Announced Primary Inspection

Name of Establishment:	**Edenvale Care Home**
Establishment ID No:	**1182**
Date of Inspection:	**30 June 2014**
Inspector's Name:	**Heather Moore**
Inspection No:	**16501**

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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1.0 General Information

Name of Home:	Edenvale Care Home
Address:	1-7 Edenmore Road Limavady BT49 0RF
Telephone Number:	(028) 7772 2055
E mail Address:	edenvale.m@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Healthcare Ltd Mr James McCall
Registered Manager:	Mrs Carol Craig
Person in Charge of the Home at the time of Inspection:	Mrs Carol Craig
Registered Categories of Care and number of places:	NH-I, NH-DE, NH-PH(E), NH-PH, NH-MP(E), NH-MP, NH-LD, NH-TI 55
Number of Patients Accommodated on Day of Inspection: **Scale of charges (per week)**	51 £581.00 - £624.00
Date and time of this inspection:	30 June 2014: 08.40 hours-16.00 hours
Date and type of previous inspection:	10 December 2013 Secondary Unannounced

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 a primary announced inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were met.

3.0 Purpose of the Inspection

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

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

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

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

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

4.0 Methods/Process

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

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

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

- analysis of pre-inspection information
- discussion with the registered manager
- examination of records

- consultation with stakeholders
- tour of the premises
- evaluation and feedback.

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

5.0 Consultation Process

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

Patients	**6 patients individually and to others in groups**
Staff	**10**
Relatives	**3**
Visiting Professionals	**0**

Questionnaires were provided, during the inspection, to patients, their representatives and staff to seek their views regarding the service. Matters raised from the questionnaires were addressed by the inspector in the course of this inspection.

Issued To	**Number issued**	**Number returned**
Patients	**6**	**6**
Relatives / Representatives	**2**	**1**
Staff	**10**	**10**

6.0 Inspection Focus

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

The criteria from the following standards are included;

- Management of Nursing Care – Standard 5
- Management of Wounds and Pressure Ulcers –Standard 11
- Management of Nutritional Needs and Weight Loss – Standard 8 and 12
- Management of Dehydration – Standard 12

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

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

The 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

The home, which is purpose built, is situated in its own grounds on the Edenmore Road, Limavady. It is a two storey building with access to the first floor via a through floor lift and stairs.

The home offers bright and spacious accommodation for 55 patients. Fifty four bedrooms are single rooms, some with en suite facilities. There is one double bedroom. Each bedroom has been furnished with a profiling or low-low bed, a range of furniture providing storage for patients' personal processions and a television. There are nine assisted bathrooms in the home ensuring that bathing facilities are available to meet all patients' needs.

There are sitting rooms and dining rooms located throughout the home. A small kitchenette is located on the first floor with facilities for making a cup of tea or a snack.

There is an activity room on the first floor where patients may undertake various activities and a reminiscence room on the ground floor where patients can unwind and relax in peace and quiet. An enclosed garden is situated at the rear of the building and this can be accessed by patients.

Toilets are located throughout the home and are clearly signed for ease of identification.

The home is registered to provide care for 55 patients under the following categories:

Nursing Care

Nursing Care (maximum 55 patients)

DE	Dementia care (21 patients)
I	Old age not falling into any other category
PH (E)	Physical disability other than sensory impairment over 65 years
MP	Mental disorder excluding learning disability or dementia under 65 years (2 patients)
MP (E)	Mental disorder excluding learning disability or dementia over 65 years (2 patients)
PH	Physical disability other than sensory impairment under 65 years (4 patients)
TI	Terminally ill (6 patients)
LD	Learning disability (1 patient)

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) accurately reflected the categories of care and was appropriately displayed in a prominent position of the home.

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (announced) to Edenvale Care Home. The inspection was undertaken by Heather Moore on 30 June 2014from 08.40 hours to 16.00 hours.

The inspector was welcomed into the home by Mrs Carol Craig, Registered Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to the registered manager and the deputy manager at the conclusion of the inspection.

