Announced Primary Inspection

Name of Establishment:	**Cornfield Care Centre**
Establishment ID No:	**1204**
Date of Inspection:	**02 June 2014**
Inspector's Name:	**Heather Moore**
Inspection No:	**16497**

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

Name of Home:	Cornfield Care Centre
Address:	51 Seacoast Road Limavady BT49 9DW
Telephone Number:	028 7776 1300
E mail Address:	cornfield.carecentre@btopenworld.com
Registered Organisation/ Registered Provider:	Mr Jervis Nutt
Registered Manager:	Mrs Mable Cole
Person in Charge of the Home at the time of Inspection:	Mrs Mable Cole
Registered Categories of Care and number of places:	NH- I, NH-DE, NH-PH, NH-PH(E), NH-TI, RC-I 76
Number of Patients/ Residents Accommodated on Day of Inspection: **Price per week**	73 Patients 1 Resident Nursing : £581.00- £624.00 plus £43.00 Top up Residential: £581.00 plus £43.00 Top up
Date and time of this inspection:	02 June 2014 08.20 hours -15.45 hours
Date and type of previous inspection:	04 November 2013 Primary Announced

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 provider
- discussion with the operations manager

- 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 and residents	**10 individually and with others in groups**
Staff	**14**
Relatives	**1**
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**	**5**
Relatives / Representatives	**3**	**3**
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

Cornfield Care Centre provides care for up to 76 patients across three distinct categories of care: general nursing, dementia nursing and residential care.

The home which is purpose built, is situated on five acres of land and is surrounded by its own landscaped grounds.

Cornfield Care Centre is located a short distance from the centre of Limavady, on the road towards Magilligan.

The home is currently registered to provide care under the following categories:

Nursing Care

I	Old age not falling into any other category
DE	Dementia care
PH	Physical disability other than sensory impairment

Residential Care

I	Old age not falling into any other category

The home is also registered for the provision of day care for three persons.

Adequate care parking facilities are provided at the front of the home.

Since the previous inspection Mrs Mable Cole has been appointed as the Registered Manager. Mrs Christine Thompson is the Operations Manager of the home.

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 Cornfield Care Centre. The inspection was undertaken by Heather Moore on 02 June 2014 from 08.20 hours to 15.45 hours.

The inspector was welcomed into the home by Mrs Mable Cole, Registered Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection were given to Mr Jervis Nutt Registered Provider, Mrs Christine Thompson Operations Manager, Mrs Mable Cole Registered Manager, Mr Ewen Harper Administration Manager and three registered nurses 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, residents, staff and one relative. 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, residents, staff and relatives during the inspection.

The inspector spent a number of extended periods observing staff resident/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 04 November 2013, one requirement and one recommendation were issued. This requirement and recommendation were reviewed during this inspection. The inspector evidenced that the requirement and recommendation 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 and residents receive safe and effective care in Cornfield Care Centre.
There was evidence of comprehensive and detailed assessment of patient and the resident's 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.

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.

- **Management of Wounds and Pressure Ulcers –Standard 11**

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 for the management of risks of pressure ulcers and wound care were maintained to a professional standard.
A recommendation is made to record the type of pressure relieving mattress and cushion on the patient's /resident's care plan on pressure area and prevention.

- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**

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

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 /residents were offered a choice of meal and that the meal service was well delivered. Patients /residents were observed to be assisted with dignity and respect throughout the meal.

- **Management of Dehydration – Standard 12**

The inspector also examined the management of dehydration during the inspection. The home was evidenced to identify fluid requirements for patients/residents and records were maintained of the fluid intake of those patients/residents assessed at risk of dehydration.
Patients were observed to be able to access fluids with ease throughout the inspection.

Inspection of four patients care records revealed a shortfall in one patient's care record in regard to recording the action taken if the patient's daily fluid target was not achieved. A requirement is made in this regard.

The inspector can confirm that based on the evidence reviewed, presented and observed; that the level of compliance with this standard was assessed as compliant.

Patients' / residents' questionnaires

Some comments received from patients' /residents' questionnaires.

- **"**I am very happy living in Cornfield."
- "Could not ask for anything more, I am very content here."

- "I find that the home is a wonderful place."
- "The home is very comfortable in every respect and the staff are all really good."
- "The home is really beautiful."

