required. The kitchen receive a copy of the SALT's recommendations and this is kept on file for reference by the kitchen. Special diets are displayed on a white board in the fridge room.</p> <p>Meals are served at the following times:- Breakfast - 9am-10.30am Morning tea - 11am Lunch - 12.40pm-12.50pm Afternoon tea - 3pm Evening tea - 4.50pm Supper - 7.30pm-8pm</p> <p>There are variations to the above if a resident requests to have their meals outside of these times. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. There are foods available outside of these times for those resident's who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedrooms, these are replenished on a regular basis.</p> <p>Any matters concerning a resident's eating and drinking are detailed on each individual care plan - including for eg. likes and dislikes, type of diet, consistency of fluid, any special equipment required and if assistance is required. A diet notification form is completed for each resident with a copy given to the kitchen and one held in the care file. Meals are not served unless a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Appropriate aids such as plate guards and specialised cutlery are available as necessary and as indicated in the plan of care.</p> <p>Each nurse has completed an education e-learning module on pressure area care. The home has a link nurse who has received enhanced training, to provide support and education to other nurses within the home on an ad hoc basis. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the home have a competency assessment completed. Competency assessments have a quality assurance element built into the process.</p>	Compliant

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



No requirements or recommendations resulted from the **unannounced** inspection of **Clandeboye** which was undertaken on **4 November 2014** and I agree with the content of the report. Return this QIP to nursing.team@rqia.org.uk.

Please provide any additional comments or observations you may wish to make below:

NAME OF REGISTERED MANAGER COMPLETING	Joanne Roy
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING	Jim McCall <i>Carol Cousins</i>

CAROL COUSINS DIRECTOR OF OPERATIONS

Approved by:	Date
<i>hinda thompson</i>	<i>17/11/14</i>