Unannounced Primary Care Inspection

Name of establishment:	**Corriewood Private Clinic**
RQIA number:	**1076**
Date of inspection:	**7 October 2014**
Inspector's name:	**Linda Thompson**
Inspection number:	**17082**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of establishment:	Corriewood Private Clinic
Address:	3 Station Road Castlewellan BT31 9NF
Telephone number:	028 43778230
Email address:	corriewoodrqia@btconnect.com
Registered organisation/ Registered provider / Responsible individual	Mrs Anne Monica Byrne & Mrs M.I. McGrady
Registered manager:	Ms Teresa Josephine McClean
Person in charge of the home at the time of inspection:	Ms Teresa Josephine McClean
Categories of care:	NH-I ,NH-PH ,NH-PH(E) ,NH-TI, NH-MP, NH-LD, RC-I
Number of registered places:	42
Number of patients / residents (delete as required) accommodated on day of inspection:	39
Scale of charges (per week):	£581.00 nursing patients
Date and type of previous inspection:	29 November 2013, primary unannounced inspection
Date and time of inspection:	7 October 2014 08.30 – 17.00 hours
Name of inspector:	Linda Thompson

2.0 Introduction

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

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

3.0 Purpose of the inspection

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

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

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

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

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

4.0 Methods/process

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

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

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

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

- discussion with the registered manager
- review of the returned quality improvement plan (QIP from the previous care inspection conducted on 29 November 2013.
- observation of care delivery and care practices
- discussion with staff on duty at the time of this inspection
- examination of records pertaining to the inspection focus
- consultation with patients individually and with others in groups
- examination of the premises
- evaluation and feedback.

5.0 Consultation process

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

Patients/Residents	25
Staff	8
Relatives	3
Visiting professionals	0

Questionnaires were provided by the inspector, during the inspection, to patients, their representatives and staff to seek their views regarding the quality of the service
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Issued to	**Number issued**	**Number returned**
Patients / residents	5	5
Relatives / representatives	3	1
Staff	10	10

6.0 Inspection focus

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

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

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

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

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

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

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

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

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

7.0 Profile of service

Corriewood Private Clinic is situated on the outskirts of the town centre of Castlewellan. The home has extensive grounds and was originally a 'gentleman's residence'.

Extensive building work is ongoing at present and it is anticipated that the first phase of the building work will complete by December 2014.

The nursing home is owned and operated by Mr & Mrs Byrne and Mrs M I McGrady.

The current registered manager is Ms Teresa McClean. Ms McClean has been with the home for many years.

Accommodation for patients is provided over two floors of the home.
Access to the first floor is via a passenger lift and stairs.

Communal lounge and dining areas are provided on the ground floor. Patients are encouraged to use the communal lounge and dining areas however they are free to choose to remain in their own rooms if preferred.

The home also provides for catering and laundry services *on the ground floor*.

A number of communal sanitary facilities are available throughout the home.

The home is registered to provide care for a maximum of 42 persons under the following categories of care:

<u>Nursing care</u>

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
PH (E)	physical disability other than sensory impairment over 65 years
LD	learning disability under 65 years (limited to 2 identified patients)
MP	mental disorder excluding learning disability or dementia under 65 years (limited to 4 identified patients)
TI	terminally ill

The home is also approved to provide care on a day basis to 2 persons.

<u>Residential care</u>

I	old age not falling into any other category (limited to one identified resident)

The homes certificate of registration is appropriately displayed in the entrance area of the home.

8.0 Executive summary

The unannounced inspection of Corriewood Private Clinic was undertaken by Linda Thompson on 7 October 2014 between the hours of 08.30 and 17.00. The inspection was supported by Ms Teresa McClean registered manager and by Mrs M.I. McGrady registered person who joined the inspection shortly after commencement.

Feedback was provided to the registered manager and the registered person at the conclusion of the inspection.