Relatives/ Representatives Questionnaires

One relative took the opportunity to speak to the inspector, three relatives completed questionnaires and one relative wrote a letter to the inspector following the inspection.

Some comments received from relatives/questionnaires:

- "I cannot speak highly enough of the staff here they are all so good, I can leave here and know that my husband is well looked after."
- "I have found the level of care to be excellent. The needs of the patients are always the priority."
- "There is great attention to detail and there is great effort to keep relatives informed."
- "I would recommend Cornfield, its excellent."
- "Cornfield is an immaculately cared for and welcoming place, I am happy to know when I leave that my mother is well looked after. She is treated with dignity and respect by all the staff."
- "Very happy with the care given at Cornfield, it's a lovely friendly home."

Staff /questionnaires

Some comments received from staff;

- "Cornfield Care Centre is a lovely place to work; residents are looked after very well."
- "Residents are looked after very well. We try to maintain their independence as long as possible according to their needs."

- "I feel that we provide a high standard of care as we all work as a team and help each other. Residents are put first in everything; we ensure that the residents' needs are met."
- "I have my NVQ level 3."
- "Yes I have been trained in wound management."
- "The standard of care is very good here."
- "I have worked here for the past 12 years and can safely say that the quality of care is always of the highest standard."
- "I have worked here for a year and I am very happy here, the patients are all very well looked after and are always treated with dignity and respect."
- "The home is very well managed, Mr Nutt is excellent."
- "I have worked in Cornfield for a number of years and find that the staff all get on well with each other."

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 *and visiting professionals*
- 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 /residents were observed to be treated with dignity and respect.

However areas for improvement are identified. Two requirements and one recommendation 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 residents, the visiting relative, registered provider, registered manager, administration manager, registered nurses and staff for their assistance and co-operation throughout the inspection process.

The inspector would also like to thank the patients, residents', relatives 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 four patients care records confirmed that a specific care plan on pain management was available.	**Compliant**

No	Minimum Standard Ref.	Recommendation	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	5.3	It is recommended that Braden pressure ulcer risk assessments are reviewed and updated monthly or more often if deemed appropriate.	Inspection of four patients care records confirmed that Braden pressure ulcer risk assessments were reviewed monthly or more often if deemed appropriate.	**Compliant**

10.0 Inspection Findings

Section A

Standard : 5.1

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

Standard 5.2

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

Standard 8.1

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

Standard 11.1

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

Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3

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.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

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

Inspection Findings:

Policies and procedures relating to pre-admission and admission for planned and emergency admissions were available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing

Homes Minimum Standards (2008) and NMC professional guidance.

There was evidence to demonstrate that patients'/residents 'individual needs were established on the day they were admitted to the nursing home, and effective procedures were in place to manage any identified risks.

The inspector reviewed four patients' care records which evidenced that at the time of each patient's admission to the home, a registered nurse carried out initial risk assessments and developed agreed plans of care to meet the patient's immediate care needs.

Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, pain and continence were also completed on admission.

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

Section 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.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

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

Standard 5.3

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

Standard 11.2

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

Standard 11.3

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

Standard 11.8

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

Standard 8.3

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

Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16
Inspection Findings:
The inspector observed that a named nurse system was operational in the home. Review of four patients' care records and discussion with 10 patients/ residents individually and one patient's representative evidenced that patients and/or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Records also evidenced discussion with patients and/or their representatives following changes to the plans of care. In relation to wound care, the inspector examined two patients' care records. Body mapping charts were completed for patients on admission. These charts were reviewed and updated when any changes occurred to the patients' skin conditions. A recommendation is made that patients care plans on pressure care and prevention are reviewed and updated to specify the pressure relieving equipment in place on the patients' beds and also when sitting out of bed. There was evidence that patients' had pressure relieving devices in place, and the type of mattress in use was based on the outcome of the pressure risk assessment. A daily repositioning and skin inspection chart was in place for patients with wounds and or at risk of pressure damage. A review of two repositioning charts revealed that patients' skin was inspected for evidence of change, patients were assessed at every positional change and a record of the findings was maintained. Patients /residents' moving and handling needs were assessed and addressed in their care plans. There was evidence that manual handling aids were used to minimise risk of friction. Staff consulted confirmed there was sufficient nursing equipment available to move and handle patients' appropriately. Wound observation charts outlined the dimensions of wounds and were completed each time dressings were changed. Entries were also made in wound care records each time the dressings were changed. Care plans based on the outcome of a pain assessment was drawn up for patients/residents.

