Announced Primary Care Inspection

Name of Establishment:	**Springlawn**
Establishment ID No:	**1213**
Inspector's Name:	**Heather Moore**
Date of inspection:	**30 September 2014**
Inspection No:	**IN016491**

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

Name of home:	Springlawn
Address:	44 Old Dromore Road Omagh BT78 1RB
Telephone number:	028 8224 4550
Email address:	springlawn@hotmail.com
Registered organisation/ registered provider:	Mrs Bernadette Kiernan O'Donnell
Registered manager:	Mrs Sharon Colhoun
Person in charge of the home at the time of inspection:	Mrs Sharon Colhoun
Categories of Care:	NH-I, NH - PH, NH - PH (E), RC-I, RC-PH, NH-LD(E) 2 designated persons
Number of registered places:	40
Number of patients/residents accommodated on day of inspection:	27 Patients 5 Residents
Scale of charges (per week):	£581.00 Nursing £461.00 Residential
Date and type of previous inspection:	30 September 2013: Primary Unannounced Inspection
Date and Time of Inspection:	30 September 2014 08.40 hours to 15.10 hours
Name of Lead Inspector:	Heather Moore

2.0 Introduction

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

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

3.0 Purpose of the inspection

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

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

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

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

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

4.0 Methods/process

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

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

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

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

- discussion with the senior manager
- discussion with the registered manager
- review of the returned quality improvement plan (QIP) from the previous care inspection conducted on the 30 September 2014
- observation of care delivery and care practices
- discussion with staff on duty at the time of this inspection
- examination of records pertaining to the inspection focus
- consultation with patients/residents individually and with others in groups
- tour of the premises
- evaluation and feedback.

5.0 Consultation process

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

Patients/Residents	**10 individually and with others in groups**
Staff	**10**
Relatives	**2**
Visiting professionals	**0**

Questionnaires were provided by the inspector during the inspection, to patients / residents, their representatives and staff to seek their views regarding the quality of the service.

Issued to	**Number issued**	**Number returned**
Patients / residents	**8**	**8**
Relatives / representatives	**1**	**1**
Staff	**10**	**10**

6.0 Inspection focus

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

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

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

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

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

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

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

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

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

7.0 Profile of service

Springlawn is situated in its own tastefully landscaped and well maintained grounds in a quiet and private residential setting, on the outskirts of Omagh in County Tyrone.

The home is divided into two units, a general nursing unit and a residential unit known as "Windymount", which share a main kitchen, laundry, staff accommodation and offices. The general nursing unit comprises of 29 single bedrooms, two double bedrooms, a dining room, a choice of three sitting rooms and toilet/washing facilities.

Windymount comprises of seven single bedrooms, a main sitting room, a kitchenette and toilet/washing facilities.

The home is a two-storey building with access to the first floor via a lift and stairs. There are car parking facilities at the back of the home.

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

Nursing Care

NHI - Old age not falling into any other category
NH-PH – Physical disability under the age of 65 years
NH- LD (E) - Learning disability (A maximum of 2 patients only) over the age of 65 years.

Residential Care

RC I - Old age not falling into any other category
RC-PH- A maximum of two residents.

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) was reviewed and was appropriately displayed in the foyer of the home.

The nursing home is owned and operated by Mrs Bernadette Kiernan O'Donnell.

The current Registered Manager is Mrs Sharon Colhoun.

8.0 Executive summary

The announced inspection of Springlawn was undertaken by Heather Moore on 30 September 2014 between the hours of 08.40 hours and 15.10.hours. The inspection was facilitated by Mrs Sharon Colhoun, Registered Manager, who facilitated the inspection and was available for verbal feedback at the conclusion of the inspection

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

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

The inspector also considered the management of patient's human rights during this inspection. The requirement made as a result of the previous inspection was also examined. The inspector evidenced that this requirement was fully complied with.

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. This self-assessment was received on 27 March 2014. The comments provided by the responsible individual/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

During the course of the inspection, the inspector met with patients, residents, staff and two 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 nursing home environment.

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

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

Inspection of a sample of staff duty rosters and discussions with staff confirmed that staffing levels on the day of inspection were satisfactory and in line with RQIA's recommended minimum staffing guidelines. No issues or concerns were brought to the attention of the inspector on the day of inspection.

Conclusion

There were systems and processes in place to ensure the effective management of the standards inspected. However, areas for improvement were identified. Four requirements and five recommendations are made.

These requirements and recommendations are addressed throughout the report and in the quality Improvement Plan (QIP).

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

The inspector would like to thank the patients, residents, relatives and staff who completed questionnaires.