The theme for the 2014 – 15 inspection year is 'Nursing Care' (Standard 5) and the inspection focused on three areas of practice related to:

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

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

The requirements and recommendations made as a result of the previous inspection were also examined.

Prior to the inspection, the registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. This self-assessment was received on 11 September 2014. The comments provided by the registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

The inspector in preparation for the inspection examined all documents received prior to the inspection visit. The self-assessment submitted by the registered manager was well presented and comprehensive in detail. Other documents submitted confirmed that management of the home is in keeping with the Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Nursing Home Minimum Standards 2008.

The inspector can confirm that during the inspection patients were well presented, suitably dressed for the season and appeared to be well cared for. There was a relaxed, homely and welcoming atmosphere in the home throughout the day.

The inspector can confirm that at the time of this inspection, the delivery of care to patients/residents was evidenced to be of a good standard and patients were observed to be treated by staff with dignity and respect.

Refer to section 11.0 for further details about patients and residents.

The inspector examined the staff duty rota as part of the inspection process and can confirm that the staffing compliment was in keeping with the Rhys Hearn dependency assessment as recommended by RQIA.

The homes general environment was observed to be well maintained clean and tidy. The inspector raised one concern regarding a malodour from a communal bathroom at the rear of the dining room / lounge. It was confirmed that this was due to damp from old bathing equipment. The inspector can confirm that actions to address the matter were taken immediately during inspection. No other malodours were evidenced throughout the home.

Despite extensive building work ongoing on site there was no evidence of disruption to the patients.

There were systems and processes in place to ensure the effective management of the standards inspected. However, areas for improvement were identified in relation to the management of wound care records and in general to the assessment of patient need the review of risk assessments, general assessments and care plans and the layout of nursing care records.

The inspector reviewed and validated the home's progress regarding the previous requirements and recommendations made at the last inspection. The inspector can confirm that all previous requirements and recommendations have been fully complied with.

Verbal feedback of the inspection outcomes was given to the registered manager and registered person throughout the inspection and at the conclusion of the inspection process.

Conclusion

As a result of this inspection, all requirements and all recommendations made previously have been evidenced to have been actioned appropriately.

As a consequence of this inspection four requirements and three recommendations are raised.

Details can be found under Section 10.0 in the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, their representatives, the registered person, 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 secondary unannounced care inspection conducted on 31 March 2014

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
C/F	27(2)(t)	The registered person must ensure that a risk assessment to manage health and safety has been carried out and updated when necessary Carried forward for review at the next inspection	The inspector can confirm that the risk assessment has been carried out as required.	Compliant
C/F	24(3)	The registered person must provide confirmation to RQIA that the investigation of one complaint has been concluded and advise RQIA on the complaint outcome. Carried forward for review at the next inspection	The inspector can confirm that the complaint identified has been fully concluded and appropriately managed.	Compliant

C/F	32(h)	The registered person shall give notice in writing to the Regulation and Quality Improvement Authority as soon as it is practicable to do so, if any of the following events takes place or is proposed to take place: • the premises of the nursing home are significantly altered or extended, or additional premises are acquired • the registered persons must inform RQIA upon the completion of each phase of the variation to ensure approval by RQIA before it becomes operational. Carried forward for review at the next inspection	The inspector can confirm that appropriate notification as required is provided. The management of Corriewood Private Clinic are ensuring that RQIA are kept fully informed of the progress of the homes building works.	Compliant

C/F	14(3)	The registered person must ensure that a safe system for moving and handling patients is provided at all times. • RQIA require confirmation that the competency of staff involved in moving and handling patients has been reassessed, and, additional training is provided where deficits in practice have been identified. • The registered person should provide written confirmation that all staff are appropriately updated and deemed competent in safe moving and handling of patients. • Evidence of training and competency must be retained for inspection. Carried forward for review at the next inspection	The inspector can confirm that all staff are appropriately trained in safe moving and handling. Competency assessments are maintained to ensure that training received is fully embedded into practice.	Compliant