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

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

Questionnaires were issued to patients, staff and two relatives during the inspection.

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

These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool is designed to help evaluate the type and quality of communication which takes place in the nursing home. A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix two.

As a result of the previous inspection conducted on 10 December 2013, three requirements and three recommendations were issued. These requirements and recommendations were reviewed during this inspection. The inspector evidenced that the requirements and recommendations had been fully complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

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

Standard 8: Nutritional needs of patients are met. (Selected criteria)
Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)

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

Inspection Findings:

- **Management of Nursing Care – Standard 5**

The inspector can confirm that at the time of the inspection there was evidence to validate that patients receive safe and effective care in Edenvale Care Home.
The inspector examined three patients care records.

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

Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis plus as required.

There was also evidence that the referring HSC Trust maintained appropriate reviews of the patient's satisfaction with the placement in the home and the quality of care delivered.

COMPLIANCE LEVEL: Compliant

- **Management of Wounds and Pressure Ulcers –Standard 11 (selected criteria)**

The inspector examined one patient's care record in regard to wound care intervention.

The inspector evidenced that wound management in the home was well maintained. There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment. Care plans on wound care were maintained to a professional standard.

Inspection of an identified patient's care record revealed that the patient's pressure ulcer risk assessment was not reviewed on a monthly basis. A recommendation is made in this regard.
A recommendation is also made that the patients' pressure relieving equipment in use on patients' beds and when sitting out of bed be addressed in patients' care plans on pressure area care and prevention.

COMPLIANCE LEVEL: Substantially Compliant

- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12 (selected criteria)**

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

Inspection of three patients care records revealed that one identified patient's Malnutrition Universal Screening Tool (MUST) assessment was not reviewed on a monthly basis. A recommendation is made in this regard.

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

The inspector also observed the serving of the lunch meal and can confirm that the patients were offered a choice of meal and that the meal service was well delivered. Patients were observed to be assisted with dignity and respect throughout the meal.

COMPLIANCE LEVEL: Substantially Compliant

- **Management of Dehydration – Standard 12 (selected criteria)**

The inspector also examined the management of dehydration during the inspection. The home was evidenced to identify fluid requirements for patients and records were maintained of the fluid intake of those patients assessed at risk of dehydration.

Patients were observed to be able to access fluids with ease throughout the inspection.

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

COMPLIANCE LEVEL: Compliant

Patients / their representatives and staff questionnaires

Some comments received from patients':

- "I have no complaints."
- "The care here is good."
- "I am happy here."
- "I am always offered a choice of food here."
- "Staff are always polite."
- "I love playing bingo."

Representatives Comments

Some comments received from patients' representatives:

- "It's a first class home."
- "It's a well-run home have no problems."
- "Everyone is well looked after."

Staff Comments

Some comments received from staff:

- “Busy environment would like more time to speak with the residents.”
- “I would recommend Edenvale Care Centre; it provides a caring and friendly service.”
- “Edenvale Care Home is a good place to work, the care here is very good.”
- “I feel we have a great home here as we always work well together as a team.”
- “Our aim is to provide good quality care to our residents.”
- “Yes I had had training in wound management.”
- “We had pressure area care training by e–learning.”

A number of additional areas were also examined

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

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

Conclusion

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

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

However areas for improvement are identified. One requirement and three recommendations are made. This requirement and recommendations are addressed throughout the report and in the Quality Improvement plan (QIP).