Discussion with two registered nurses and review of four patients' care records confirmed that where a patient was assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention plan and treatment programme. Advice sought from the relevant healthcare professionals was recorded. Care records reflected advice provided by these professionals, and records reviewed demonstrated that the advice provided was adhered to.

The registered manager confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local healthcare trust. Staff spoken with was knowledgeable regarding the referral process. Discussion with two registered nurses evidenced that they were knowledgeable of the action to take to meet the patients' and residents' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

Review of the records of incidents revealed that the incidence of pressure ulcers, grade 2 and above was reported to the RQIA in accordance with Regulation 30 of the Nursing Home Regulations (Northern Ireland) 2005. However a requirement is made in regard to the non –reporting of a patient with unexplained bruising. A requirement is made in this regard.

Patients' and residents' weights were recorded on admission and on at least a monthly basis or more often if required.

Patients' and residents' nutritional status was also reviewed on at least a monthly basis or more often if required.

Daily records were maintained regarding patients'/residents daily food and fluid intake. Patients' recommended daily fluid intakes were recorded in their care plans. However inspection of one patient's care record revealed that the actions to be taken if the fluid targets were not achieved were not recorded in the patient's care plan on eating and drinking. A requirement is made in this regard.

Policies and procedures were in place for staff on making referrals to the dietician. These include indicators of the action to be taken and by whom.

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

Care records reviewed evidenced that patients were referred for dietetic assessment in a timely manner.

Observation of practice and discussion with patients and staff evidenced that the nutritional care plans were being implemented.

Review of staff training records revealed that registered nurses had received training in wound management on; care assistants had also received training in pressure area care and prevention on by the wound care link nurse.

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

Section C

Standard 5: 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.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

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

Standard 5.4

- **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16

Inspection Findings:

Review of four patients' care records revealed that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs.

Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care including wound

management for each patient.

Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required.

Review of two patients' care records in relation to wound care and management of nutrition indicated that they were reviewed at least weekly.

The evaluation process included the effectiveness of any prescribed treatments, for example prescribed analgesia.

Discussion with the registered manager and review of governance documents evidenced that the quality of care records was audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

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

Section D

Standard 5: 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.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

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

Standard 5.5

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

Standard 11.4

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

Standard 8.4

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

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

Inspection Findings:

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

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

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

- The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes for Older People
- The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care
- The European Pressure Ulcer Advisory Panel (EPUAP).

Discussion with the registered manager and registered nurses confirmed that they had a good awareness of these guidelines. Review of four patients' care records evidenced that registered nurses implemented and applied this knowledge.

Discussion with the registered manager and review of governance documents evidenced that the quality of pressure ulcer/wound management was audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Two registered nurses and two care staff consulted could identify patients who required support with eating and drinking.

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

Section 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.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

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

Standard 5.6

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

Standard 12.11

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

Standard 12.12

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

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25

Inspection Findings:

A policy and procedure relating to record management was available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Home Minimum Standards (2008) and NMC professional guidance.

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

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

Review of four patients' care records evidenced/confirmed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient.

These statements reflected wound and nutritional management intervention for patients if required.

Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patient's status or to indicate communication with others concerning the patient.

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

The inspector reviewed a record of the meals provided for patients. Records were maintained in sufficient detail which enabled the inspector to judge that the diet for each patient was satisfactory. For example, the record evidenced a choice at each mealtime.

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

- Daily records of food and fluid intake were being maintained
- The nurse in charge had discussed with the patient //resident /representative regarding their dietary needs
- Where necessary a referral had been made to the dietician and or the speech and language therapist
- Care plans had been devised to manage needs and were reviewed regularly, monthly or more often if deemed appropriate
- Care plans were reflective of recommendations made by specialist healthcare professionals.

However inspection of one patient's care record revealed that the patient was at risk of dehydration and the action taken if the patient had not achieved the daily fluid target was not recorded in the care plan on eating and drinking.
A requirement is made in this regard.
Staff spoken with were knowledgeable regarding patients' and the resident's nutritional needs.