1.	20(1)(c)(i)	The registered person must provide written confirmation to RQIA with the return of the QIP that any nurse working in the home who undertakes wound care tasks has received the required training and has been assessed and deemed competent to perform wound care safely and effectively. Records of the training and subsequent competency of the registered nurse must be maintained for inspection.	The inspector can confirm that this confirmation has been received by RQIA as required.	Compliant
2.	20(1)(c)(i)	The registered person must provide written confirmation to RQIA that all staff are up to date with mandatory training and or training updates. Confirmation is also required that supervisory staff have received arranged training.	The inspector can confirm that mandatory training is well maintained. Supervisory staff have received training in supervision.	Compliant

3.	12 (3)	The registered manager must ensure that; • all emergency equipment is maintained is an hygienic state and is ready for use at all times • the damaged nebuliser must be repaired or replaced with urgency • Blood testing equipment must be maintained ready for use. • a quality assurance process for the checking and management of emergency equipment must be initiated and maintained. Records must be retained for inspection.	The inspector can confirm that all emergency equipment is maintained clean and ready for use. The damaged nebuliser has been appropriately repaired. Blood testing equipment was observed to be appropriately maintained. Records for inspection and management of all emergency equipment were examined and the inspector can confirm that they are maintained appropriately.	Compliant

4.	14 (2)	The registered manager must ensure that; • emergency oxygen is made readily available throughout the home • oxygen cylinders required to be moved throughout the home should be stored in an appropriate trolley • oxygen signage should be available when oxygen is in use in the home.	The inspector can confirm; Emergency oxygen was observed to be available at various locations throughout the nursing home. Emergency oxygen required for use throughout the home is stored on wheeled trolleys ready for ease of transfer. Oxygen signage was observed as required.	Compliant
5.	19(3)(a)	The registered manager must ensure that records are appropriately maintained in respect of; • when a review of advanced care planning is undertaken. • All patient care records are wholly completed by the registered nursing team. This specifically refers to the management of repositioning records.	The inspector can confirm that the nursing care records have been maintained as required.	Compliant

No	Minimum Standard Ref.	Recommendations	Action taken – as confirmed during this inspection	Inspector's validation of compliance
C/F	25.13	The registered person should ensure that the annual quality report is developed further to include the following information. • proposed areas for improvement • qualitative information recorded from patients and representatives on their experience of living in the home and their views of the services provided • information as to how a copy of the report is made available to patients in compliance with regulations **Carried forward for review at next inspection**	The inspector can confirm that the annual quality is appropriately maintained.	Compliant
C/F	26.6	The registered person must ensure that any revision to, or introduction of new policies and procedures is ratified by the registered provider. **Carried forward for review at next inspection**	The inspector can confirm that this recommendation has been fully actioned.	Compliant

C/F	10.7	The registered person should ensure the restraint policy is reviewed and updated to reflect Human Rights Legislation, the recording of best interest decisions and the DHSSPS Deprivation of Liberty Safeguards. (DOLS) **Carried forward for review at next inspection**	The inspector can confirm that the restraint policy is appropriately updated and staff are fully aware of Human Rights Legislation.	Compliant
C/F	5.5	The registered person should ensure the home's policies and procedures pertaining to the prevention and management of pressure ulcers and wound care are updated to incorporate / reference the most recent evidence based literature. **Carried forward for review at next inspection**	The inspector can confirm that the policy documents pertaining to prevention and management of pressure ulcers and wound care are appropriately updated and reference the most recent evidence based guidance.	Compliant

C/F	32.11	The registered person should ensure that RQIA are notified in a timely way of : • all structural changes or change of use to the registered building and or alterations to engineering services are approved by the Regulation and Quality Improvement Authority and, where relevant other statutory bodies. • prior to work commencing, a timetable for each phase should be submitted to RQIA. When submitting this information, the registered persons are requested to include the measures which will be in place to ensure that any disruption to the existing home is kept to an absolute minimum throughout the proposed works **Carried forward for review at next inspection**	The inspector can confirm that appropriate notification is maintained as required.	Compliant