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

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

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	16 (1)	The registered person shall ensure that a specific care plan on pain management is maintained in the identified patient's care record.	Inspection of three patients care records confirmed that a specific care plan on pain management was maintained.	**Compliant**
2	30 (1) (d)	The registered person shall give notice to the Regulation and Quality Improvement Authority without delay of the occurrence of any event in the nursing home which adversely affects the wellbeing or safety of any patient.	Inspection of a sample of incidents confirmed that RQIA were informed of incident s in a timely manner.	**Compliant**
3	27 (2) (b)	The registered person shall ensure that the identified patient's bedroom carpet is replaced.	During the inspection process it was confirmed that the patient's bedroom carpet was replaced.	**Compliant**

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	5.3	It is recommended that a pain assessment chart is maintained in the identified patient's care record and that this assessment chart is recorded appropriately.	Inspection of three patients care records confirmed that pain assessments were maintained appropriately.	**Compliant**
2	20.2	It is recommended that the emergency equipment is checked daily (unless otherwise recommended by the manufacturer's instructions).	Inspection of the emergency equipment check lists confirmed that the emergency equipment was checked daily.	**Compliant**
3	20.4	It is recommended that written evidence is held to evidence registered nurses competency and capability in cardio pulmonary resuscitation.	Inspection of records confirmed that written evidence was held in the home to evidence registered nurses competency and capability in cardio pulmonary resuscitation.	**Compliant**

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

Since the previous care inspection on the 13 December 2013, RQIA have received nil notifications of safe guarding of vulnerable adult (SOVA} incidents in respect of Edenvale Care Home.

11.0 Additional Areas Examined

11.1 Documents required to be held in the Nursing Home

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

- The home's statement of purpose
- The patient's guide
- Sample of reports of unannounced visits to the home under regulation 29
- Sample of staff duty rosters
- Record of complaints
- Sample of incident/accidents
- Record of food provided for patients
- Statement of the procedure to be followed in the event of a fire
- Sample of the minutes of patients/relatives and staff meetings.

11.2 Patients 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. During the inspection there were no patients in the home who were subject to a guardianship order.

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

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

11.4 Quality of interaction schedule (QUIS)

The inspector undertook a number of periods of observation in the home which lasted approximately 30 minutes each.

The inspector observed the patients' lunch meal which was served in the dining rooms.

The observation tool used to record these observations uses a simple coding system to record interactions between staff, patients and visitors.

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix 2.

The staff were observed seating the patients in preparation for their lunch in an unhurried manner.

The staff explained to the patients their menu choice and provided adequate support and supervision.

Observation of care practices during these periods of observation revealed that staff were respectful in their interactions with the patients.

Overall the periods of observations were positive.

11.5 Complaints

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

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

11.6 Patient Finance Questionnaire

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

11.7 NMC declaration

Prior to the inspection the 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 manager were registered with the NMC.

11.8 Staffing /Staff Comments

On the day of inspection the inspector examined staff duty rosters for three weeks. Inspection confirmed that registered nurses and care staff staffing levels for day and

night duty were in accordance with the RQIA's recommended minimum staffing guidelines.

The inspector spoke to 10 staff members during the inspection process and 10 staff completed questionnaires.

Examples of staff comments were for as follow:

- "Busy environment would like more time to speak with the residents."
- "I would recommend Edenvale Care Centre; it provides a caring and friendly service."
- "Edenvale Care Home is a good place to work, the care here is very good."
- "I feel we have a great home here as we always work well together as a team."
- "Our aim is to provide good quality care to our residents."
- "Yes I had had training in wound management."
- "We had pressure area care training by e–learning."

11.9 Patients' Comments

The inspector spoke to six patients individually and with others in groups. Six patients completed questionnaires.

Examples of their comments were as follows:

- "I have no complaints."
- "The care here is good."
- "I am happy here."
- "I am always offered a choice of food here."
- "Staff are always polite."
- "I love playing bingo."

11.10 Relatives' / Representatives' Comments

The inspector spoke to three relatives, one relative completed a questionnaire.

An example of the relative's comments is:

- "It's a first class home."
- "It's a well-run home have no problems."
- "Everyone is well looked after."

11.11 Environment

The inspector undertook an inspection of the home and viewed a number of patients' bedrooms, communal facilities and toilet and bathroom areas.

The home presented as clean warm and comfortable.

