Unannounced Care Inspection

Name of Establishment:	**Bohill House**
RQIA Number:	**11142**
Date of Inspection:	**11 March 2015**
Inspector's Name:	**Lyn Buckley**
Inspection ID:	**IN020238**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of establishment:	Bohill House
Address:	69 Cloyfin Road Coleraine BT52 2NY
Telephone number:	02870325180
Email address:	traceyhenry@priorygroup.com
Registered organisation/responsible individual/Registered provider:	Priory Care Homes Number 2 Ltd Mrs Caroline Denny – responsible individual
Registered manager:	Mrs Tracey Henry
Person in charge of the home at the time of inspection:	Mrs Tracey Henry
Categories of care:	NH – I, DE and PH RC - DE
Number of registered places:	80 RC – to a maximum of 18 persons
Number of patients accommodated on day of inspection:	Nursing 61 Residential 15
Scale of charges (per week):	£486 - £606
Date and type of previous inspection:	16 December 2013 Unannounced secondary care inspection
Date and time of inspection:	11 March 2015 10:15 – 15:00 hours
Name of inspector:	Lyn Buckley

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- discussion with the registered manager
- discussion with the regional operations manager
- discussion with staff
- discussion with patients/residents individually and with others in groups
- consultation with relatives
- review of a sample of staff training records
- review of a sample of staff duty rotas
- review of a sample of care records
- review of the complaints records
- observation during a tour of the premises
- evaluation and feedback.

5.0 Consultation Process

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

Patients/Residents	**11 individually and with other in smaller groups**
Staff	**10**
Relatives	**2**
Visiting Professionals	**0**

Questionnaires were provided by the inspector for distribution by the registered manager following the inspection, patient representatives and staff to seek their views regarding the quality of the service. At the time of issuing this report none had been returned. Any concerns raised within returned questionnaires will be addressed with the registered manager.

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**6**	**0**
Relatives/Representatives	**6**	**0**
Staff	**10**	**0**

6.0 Inspection Focus

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible person/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

However, due to workload pressures and contingency measures within the Regulation Directorate, the themes/standards within the self-assessment were not inspected on this occasion.

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

Standard 19 - Continence Management

Patients receive individual continence management and support.

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

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

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

7.0 Profile of Service

Bohill House Nursing Home is a three story purpose built nursing home located on the outskirts of Coleraine town in rural setting. The nursing home is owned and operated by Priory Group Number 2 Ltd. The registered responsible individual is Mrs Caroline Denny and the registered manager is Mrs Tracey Henry.

Accommodation for patients/residents is provided on the ground and first floors of the home. Patients/residents bedrooms are all single with ensuite facilities. Lounge and dining rooms are located throughout the home providing a choice of where to sit. The main lounge and dining room on the ground floor looks out onto the front entrance and gardens. The first floor lounges provide a panoramic view of the surrounding country side. A number of communal sanitary facilities are available throughout the home.

Access to the first floor is via a passenger lift and stairs.

The second floor of the main house accommodates the staff rest rooms, storage space, office space and a staff training room. Catering and laundry services are on the ground floor.

The home also provides a hairdressing room, café/ice cream parlour and a secure garden to the rear of the house with access from the ground floor.

The home is registered to provide care for a maximum of 80 persons under the following categories of care:

Nursing care (NH)

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
DE	dementia care to a maximum of 36 patients accommodated within the dementia unit on the ground floor.

Residential care (RC)

DE	dementia care to a maximum of 18 residents accommodated within the dementia unit of the first floor.

8.0 Executive Summary

This unannounced inspection of Bohill House was undertaken by Lyn Buckley on 11 March 2015, between 10:15 and 15:00 hours. The inspection was facilitated by the registered manager, Mrs Tracey Henry. Verbal feedback at the conclusion of the inspection was provided to Mrs Henry and Mr Gavin O'Hare-Connolly, regional operations manager.

As a result of the previous care inspection two requirements were made. It was evidenced that both requirements had been complied with. For details refer to the section immediately following this summary.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection on 16 December 2013.

Inspection findings

Review of three patients' care records evidenced that bladder and bowel continence assessments were undertaken at the time of admission to the home. The outcome of these assessments was incorporated into the patients' care plans on continence care.

The care plans reviewed generally addressed the patients' assessed needs in regard to continence management. A recommendation was made in relation to care planning. Discussion with the registered manager, nursing and care staff and review of training records confirmed that staff were trained in continence/incontinence care. Refer to section 10 for details.