1.	25(2)	The registered persons must ensure the time of completing the Regulation 29 visit is consistently recorded.	The inspector can confirm that the Regulation 29 visits and subsequent reports are maintained as required.	Compliant
2	32.1	The registered person should ensure that the building is kept clean and hygienic at all times and decorated to a standard acceptable for patients.	The inspector can confirm that the nursing was evidenced to be clean and well maintained on the day of inspection.	Compliant
3.	20.3	It is recommended that the registered manager ensure that staff have access to and are familiar with professional guidance documentation in respect of resuscitation. Guidance documents such as; • Resuscitation Council UK Guidelines • NMC Guidelines for resuscitation	The inspector can confirm from discussion with the registered manager and the registered nursing staff that the documentation / professional guidance required is available in the home.	Compliant
4.	35.3	It is recommended that the registered manager ensure that staff are made fully aware of the first aider identified on each shift.	The inspector can confirm that staff are knowledgeable of the first aider on duty each day.	Compliant

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

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

Since the previous inspection in March 2014, RQIA have not been notified by the home of any ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues.

10.0 Inspection findings

Section A – On admission a registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Standard criterion 5.1, 5.2, 8.1 and 11.1 examined.
Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance. The inspector reviewed two patients' care records which evidenced that 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. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks. Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart and continence were also completed on admission. 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 two patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 11 days of the patient's admission to the home. The inspector discussed wound management with one registered nurse who was very aware of the needs of the patient in respect of wound care. Unfortunately the wound care records failed to adequately record the wound dressing details. The registered nurse however demonstrated a good awareness of the patient 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. **A requirement is raised in accordance with Regulation 19 (1)(a) schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005 in respect of wound care records.**

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

Section B –A registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Care records evidence involvement of the patient and /or their representative and that care planning and delivery reflect the recommendation from relevant health professionals. Referrals to healthcare professionals are made as required and in a timely manner. Standard criterion 5.3, 11.2, 11.3, 11.8 and 8.3 examined.

The inspector observed that a named nurse and key worker system was operational in the home. The roles and responsibilities of named nurses and key workers were outlined in the patient's guide.

Review of two 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 appropraitely addressed in the patients' care plans The inspector was able to confirm that pain assessments were appropriately used for these patients.

The registered manager informed the inspector that there was one patient in the home who required wound management. Review of this patient's care records revealed the following:

- A body mapping chart was completed for the 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 for the patient with the wound and also for patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these charts revealed that the patients' skin condition was inspected for evidence of change at each positional change. It was also revealed that the patient was repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention.

Discussion with the registered manager and two registered nurses and a 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.

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 healthcare 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. A tissue viability link nurse was employed in the home which is commendable.

However as discussed in Section A above the wound care records maintained for one identified patient were evidenced to be below an acceptable professional standard.

Records examined evidenced the following;

- Professional assessment recommends renewal of wound dressings 3 times per week
- Records for right foot and right leg evidence that dressings renewed 17/8/14, 25/8/14, 3/9/14, 5/9/14 and 5/10/14, 6/10/14
- Records for left foot evidenced that dressings renewed 17/8/14, 25/8/14, 3/9/14, 5/9/14 and 6/10/14

The inspector however can confirm that the TVN assessed the level of improvement in wounds within 10 days of the inspection and noted significant improvements in healing. The wound care link nurse stated that dressing had been renewed with the required frequency however the records failed to demonstrate this action.

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

The patient's weight was recorded on admission and on at least a monthly basis or more often if required.

The patient's nutritional status was also reviewed on at least a monthly basis or more often if required.
Daily patient progress records were examined by the inspector. Entries in these records failed to evaluate fully the care prescribed in care planning.