A requirement is made that the identified patients' bedrooms are repainted

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed Mrs Carol Craig, Registered Manager and Ms Moore, Deputy 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:

Heather Moore
The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS

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**
Before admission to care centre the home manager or a senior nurse from the home carries out the pre admission assessment .Information is gathered from the resident and if not possible the residents relative/representative.Also taken into consideration is the care records and documentation made available on day of assessment and also information from the care manager and mutidisciplinary team.Risk assessmets such as braden are carried out if possible at this stage.Follwing pre admission assessment and information gathered from mutidisciplinary team a decision is made of the suitability of the home to meet the potential residents needs and a letter is purchased in reference to this .If an emergency admission is needed and a pre admission assessment can not be done in the short	Compliant

time frame due to location of resident or no one available at short notice to carry assessment a pre admisision assessment is carried out over the telephone with written comphrehension ,multidisciplinary information regarding the resident been faxed and then delivered to care centre.only when the home maanger or nurse in charge that day makes the decision that the Care Centre can meet the residents needs that the admisiion will take place. On admission to the care centre the nurse inn charge of the admisiion completes initial assessments and documentation ensuring a patient centered approach. The nurse will communicate with the resident and relative and the documentation provided along with the pre admission assessment to assist them in this process.An admisiison assessment and record of personal effects is completed on admisiion along side body map,braden,inintial wound assessment if applicable ,moving and handling assessment,falls risk assessment ,bed rail assessment ,pain assessment and MUST tool ,fshc nutritional and oral assessment .A continenece assessment and a bowel assessment is carried out also .All protocol for admission is carried out as per policy.Following discussion with resident and relative and taken in to consideration all information gathered a plan of care is formulated to meet the residents needs in realtion to their identified risks and needs taken in to consideration the individuals risks ,wishes ,likes and dislikes. The home maanger ,deputy manager and regional manager complete audits on a regular basis to quality assure this 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**
A named nurse completes a comprehensive needs assessment of the residents care needs using the assessment tools eg braden,continence assessment ,abbey pain scale,moving and handling ,oral assessment etc within 7 days of admisiion to the care centre.The named nurse then completes careplans to meet the identified needs and this is done in consultation with the resident or their relative .The careplan will allow staff to know the maximum ability of the resident and what they need to do to ensure that the care is provided to the highest standard and that their identified needs are met .Any information in relation to the care that has been received from the multidisciplinary team is incorporated in the care plan. All careplans have goals set that are realistic and acheivable to the individuals needs .Registered stafff within the care home are fully aware of the process in which a referral is made to the TVN when it is necessary.Als trained staff are aware of the referral forms and there location with in thre unit that they are based in .Staff are also aware that they can contact the TVN even though referral has been made and they have not yet visited the care centre and get advice from the TVN in reference to any wound .Staff are ware of the contact number and were it is kept .Staff are also aware of how to make a referral to a podiatrist in relation to a resident having lowere limb or foot ulceration and if necessary a further referral may be necessary to a vascular surgeon but tis will be made by GP ,TVN or the Podiatrist. Where a resident has been assessed at been at risk of developing pressure ulcers a pressure ulcer treatment plan is commenced. staff will devise a careplan that will include mattress type and setting ,also cushion type and setting and will include the frequency of repositioning in it .care staff record frequency of repostioniong on Epic care touch screens.The careplan will also include any information that has been given by multidisciplinary team and the careplans goals and measures will be drawn up with the resident /representative at all times and careplan agreement form completed.The regional manager is informed of all wounds in the wound analysis form that is completed by the home manager or deputy manager on a monthly basis and also during the Reg 29 visit. The registered staff also make referrals to Dietician via referral form that also is available to all staff in there units with	Compliant