Additional areas also examined included:

- care practices
- complaints
- patient finance questionnaire
- NMC registrations
- patients' views
- relatives' comments
- staff comments
- staffing
- patient care records
- environment.

Refer to section 11 for details of the inspection findings.

Conclusion

During the inspection staff were observed to treat the patients with dignity and respect. Good relationships were evident between patients/residents and staff. Patients, residents and relatives spoken with were complimentary regarding the care received and the management of the home.

Based on the evidenced examined the inspector concluded that the delivery of care to patients and residents was safe, effective and compassionate.

Standard 19: continence management was assessed as compliant. Refer to section 10 for details.

As a result of this inspection one requirement in relation to COSHH and one recommendation in relation to care planning were made. Refer to sections 10(19.1) and 11.8 for details.

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

The inspector would also like to thank all those who completed questionnaires.

9.0 Follow-Up on previous requirements made as a result of the previous inspection conducted on 16 December 2013.

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	14(2)(a)(b) and (c)	It is required that the air pockets noted on the flooring on the first floor corridor are addressed and that checks are made to ensure that all flooring, throughout the home, is secure. RQIA should be informed when this issue has been addressed.	Discussion and observation evidenced that this requirement had been complied with and the flooring replaced. The registered manager and maintenance person confirmed that recently patches of flooring had started to 'bubble' again. Plans to replace flooring again were already in place. The inspector was satisfied that this matter was proactively managed.	Compliant
2	12(2)(a)	It is required that equipment in use is suitable for the purposes for which it is to be used.	Observations and discussion evidenced that this requirement had been complied with in relation to the provision of crash/fallout mats.	Compliant

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

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if 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. Details regarding complaints can be found in section 11.2

Since the previous inspection RQIA have been notified, by the home, of ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues. The Northern Health and Social Care Trust (NHSCT) safeguarding team are managing SOVA issues under the regional adult protection policy/procedures.

Following discussion with the registered manager RQIA was satisfied that the registered manager had dealt with SOVA issues in the appropriate manner and in accordance with regional guidelines and legislative requirements.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of three patients' care records evidenced that bladder and bowel continence assessments were undertaken at the time of admission to the home. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. The care plans reviewed generally addressed the patients' assessed needs in regard to continence management. However, in one of the care records registered nurses had written one care plan to manage the care of two identified needs; in another care record the care plan to manage a urinary catheter lacked detail. A recommendation is made. There was evidence that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. Urinalysis was undertaken as required by nursing staff and patients were referred to their GPs appropriately. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Compliant.

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place and available to staff: • continence management / incontinence management • stoma care • catheter care. A resource file on the management for continence/incontinence was available to staff and included the following guidance: • RCN continence care guidelines • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not inspected on this occasion.	Not assessed.
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, nursing and care staff and review of training records confirmed that staff were trained in continence/incontinence care. A number of registered nurses in the home were deemed competent in female and/or male catheterisation. Those who required training could access this through the Trust. Stoma management was addressed on an individual patient basis with support from the Trust's stoma nurse and product providers as required.	Compliant.

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

11.0 Additional Areas Examined

11.1 Care Practices

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.

Observation of moving and handling of patients using a hoist was appropriate and considerate of the patients' privacy and dignity.

11.2 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.

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.

11.3 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.

11.4 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.

Review of the NMC registration record confirmed that the registration status of nurses employed by the home was checked at the time of expiry.

11.5 Patients'/residents' views

During the inspection the inspector spoke to 11 patients/residents individually and with others in groups. These patients expressed high levels of satisfaction with the standard of care, facilities

and services provided in the home. A 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'/residents' comments were as follows:

'I am really comfy here'
'All is okay dokey'
'lovely here, plenty of tea and company; the staff are polite and caring'
'Very good, staff kind and caring'.

There were no concerns raised with the inspector.

11.6 Relatives' comments

Two relatives spoken with were very complimentary regarding the care their loved ones received, staff attitude and management of the home.

There were no concerns raised with the inspector.

Six questionnaires were forwarded to the home for distribution. At the time of issuing this report none had been returned. Any concerns raised by relatives in returned questionnaires received after the report is issued will be addressed with the registered manager.

11.7 Staff comments

During the inspection the inspector spoke with 10 staff. Staff responses in discussion indicated that staff received an induction, completed mandatory training, completed additional training in relation to meeting patients/residents needs and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect.