The inspector recommends the following changes to nursing care records;

- Patient care records should be stored in one individual folder per patient. The current practice has the patient assessment, care plans and reviews stored in a separate folder from the daily progress notes. To complete an appropriate review of the delivery of care each day the staff should be referring to the care plans established.
- A comment on each prescribed care plan should be made daily. If an assessed need is identified and a care plan established to address the need, then the delivery of care to meet that identified need should be evaluated in the daily progress records.
- Records on daily progress records should refer to the numbered care plan. An index of care plans would ensure that staff were prompted to record delivery of care appropriately.
- Any patient at risk of dehydration and requiring fluid intake monitoring should have an identified fluid intake target established in line with Nutritional guidelines. The level of fluid consumed over 24 hours should be recorded into daily progress records and an evaluation of the actual intake against the target intake evaluated. Referral should be made to the patient's GP should the target oral intake not be achieved for a predetermined period. The GP retains responsibility to reset the target of fluid to be consumed should the volume need to be reduced.

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.

Review of care records for one patient evidenced that the patient was referred for a dietetic assessment in a timely manner.
This patient was also referred to the speech and language therapist.

Discussion with the registered manager, registered nurses, care staff and review of the staff training records, revealed that staff were trained in wound management and pressure area care. Staff were also trained in the management of nutrition.

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.

The registered manager and registered nurses informed the inspector that pressure ulcers were graded using an evidenced based classification system.

One requirement as discussed in section A and three recommendations are made in regard to shortfalls in patients' care records inspected.

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

Section C - Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans. Standard criteria 5.4 examined.
Review of two 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. The re assessment on a daily basis however failed to be recorded with sufficient detail. This was discussed in section B above. The nursing care records for one identified patient illustrated that following; • The assessment of activities of daily living had not been updated since 16/9/11. This should be updated as required and at least annually. • The risk assessments for the same identified patient illustrated that the Braden Scale and falls risk assessments had not been updated since July 2014 • The MUST assessment had not been updated since June 2014 • Care plans were reviewed and updated on at least a monthly basis or more often if required. The inspector however raised concerns regarding the quality of the monthly review (see section B above). Records examined evidenced that the monthly review was recorded as multiple entries of 'no changes'. This comment fails to represent a profession review of care planned. **Requirements are raised in respect of review of assessments of need and care plans**

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

Section D – All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. Standard criterion 5.5, 8.4 and 11.4 examined.

The inspector examined two 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)

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 a review of dressing care records indicated that an improvement in the audit and governance of nursing care records and wound records is required to ensure that appropriate professional standards are maintained.

Registered nursing staff however was 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.

All staff consulted could identify patients who required support with eating and drinking. The inspector raised concerns regarding the display of confidential information on patient assessment by the speech and language team for a number of patients was displayed openly in the dining room. These confidential records were removed immediately from display. Whilst it is fully appreciated by the inspector that the information should be known by staff it is not acceptable that it is openly displayed in such a public place.

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

Section E – 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 criterion 5.6, 12.11 and 12.12 examined.

A policy and procedure relating to nursing records management was available in the home. Review of these policies evidenced that they were reflective of 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 two 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 however failed to illustrate the entire level of care delivered and did not reflect a professional approach to record keeping. There was no reference in daily progress of the nursing records inspected of wound and nutritional management intervention.

Entries were noted to be timed and signed with the signature accompanied by the designation of the signatory.

The inspector also raised concerns that the daily progress records are stored separately from the assessment of need, risk assessments and care plans. This separation of records increases the risk that staff will NOT refer to the assessments of need and care plans when recording daily care delivery. The care plans should be used to direct care and therefore must be referred to daily.

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 one patient 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.

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

Requirements are raised in respect of the nursing care records as detailed in section C above.