Discussion with the registered manager and review of governance documents evidenced that the quality of record management was in keeping with DHSSPS minimum standards and NMC guidelines.

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

Section 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.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

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

Standard 5.7

- **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16

Inspection Findings:

Please refer to criterion examined in section E. In addition the review of patients'/ residents ' care records evidenced that consultation with the patients and/or their representatives had taken place in relation to the planning of their care. This is in keeping with the DHSSPS minimum standards and the Human Rights Act 1998.

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

Section G

Standard 5: 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.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

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

Standard 5.8

- **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate**

Standard 5.9

- **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)

Inspection Findings:

Prior to the inspection a patients' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that all of the patients in the home had a care review undertaken through care management arrangements between 01 April 2013 and 31 March 2014.

The registered manager informed the inspector that care management reviews were held post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff attends each review. A copy of the minutes of the most recent review was held in the patient's care record file.

The inspector viewed the minutes of four care management reviews which evidenced that, where appropriate patients and their representatives had been invited to attend. Minutes of the review included the names of those who had attended an assessment of the patients' needs and a record of issues discussed. Care plans were updated to reflect recommendations made at care management reviews where applicable.

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

Section H

Standard 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 Homes Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)

Inspection Findings:

A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance.

There was a five weekly menu planner in place. The registered manager informed the inspector that the menu planner had been reviewed and updated in consultation with patients, residents, their representatives and staff in the home. The current menu planner was implemented on 01 April 2014.

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

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

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

therapist or dieticians. As previously stated under Section D relevant guidance documents were in place. Review of the menu planner and records of patients' choices and discussion with a number of patients, registered nurses and care staff it was revealed that choices were available at each meal time. The registered manager confirmed choices were also available to patients who were on therapeutic diets.

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

- **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 Homes Regulations (Northern Ireland)2005:Regulation/s13 (1) and 20

Inspection Findings:

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

Review of training records revealed that staff had attended training in dysphagia awareness.

Review of patients' care records who had been assessed by a speech and language therapist confirmed that their care plans had been reviewed to include the speech and language therapist's recommendations.
Discussion with registered manager confirmed that meals were served at appropriate intervals throughout the day and in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.

The registered manager confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning, afternoon and at supper times.

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

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Two registered nurses and two care staff consulted could identify patients who required support with eating and drinking.

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

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

for the meal served.

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

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

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

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 room in each unit of the home.

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/residents 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 managed appropriately by the management of the home.

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 14 staff members during the inspection process and eight staff completed questionnaires.

Examples of staff comments were for as follows:

- “Cornfield Care Centre is a lovely place to work; residents are looked after very well.”
- “Residents are looked after very well. We try to maintain their independence as long as possible according to their needs.”

- “I feel that we provide a high standard of care as we all work as a team and help each other. Residents are put first in everything, we ensure that the residents needs are met.”
- “I have my NVQ level 3.”
- “Yes I have been trained in wound management.”
- “The standard of care is very good here.”
- “I have worked here for the past 12 years and can safely say that the quality of care is always of the highest standard.”
- “I have worked here for a year and I am very happy here, the patients are all very well looked after and are always treated with dignity and respect.”
- “The home is very well managed, Mr Nutt is excellent.”
- “I have worked in Cornfield for a number of years and find that the staff all get on well with each other.”

11.9 Patients’ /residents’ Comments

The inspector spoke to 10 patients individually and with others in groups. Six patients completed questionnaires.

Examples of their comments were as follows:

- **“**I am very happy living in Cornfield.”
- “Could not ask for anything more, I am very content here.”
- “I find that the home is a wonderful place.”
- “The home is very comfortable in every respect and the staff are all really good.”
- “The home is really beautiful.”

11.10 Relatives’ Comments

The inspector spoke to one relative, three relatives completed questionnaires and one relative wrote to the inspector following the inspection.

An example of the relative’s comments is:

- “I cannot speak highly enough of the staff here they are all so good, I can leave here and know that my husband is well looked after.”
- “I have found the level of care to be excellent. The needs of the patients are always the priority.”
- “There is great attention to detail and there is great effort to keep relatives informed.”
- “I would recommend Cornfield, its excellent.”