There were no concerns raised with the inspector.

Ten staff questionnaires were forwarded to the home for distribution. At the time of issuing this report none had been returned. Any concerns raised by staff in returned questionnaires received after the report is issued will be addressed with the registered manager.

11.8 Staffing

The registered manager confirmed that staffing levels were kept under review to ensure that the assessed needs of patients/residents were met. The planned staffing level was as follows:

<u>Nursing</u>
Morning shift 4 registered nurses and 10 care assistants
Afternoon shift 4 registered nurses and 9 care assistants
Night duty 2 registered nurses and 6 care assistants

<u>Residential</u>
Morning shift 1 senior care assistant and 1 care assistant
Afternoon shift 1 senior care assistant and 1 care assistant
Night duty 1 senior care assistant and 1 care assistant plus a second care assistant x 3 nights and a second care assistant from 18:00-23:00 hours x 4 nights.

Review of duty rotas, discussion with patients, relatives and staff; and observation of care delivery confirmed that staffing levels met the assessed needs of the patients.

11.9 Patient care records

Review of three patient care records evidenced that registered nurses assessed, planned and evaluated care in accordance with evidenced based practice and professional guidance.

A comprehensive and robust pre admission assessment of nursing need was carried out by either the registered or deputy managers. On the day of admission nursing risk assessments and care plans were completed to manage identified needs. However, advice was given to the registered manager regarding how the assessment of nursing needs, on the day of admission, to the home was evidenced within the records reviewed. The registered manager agreed to review this with senior staff.

11.10 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients/residents' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a high standard of hygiene.

The registered manager confirmed that a refurbishment programme for the whole home had recently been approved.

Observation of one sluice within the dementia unit evidenced that staff had not closed the door fully which resulted in the fitted lock not engaging and securing the door. This was a potential hazard to patients because of the chemicals stored within the sluice. When brought to the attention of the registered manager, she addressed this issue with staff on duty at the time. It is required that the registered manager ensures that staff are aware of the importance of checking sluice room doors are locked as required to eliminate risks to patients.

12.0 Quality Improvement Plan

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

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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The Regulation and Quality Improvement Authority
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Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Prior to admission a pre admission assessment is carried out to determine the care needs of the service user and to ensure all needs can be met in the home. Close liaison with the Care Management team is maintained also during this process and documentation received in regard to plan of care and intermediate care needs. The MUST tool is used in the admission assessment and all relevant up to date SALT information and/or dietician reports are provided. This continues to be reviewed on a monthly basis or more often if required. The weights of all the service users are also recorded on the compliance system on a monthly basis and the outcomes filtered through to the relevant in house departments - House Manager/Named Nurse and Head chef for review.	Compliant

The Braden assessment is used to assess the service users at risk of developing pressure ulcers and are reviewed on a monthly basis or more often if required. Other assessments completed include nutritional, pain and continence assessments. A body map is also completed as part of the pre -admission and admission process.	

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Each individual service user has a Named Nurse and also a Key worker allocated on admission to assist with the development of a care plan in conjunction with the service user, family and multi –disciplinary team. The Named Nurse	Compliant

is responsible for the monthly review and update of care plan needs. This may be more frequent if required. Referrals to the Tissue Viability Nurse are made directly from the qualified staff via telephone or urgent fax request. The TVN liaises with the home via telephone and or visit to offer support and advice. The TVN offers support and guidance in regard to dressings/intervention in regard to wound care. In line with the TVN a plan of care is developed which details type of dressing used, frequency and dimensions of wound and ongoing assessments to be completed. A grading of the pressure ulcer is also recorded by the TVN and subsequent recommendations in regard to position change and or equipment used. This is reviewed and evaluated. Referrals are made directly to the podiatrist for the service users who require intervention in regard to lower limb or foot ulceration. Referrals to the dietician are made through the GP by the Qualified staff and or Residential Care Staff. Following review of the service users weight/MUST and BMI score the Qualified staff request same based on clinical judgement and assessment of weight loss or gain. Following assessment of dietician a plan of care is drawn up to incorporate the recommendations made by the dietician. This will be reviewed on a monthly basis or more frequently if required.	