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

Section F – 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. Standard criteria 5.7 examined.
Please refer to criterion examined in Section C and E. In addition, the review of two 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 criteria assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criteria assessed	**Moving towards compliance**

Section G – The management and involvement of patients and/or their representatives in review of care. Standard criterion 5.8 and 5.9 examined.
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 two 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 criterion assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**

Section H – Management of nutrition including menu choice for all patients. Standard criterion 12.1 and 12.3 examined.
A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance. There was a three 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 inspector discussed the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients with the registered manager and a number of staff. Staff spoken with were knowledgeable regarding the individual dietary needs of patients and 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 concern was raised regarding the displaying of a number of patient's SALT assessments in one dining room. As previously stated under Section D relevant guidance documents were in place. From a review of the menu planner and records of patients' choices and discussion with a number of patients, registered nurses and care staff, it was revealed that choices were available at each meal time. The registered manager confirmed choices were also available to patients who were on therapeutic diets

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

Section I – Knowledge and skills of staff employed by the nursing home in relation to the management of nutrition, weight loss, dehydration, pressure area care and wounds. Standard criterion 8.6, 11.7, 12.5 and 12.10 examined.

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

Review of training records revealed that staff had attended training in dysphagia awareness during the previous three years and further training was planned for the incoming year. All staff had also attended training in first aid during the previous 12 months.

Review of one patient's care record evidenced that the care plan failed to fully reflect 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.

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.

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. All staff consulted could identify patients who required support with eating and drinking.

On the day of the inspection, the inspector observed the lunch 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.

A tissue viability link nurse was employed in the home.

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.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**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; and review of a selected sample of documents by the inspector confirmed that the required records were maintained in the home and were available for inspection.

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 accommodated at the time of inspection in the home who were subject to guardianship arrangements.

11.3 Quality of Interaction Schedule (QUIS)

The inspector undertook two periods of enhanced observation in the home which lasted for 20 minutes each.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area. A description of the coding categories of the Quality of Interaction Tool is appended to this report.

Total number of observations	
Positive interactions	35
Basic care interactions	3
Neutral interactions	0
Negative interactions	0

The inspector evidenced that the quality of interactions between staff and patients was in the main very positive. No neutral or negative interactions were observed. Patients were treated with respect and dignity.

11.4 Complaints

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home. (Insert if an inspection was undertaken following receipt of a complaint and outcome: refer to inspection report)

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

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

11.5 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.

11.6 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.

11.7 Questionnaire findings

11.7.1 Staffing levels and staff comments

Discussion with the registered manager and review of the nursing and care staff duty roster for week commencing 7 October 2014 evidenced that the registered nursing and care staffing levels were in keeping with the RQIA's recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection.

Staff were provided with a variety of training, including mandatory training, since the previous inspection. Attendance at mandatory training was 99.9%. Review of records, discussion with the registered manager and staff evidenced that this attendance level was achieved by proactively managing staff development and training through regular supervision sessions and annual appraisal.

During the inspection the inspector spoke with eight staff this included registered nursing staff, care staff, ancillary and catering staff. The inspector was able to speak

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

Some comments taken from the returned staff questionnaires are detailed below;

'I am looking forward to moving into the new building as this will enhance the care provided by ourselves and each resident will have more modern facilities'
'Staff and management bend over backwards for residents'
'The staff provides a friendly and loving place for all who live here. The staff also have a great work ethic and bond well as a team of both care assistants and nurses together.'
'Managers and nurses are easy to approach and get along with. We work well as a team'
'Lots of patients would love you to sit and have a wee chat but at times you just don't have the time.'

11.7.2 Patients/residents and relatives comments

During the inspection the inspector spoke with 25 patients/residents individually and with the majority of others in smaller groups.

Patient spoken with and the questionnaire responses confirmed that patients were treated with dignity and respect, that staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home.
There were no concerns raised by any patients or relatives either in conversation or in questionnaires.

Some comments received from patients and their relatives are included below;

"I am very happy here and am looking forward to moving to my new room"
"I have no problems in the home the staff look after me well"
"I feel if there was anything wrong I would be able to talk to Teresa"
"I feel safe in the home"
"The food is great and there is always a choice of meals"

"My mother is very well cared for in the home and the home is very relaxed and welcoming every time I visit"
"I am very happy with the care my mother receives and I am always kept informed of any changes in her health"

11.7.2 Professionals' comments

No professionals visited the home during the inspection.