in the care centre and this is made depending on the residents MUST score and their own professional judgement. The dietician is also available via telephone for advice in relation to the individual resident.All advice treatment or recommendations given are recorded on the multidisciplinary section and careplan is updated when advice has been given to ensure the best possible care is been provided at all times . The individual resident and there representative /NOK and care manager are kept up to date with all changes.	
Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All assessments and care plans are reviewed and evaluated on a regular basis with a minimum of one entry been made or more frequently if any change has occurred.The careplan indicates the frequency of review and the need for re assessment and this is recorded on plan of care. The resident continues to be assessed on a daily basis which is documented in their progress notes and careplans evaluations forms .Home maanger is informed of changes on a daily basis via 24 hr report were changes are recorded and also verbally from the staff .The home manager and deputy manager carry out careplan and assessment audits monthly .Regional Manager also completes audits to quality assure the above process and complete action plan for home manager and staff to action when any deficit is noted.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All nursing interventions ,activities and procedures are supported by European Pressure Ulcer Advisory Panel 2009 ,NICE Guideliness,THe prevention and treatment of Pressure Ulcers 2005 NICE Guidelines ,The use of pressure relieving devices (beds,mattress and overlays) for the prevention of pressure ulcers in primary and secondary care 2003 ,Also NIPEC ,RQIA Pha ,HSSPS are available for staff to refer to within a resource file. The named nurse who is responsible for assessing and screening the resident who has skin damage uses the validated EPUAP grading system.If a pressure ulcer is present on admission or if a resident develops a pressure sore while in the care centre an initial wound assessment is carried out and a careplan is impleted detailing cleaning agent ,dressings to be used and also frequency of changing dressing .Also included in careplan is the matress and cushion that is used and settings of both .Thereafter a ongoing wound assessment is completed and information is recorded in the careplan evaluation every time wound care is completed detailing change to wound or dressing . There are up to date guidelines such as Promoting Good Nutrition ,RCN Nutrition Now ,PHA-Nutritional guidelines and menu check list for residential and care homes and NICE guidelines -Nutrition support in adults ,available for staff to	Compliant

refer to on going basis .Staff also refer to FSHC policies and procedures in relation to nutritional care ,diabetic care and care of subcuteaneous fluids and care of percutaneous endoscopic gastrostomy (PEG)	
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 are kept of all nursing interventions ,activities and procedures that are carried out in relation to each resident .These records are in accordance with NMC guidelines .All care delivered includes evaluation and out come of plan. Nurses have acess to policies and procedures in relation to record keeping . Records of the meals that are provided for each resident at each meal time are recorded on a daily menu choice form in the general unit and in the dementia care unit the residents are offered their meal from the bain marie at mealtimes.The catering manageress also keeps a record of all food served and this includes any special dietary	Compliant

needs. Any resident whether they have been identified as high risk of malnutrition ,dehydration or eating excessively have their food and fluids recorded on a daily basis and the registered nurse totals the fluid intake at end of 24 hrs and this is recorded in the residents progress notes.Any deficits are actioned that have been identified and referrals may be made if this is required .Any changes that are made are discuseed with the resident themselves or representative and care manager is informed. Care records are audited on a regular basis by the home manager and an action plan is compliled if any deficits noted and actioned by staff.This may then be used as supervision with staff if deficits are identified .	
Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
the outcome of care delivered is monitored and recorded on a daily basis on the progress notes with at least a minimum of one entry during the day and night.The outcome of the care is reviewed as indicated on the resdents care plan or more frquently if there is any change in the residents condition. Residents or representatives are involved in the evaluation process.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
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**
Reviews are carried out by care managers initially 6-8 weeks after admission to the care centre and then annually thereafter.Reviews can also take place if residents needs have changed or if family or resident has expressed any concern /dissatisfaction with the care that they are receiving. The nominated trust are responsible for orgnising the care reviews and inviting resident /representative to the care review which is accomadated in the care centre .During the review the registered nurse on duty attends the care review .Following the review the care manager will send copies to the care centre to be kept in residents file and also the residents representative will also get a copy.Any identified changes that need to be met are actioned by the home and care plans are reviewed to reflect the changes that have been which has involved the resident and representative.	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 care centre follows FSHC policies and procedures in relation to nutrition and follows best practice guidelines .Registered nurses fully assess each residents dietary needs on admission and review this on an on going basis .The care plan reflects the type of diet and any special dietary needs any likes and dislikes and any specialised equipment that is required by the resident.Also documented is if the resident requires any level of assistance with feeding and any recommendations that have been made by the dietician or the speec and language Therapist. The care centre has a 4 weekly menu which is reviewed 6 monthly taking in to account seasonal foods.The menu is complied following consultation with the residents and representatives either in residents meetings or one to one meetings and food questionaries.The Nutritional and menu check list for residential and nursing homes is used to ensure that the menu is nutritious and varied. The kitchen are informed via diet notification forms which are kept in kitchen of each residents specific diets needs .The kitchen also gets copies and recommendations from the dieticians and speech and language therapists which	Compliant