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The Named Nurse reviews the plan of care on a monthly basis as a minimum using the assessment tools and clinical records. This progress of care is reviewed on a daily basis by the qualified staff.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All assessment tools and clinical assessments are based on evidence based tools and are supported by research evidence and guidelines as defined by professional bodies.(NICE) (Roper,Logan,Tierney) (Pressure ulcer management) Research files on tissue viability/nutrition are available on each floor for the Qualified and care staff for guidance and support. As well as policy and procedures in regard to wound management (AM 44). Nutritional guidelines are also available in the kitchen and on each floor. This has assisted with the development of menus and residents choice. Dietician input has also been sought in regard to menus and resident choice. This is further developed by the Chef through one to one communication with service users and the development of resident of the day to enhance the positive meal experience.	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 plans 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**
The progress notes are updated at least twice daily on all residents. Completed by the qualified staff and by the Residential staff in the residential unit. Care plan assessments, risk assessments and care plan review and evaluation are carried out at least on a monthly basis as a minimum. A meal record is maintained for each service user detailing what has been eaten/offered/refused for each resident and a record of service user choice. All service users when their care plans indicates, fluids are recorded and a daily target for 24hrs is recorded and the actual daily intake in the progress notes. This is also recorded on an individual basis to include consistency recommended by SALT.	Compliant

Each individual service user care plan reflects target fluids and if the optimal target fluid is not met advice from the MDT team is sought and recorded in the care plan of action taken or guidance given.	

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**
Each service users progress notes are updated twice daily as a minimum within a 24hr period. A review of care needs are recorded and detail changes, outcomes and care interventions carried out. The care plans and risk assessments are evaluated on a monthly basis as a minimum and a review of care is carried out in conjunction with the Care Manager, family and members of the multi disciplinary team. A care review tracker is in place to ensure all care reviews are held in a timely manner to ensure a holistic approach is maintained to care given.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care reviews are attended by the Named Nurse, Care Manager, family and where possible the service user. All care reviews are minuted and any actions agreed at the meeting with timescales for completion. A copy of the review is kept in the residents file and a copy sent to the next of kin.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The menus have been devised in conjunction with the Head cook, dietician and nutritional guidelines. Taking into consideration Health promotion, service user likes, dislikes and service user choice. The Head Cook is keen to develop specialised diets and presentation and improvising meal preparation has been a focus to develop the positive meal experience for the service users. Choice is paramount and alternatives are available for service users, particularly if a meal has been un eaten or an alternative is requested. The nutritional guidelines are available for the kitchen/ qualified and care staff.	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**
A training plan is available for all qualified and care staff to keep their knowledge up to date and skills are maintained for assisting service users with swallowing difficulties. Following SALT and or dietician assessment a plan of care is developed to incorporate the recommendations in regard to assistance at mealtimes and recommendations for assistance at meals – this is communicated to the care and kitchen staff and highlighted on the allocation sheets on a daily basis. The qualified staff following assessment and clinical judgement can contact SALT if they are concerned in regard to a	Compliant

swallowing deterioration or changes of plan of care. Meals are provided at conventional times for the residents and additional snacks and hot/cold drinks are always readily available. If a service user is unable to verbalise a request staff use there non -verbal cues to determine their request. Finger foods and fruit are available throughout the day. Staff are updated daily in regard to risks or changes to the needs of eating and drinking of service users. This is communicated through handover, staff meetings and daily de brief meetings. The qualified staff have attended wound care training and are supported by the TVN for additional guidance and support. A wound management file has been set up on both floors for research and reference for the qualified staff. A wound link nurse is also available in the home to develop pressure ulcer management .	

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

Quality Improvement Plan

Secondary Unannounced Care Inspection

Bohill House

11 March 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs T Henry registered manager, and Mr G O'Hare-Connolly, regional operations manager, either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	14 (2) (c)	The registered manager must ensure that staff are aware of the importance of checking sluice room doors are locked, as required, to eliminate risks to patients. Ref; section 11.8	One	This was actioned on the day of the visit and reiterated at staff meetings. Addressed at Qulaity compliance and review meeting also.	By end of March 2015.

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	19.1	Care plans should be devised for each identified need in relation to the management of bladder and/or bowels and contain specific details regarding the care and management of urinary catheters if required. **Ref: Section 10 (19.1)**	**One**	The care plans relating to catheter care have been reviewed and are specific to the care and management of urinary catheters.	By the end of April 2015.

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Tracy Henry
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Caroline Denny

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Lyn Buckley	28/04/15
Further information requested from provider			