11.8 Record keeping

In accordance with Regulation 19 (2) Schedule 4, a number of records are required to be kept in a nursing home. Prior to this inspection the registered person/s completed and returned a declaration to confirm that these documents were available in the home. If the document was not available an explanation was required.
The returned declaration for Schedule 4 documents confirmed that all documents listed were available in the home. The inspector sampled a number to confirm this as follows:

- A copy of the regulation 29 visit reports
- A copy of the staff duty rota
- Complaints records
- Records of food provided for patients
- Staff training records

Review of two patient care records evidenced that improvements are required in the recording of nursing care records and the organisation of each patient's individual nursing care record.

The deficits in record keeping have been discussed in detail in section 10.0 above and have required the issuing of a number of requirements and recommendations.

12.0 Quality Improvement Plan

The details of the quality improvement plan appended to this report were discussed with Ms McClean registered manager and Ms McGrady registered person as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered 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:

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

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
A pre admission assessment is carried out for all planned admissions, following a review of all information collated from the care management team a decision is made in regard to the home's ability to meet the needs of the patient. Following admission for all patients a comprehensive assessment is completed using the Roper Logan and Tierney model of nursing which will be completed within 11 days of admission. A plan of care is derived from the assessment which specifies interventions to meet the patient's needs. Specific validated risk assessment tools, such as Braden scale, MUST nutrition, falls risk, continence, moving and handling, Abbey pain scale and distress tools are used to direct the plan of care.	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 named nurse system is in operation within the home. The named nurse with the involvement of the patient and or their relative will promote maximum independence and rehabilitation in collaboration with the multi disciplinary team. The nurses will make referrals to the relevant healthcare professionals such as dietician, tissue viability nurse, speech and language therapist, physiotherapists and care mangers where appropriate to coordinate best interest meetings. Any treatment plan or recommendations from specialist practitioner's form part of the care of the patients and are adhered to.	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**
Re-assessment is an ongoing process and is carried out daily at an identified agreed time intervals as recorded in the individual care plan. Day and Night Staff record an evaluation in the daily progress notes in relation to the delivery of care to each patient during that time span. Entries correlate to the individual's plan of care. Risk assessments and care plans are reviewed on a monthly basis or more frequently as required.	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**
Validated assessment tools such as Roper, Logan and Tierney assessment of activities of daily living, Braden pressure risk assessment, Must nutritional risk assessment, Nutritional audit tools, EPUAP and Nice guidance for wound and pressure ulcer care however there are no regional guidance tissue viability specialist Nurse would prefer that we use the EPUAP guidance.	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 record in the daily progress notes in a contemporaneous manner which will include patient outcomes. The records will reference the corresponding care plan and input from the multidisciplinary team. Records are in keeping with the NMC guidance for records and record keeping. A diary of what a patient eats and drink is also kept. Recommendations form records reviewed will be acted on and referrals made where appropriate.	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**
Records of care delivered are meaningful and reflect the outcome of the care delivered. Care plans are evaluated monthly or more often if required. Evaluations reflect the effectiveness of the care interventions in the care plan and are discussed with the patient and or their relatives.	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**
Where possible the patients are encouraged to attend review meetings. Outcomes discussed at the review meetings will be auctioned and a new plan of care drawn up if required. Nursing staff provide a report to the review meeting. A Copy of this report ad a copy of review meetings is held on file.	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**
A policy and procedure is in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure is reflective of best practice. Menus are reviewed seasonally and menus are rotated every three weeks. Patient's likes and dislikes are recorded on admission and reviewed regularly. A choice of menu is available to patients on request. The nutritional guidelines and menu checklist for Residential and Nursing Homes for Older people and for those providing community meals are used as a guide to ensure the correct nutritional value of the menu is being achieved. A safe system is in place to cascade information to the staff form specialist such as dietician and speech and language therapists.	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing staff have the skills and knowledge to allow them to manage the feeding techniques for patients with swallowing difficulties and they will ensure that the staff team are fully informed adhere to recommendations by the speech and language therapist. Catering staff and care staff receive training same. A choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices are offered mid morning, afternoon and at super time.	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.