- “Cornfield is an immaculately cared for and welcoming place, I am happy to know when I leave that my mother is well looked after. She is treated with dignity and respect by all the staff.”
- “Very happy with the care given at Cornfield, it’s a lovely friendly home.”

11.11 Environment

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

The home is furnished to a high standard with furnishings and fabrics of a high quality.

The premises presented as warm, clean and comfortable with a friendly and relaxed ambience.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr Jarvis Nutt Registered Provider, Mrs Christine Thompson Operations Manager, Mrs Mable Cole Registered Manager, Mr Ewen Harper Administration Manager and three registered nurses 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**
The Home has a Pre-Admisission Assessment policy where by each Resident is assessed prior to admission to determine their suitability for the particular unit ,this involves a member of staff attending their Home or Hospital to see the Resident and gain the required information.The Residents details are then recorded onto the Eppicare Package prior to their admission to the Home.The Staff on duty on the day of admission then complete the initial assessment of the care needs based on all the information at hand. The comprehensive holistic assessment of the Residents needs are completed prior to 11 days post admission using the validated tools.	Compliant

Trained Staff carry out nutritional screening for each Resident on admission using the validated MUST Tool and a Nutritional score is obtained.. A Body map,MUST,Abbey and Continence assessment are completed within 24 hours of admission to the Home At the Pre admission the skin assessment is completed following discussion with the Residents Family and Staff and information is taken from the Residents notes.All equipment is available, all Beds are Profiling and the Home always has spare Airflow mattresses for residents who are admitted or if their skin deteriorates.	

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 is allocated to each Resident and it is their responsibility to ensure that the planned care of the Resident is agreed and discussed with the family and the Resident where applicable.The care of the Resident is based on an holistic assessment of their care needs and this is reviewed with the Care Manager and the family six weeks after admission then 6 monthly and yearly.Any changes in the Residents condition are discussed with the family and the Care Manager is notified. All care plans take into account any relevant recommendations from health care Professionals. There are two Tissue Viability Link Nurses in the Home and they receive regular updates provided by the Trust.If required Residents can be referred to the Tissue Viability Nurse within the trust and a visit to the home will be provided. Each Resident who is at risk of developing a Pressure ulcer will have a pressure Ulcer prevention care plan in place. Any Resident who develops a pressure ulcer will have a care plan and a wound chart to chart the progress of the ulcer..Relevant healthcare professionals and the residents Family are kept informed of any changes. Residents Any resident with lower limb or foot ulceration can be referred to the Leg Ulcer Clinic in Limavady and a member of our Staff will escort them to their appointment in our Bus. nutritional screening is carried out on all residents on admission using the validated MUST Tool, and this is repeated monthly or more frequently depending on the individuals assessed needs.Any Resident giving cause for concern will be immediately referred to the Dietician for assessment. Once assessed the Staff will adhere to the Dieticians Treatment plan.	Compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Re-assessment is ongoing and is carried out daily at identified times and recorded in the daily progress notes. If there are any changes in the Residents care the Care Plan is updated care Manager and family are always kept informed..	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 carried out in accordance with NMC Guidelines. RCN and Nursing For Older People Royal Marsden. EPUAP Grading tool is used to screen Residents with skin damage, and an appropriate care plan is implemented. Staff adhere to the Nutritional Guidelines for Residential and Nursing Homes.There are Bi-Monthly staff meetings to keep staff up to date.The Operations Manager is Chair at the IHCP and is updated on current Regional and strategic level guidelines. The Tissue Viability link nurses within the Home also keep Staff up to date.each Unit has a Wound care file in place .	Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
The Home has the Epiccare System in place and all Nursing care records are in accordance with the NMC guidelines.All Nursing interventions, procedures and activities for each Resident is recorded and the outcome is included. Menus are updated three times a year taking into account seasonal availability of foods and Residents views. Where a care plan requires Staff will record the Residents daily Nutritional and Fluid intake. The Resident where applicable is informed of the reasons for monitoring their Nutritional and fluid intake,Family are also kept informed and if necessary referral is made to the Dietician and any actions are documented in the Residents progress notes and care Plans updated.	Compliant