are placed in the file along with the notification forms. Residents in the care centre are offered two choices of meal and desserts at each meal time and if the resident does not want anything that is on the menu that day they are offered an alternative meal of their choice.The menu offers the same choice as far as possible to those who are on therapeutic or specified diet . Daily menus are displayed on each dining room and the residents with in the dementia care unit also are offered their meals from the bain marie .A copy of the 4 week menu is available in a file in the dining areas. Staff continue to ensure protected meals times in the care centre.	

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**
The speech and language therapist and dietician give informal advice on Dysphagia and feeding techniques .Training on Dysphagia has been planned for May 14 and June 14 .Nurses continue to refer to the up to date guideance such as NICE guidelines -Nutrition support in adults and Dysphagia diet food texture descriptors .All recommendations made by the speech and language therapist are added into the careplan including type of diet ,consistency of fluids ,position for feeding equipment used and thae assistance required.The kitchen receives all copies of relevant documentation in relation to resident that they keep on file in kitchen .Special diets are recorded on a white board in kitchen Meals are served throughout the day with snacks and fluids available in between. Hot and cold snacks are also available through out the night and cold water is available in residents rooms and day rooms .These are frequently changed .Resients eating pattern is recordede in their care plan which details likes and dislikes ,type of diet ,consistency of fluid and any special equipment needed.Residents who require supervision are given individual attention from staff and are assisted at a pace that is suitable to them. All registered nurses and cares have completed the E Learning on nutrition /malnutrition in older people and have completed the work booklet that goes along with this . each nurse has completed E Learning module on pressure care .The home link nurse provides support and education to other nurses with in the home .All nurses within the home have a competency assessment completed and these have a quality assurance element built into the process.	Compliant

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

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Announced Primary Inspection

Edenvale Care Home

30 June 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with **Mrs Carol Craig, Registered Manager and Ms Elaine Moore, Deputy 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	Requirement	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	27 (2) (b)	The registered person shall ensure that the identified patients' bedrooms are repainted. **Ref Section 11 point 11.11 (Additional Areas Examined)**	One	Action plan has been developed and painting continues .	Two Months

Recommendations

These recommendations are based on the Nursing Homes Minimum Standards (2008), research or recognised sources. They promote curt 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	5.3	It is recommended that the patients' pressure relieving equipment in use on patients' beds and when sitting out of bed be addressed in patients' care plans on pressure area care and prevention. **Ref: Section Management of wounds and pressure ulcers**	One	Pressure relieving mattress and cushions have now been incorporated into all care plans of residents who require same.	One week
2	5.3	It is recommended that Malnutrition Universal Screening Tool (MUST) assessments be reviewed monthly or more often if deemed appropriate. **Ref: Management of nutritional needs and weight loss.**	One	This continues to be monitored and reviewed monthly	One week
3	5.3	It is recommended that patients' pressure ulcer risk assessments be reviewed monthly or more often if deemed appropriate. **Ref: Management of wounds and pressure ulcers**	One	This continues to be monitored and reviewed monthly .	One Week

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	Carol Craig
Name of Responsible Person / Identified Responsible Person Approving Qip	Jim McCall JP WATSON DIRECTOR OF OPERATIONS 27/8/2014

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable			
Further information requested from provider			

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Heather Moore	30 August 2014
Further information requested from provider			