Quality Improvement Plan

Primary Unannounced Care Inspection

Corriewood Private Clinic

7 October 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Ms Teresa McClean registered manager and Ms M. I McGrady registered person 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.	19(1)(a) Schedule 3	The registered manager must ensure that wound care records are appropriately maintained to; • illustrate the dressing prescription as prescribed by the Tissue Viability Nurse (TVN) or wound link registered nurse • the frequency of change of dressing • that the frequency planned is complied with • any omissions to redress are identified and a reason for omission recorded. **Ref section A, 10.0**	One	The wound care records now clearly illustrate the dressing prescription as prescribed by the Tissue Viability Nurse. It will include the frequency of change of dressing. The planned time of scheduled dressing recorded and adhered to. Any omissions are identified adressed accordingly and documented.	From date of inspection and on going
2.	16(2)(b)	The registered manager must ensure that a meaningful and comprehensive review of patient's care plans is maintained on a regular basis. **Ref section C, 10.0**	One	A full comprehensive review on each patient will be carried out on a regular basis.	From date of inspection and on going
3.	14(2)(c)	The registered manager must ensure that risk assessments are up dated on a monthly basis **Ref section C, 10.0**	One	Risk assessments will be updated on a monthly basis.	From date of inspection and on going

4.	15 (2)(b)	The registered manager must ensure that the assessment of daily living is reviewed and updated as required and <u>at least</u> annually. **Ref section C , 10.0**	One	The daily living assessment on each patient will be updated annually.	From date of inspection and on going

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	5.4	It is recommended that the registered manager review the management of patient care records to ensure that ; • Patient care records should be stored in one individual folder per patient. • Staff must refer to the patient's individual care plan when recording the delivery of care in daily progress records. • A comment on each prescribed care plan should be made daily. If an assessed need is identified and a care plan established to address the need, then the delivery of care to meet that identified need should be evaluated in the progress records daily. • Records on daily progress records should refer to the numbered care plan. • An index of care plans would ensure that staff were prompted to record delivery of care appropriately. **Ref section B, 10.0**	One	The manager has reviewed the mangement of patient care records and can confirm that all care records pertaining to a patient will be stored in one folder. This will include an index of care plans and each identifiable problem evaluated in the daily progress notes.	By end November 2014

2.	5.6	The registered manager must ensure that; • Contemporaneous 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 should record outcomes for patients. • Wound care records must be accurately maintained. **Ref section A, B, 10.0**	One	All wound care records will be accurately maintained. All care records will be kept of nursing interventions, procedures and outcomes in a contemporaneous manner	From date of inspection and ongoing

3.	12.12	The registered manager must ensure that ; • Any patient at risk of dehydration and requiring fluid intake monitoring should have an identified fluid intake target established in line with Nutritional guidelines. • The level of fluid consumed over 24 hours should be recorded into daily progress records and an evaluation made of the actual intake against the target intake. • Referral should be made to the patient's GP should the target oral intake not be achieved for a predetermined period. The GP retains responsibility to reset the target of fluid to be consumed should the volume need to be reduced. **Ref section B, 10.0**	One	Any patient at risk of dehydration and requiring fluid intake monitoring will have an identified fluid intake target recorded in line with Nutritional guidelines. The level of fluid taken over the 24 hours will be recorded in the daily progress notes. The nursing staff will liase with the GP to reset the fluid intake target, should their be a need to do so.	From date of inspection and ongoing

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Teresa McClean
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Mary Imelda McGrady

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	Linda Thompson	19/11/14
Further information requested from provider			