Section F

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

Criterion 5.7

- **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
The Epicare system is in place and staff Nurses record and monitor the outcome of the care delivered to each Resident on a daily basis.This is reviewed and evaluated monthly or updated if there are any changes to the Residents care.The Staff inform the Family and Care Manager of any changes when they occur.The Named Nurse will also organise Review Meetings with the Trust care Manager,the Resident where applicaple and ther family six weeks following the Residents admission to the Home and thereafter six monthly and yearly.These will be documented and any outcomes addressed.there is a Human Rights Policy which all Staff must adhere to. All care plans are audited on a 3 monthly basis and action plans devised.	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**
a Named Nurse is allocated to each Resident and where applicable Residents and their family are encouraged to be involved in the planning of their care.Review Meetings are organised with the Care Manager, Resident and their family six weeks following admission to the Home and then six Monthly and yearly. Minutes are recorded during the Review meetings and any changes to care are discussed and agreed with the Care Manager Resident and Family .Any necessary changes are made to the Residents Care Plans and the care Manager Resident and Family are kept informed of any progress towards agreed goals.	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 Cook reviews and updates the menus three times a year taking into account seasonal availability of foods and Residents views.Residents are given Menu questionnaires to ensure that their views and preferences are taken into account.The Staff adhere to any relevant guidance documents provided by Dieticians and other professionals and this will be documented in the Residents Care Plans. The daily menu is displayed in each Suite so that Residents and their family see what is available. The Residents are offered two options and an alternative is available.A choice is also offered to any Resident on therapeutic or special diets.Menus are completed for each Resident daily either by themselves or assisted by Staff.Audits are carried out on the Residents daily intake and specific diets and an action plan is given to the Sisters and Staff Nurses in each unit to address.	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**
Nurses adhere to the Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes and Nutritional screening is carried out on all Residents on admission using the validated MUST Tool. Any Resident presenting with swallowing difficulties is immediately referred to the Speech and Language Therapist for assessment and a plan of care is implemented and adhered to by all staff.	Provider to complete

Meals are provided at conventional times throughout the day. Hot and cold drinks are served mid- morning, afternoon and at supper time with homemade scones,Traybakes and biscuits..There is also a choice of fresh fruit and puddings available.Water and Juice is accessable to our Residents in the Dining Rooms, Lounges and Bedrooms. All Staff are aware of our Residents Dietary needs and adhere to each Residents individual care Plan.During Meal times a member of trained Staff supervises the dining room and the Carers as they assist any Resident requiring help with their food. All necessary aids and equipment are provided for our Residents to ensure that their Dining experience is safe and enjoyable. We have two Tissue Viability Link Nurses in the Home and they receive regular updates from the trust on wound assessment and care.They in turn provide in house training for our trained staff.If any issues occur our staff will liase with the Tissue Viability Nurse in the Trust and if required a domicillary visit to the home will be provided.	

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

Appendix 2

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

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

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

References

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

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

Quality Improvement Plan

Announced Primary Inspection

Cornfield Care Centre

02 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 Mr Jervis Nutt Registered Provider, Mrs Christine Thompson Operations Manager, Mrs Mable Cole Registered Manager, Mr Ewen Harper Administration Manager and three registered nurses 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	16 (1)	The registered person must ensure that the following has been effectively addressed: • When fluid targets are not achieved the information is recorded in the patients care plans on eating and drinking. **Section E**	One	The Care Plan for Eating & Drinking reflects the action to be taken if a Resident does not achieve their daily fluid target.	One week
2	30 (1) (d)	The registered person shall inform RQIA of any incident in the home that affects the patients' health and wellbeing. **Section B**	One	RQIA are notified of any incidents affecting the Residents wellbeing and health.	From the date of this inspection

Recommendations

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

No.	Minimum Standard Reference	Recommendation	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.3	It is recommended that the type of pressure relieving equipment on patients beds and when sitting out of bed be recorded in the patient's care plan on pressure area care and prevention. **Section B**	One	All Pressure relieving equipment is recorded in the Residents care plan on pressure area care and prevention.	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	Mabel Cole
Name of Responsible Person / Identified Responsible Person Approving Qip	Jervis Nutt

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Heather Moore	03 July 2014
Further information requested from provider			