9.0 Follow-up on the requirements and recommendations issued as a result of the previous primary unannounced care inspection conducted on 30 September 2013.

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
1	17.1	It is recommended that any expression of dissatisfaction with the care or services provided is treated as a complaint and dealt with in accordance with the relevant legislation and DHSSPS guidance on the management of complaints. Information from complaints is used to improve the quality of services.	Inspection of the complaints record confirmed that complaints were being investigated appropriately by management.	**Compliant**

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

There were no issues /concerns raised with RQIA since the previous inspection.

10.0 Inspection findings

Section A – On admission a registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Standard criterion 5.1, 5.2, 8.1 and 11.1 examined.
Policies and procedures relating to patients and residents' admissions were available in the home. These policies and procedures addressed pre- admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance. The inspector reviewed three patients' care records which evidenced that patients' and residents' individual needs were established on the day of admission to the nursing home, through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks. Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart and continence were also completed on admission. However a pain assessment chart was not maintained appropriately. A recommendation is made in this regard. Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure ulcer/wound and if required, the specific care plans regarding the management of the pressure ulcer/wound. Review of three patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 11 days of the patient's admission to the home. In discussion with the registered manager, she demonstrated a good awareness of the patient who required wound management intervention for a wound and the number and progress of patients who were assessed as being at risk of weight loss and dehydration.

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

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

The inspector observed that a named nurse and key worker system was operational in the home. The roles and responsibilities of named nurses and key workers were not outlined in the patient's guide. A recommendation is made in this regard.

Review of three patient's/resident's care records and discussion with patients and residents evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. However one patient's care record confirmed the absence of written evidence in this regard. A recommendation is made that this is adressed.

Records evidenced discussion with patients and/or their representatives following changes to the plans of care.

Patients' care records revealed that the pressure relieving equipment in place on the patients' beds and when sitting out of bed, was not addressed in patients' care plans on pressure area care and prevention. A recommendation is made in regard to this shortfall.

Examination of two patients care records revealed the absence of pain management care plans. A requirement is made in this regard. As previously stated a recommendation is made in regard to the maintenance of patients' pain assessments.

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

- A body mapping chart was completed for the patient on admission. This chart was reviewed and updated when any changes occurred to the patient's skin condition
- A daily repositioning and skin inspection chart was in place for the patient with the wound and also for patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these charts revealed that patients' skin condition was inspected for evidence of change at each positional change. It was also revealed that patients were repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention.

In discussion with the registered manager and two registered nurses and a review of three patients' care records, confirmed that where a patient was assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention plan and treatment

programme.

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

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

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

The patient's nutritional status was also reviewed on at least a monthly basis or more often if required.

Daily records were maintained regarding the patient's daily food and fluid intake.

Review of wound care in a patient's care plan evidenced that the dressing regime was recorded appropriately.

Policies and procedures were in place for staff on making referrals to the dietician. These included indicators of the action to be taken and by whom. All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment.

Review of care records for one patient evidenced that the patient was referred for a dietetic assessment in a timely manner.

Discussion with the registered manager, registered nurses, care staff and review of the staff training records, revealed that staff (were trained in wound management and pressure area care and prevention. Twenty four staff were also trained in the management of nutrition. Patients' moving and handling needs were assessed and addressed in their care plans. There was evidence that manual handling aids were used to minimise risk of friction. Staff consulted confirmed there was sufficient nursing equipment available to move and handle patients' appropriately.

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

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

Section C - Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans. Standard criteria 5.4 examined.
Review of three patients' care records evidenced that one patient's care plan was reviewed without reviewing and updating the patient's assessment of need. A requirement is made in this regard. Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. Discussion with one registered nurse and a review of governance documents evidenced that a number of care records were 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 criteria assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criteria assessed	**Moving towards Compliance**

Section D – All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. Standard criterion 5.5, 8.4 and 11.4 examined.
The inspector examined three patients' care records which evidenced the completion of validated assessment tools such as: • The Roper, Logan and Tierney assessment of activities of daily living • Braden pressure risk assessment tool • Nutritional risk assessment such as Malnutrition Universal Screening Tool (MUST). The inspector confirmed the following research and guidance documents were available in the home: • DHSSPS 'Promoting Good Nutrition' A Strategy for good nutritional care in adults in all care settings in Northern Ireland 2011-16 • The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes • The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care • The European Pressure Ulcer Advisory Panel (EPUAP). Discussion with the registered manager and registered nurses confirmed that they had a good awareness of these guidelines.

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

Section E – Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients. Standard criterion 5.6, 12.11 and 12.12 examined.

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

Registered nurses spoken with were aware of their accountability and responsibility regarding record keeping. However a requirement is made that registered nurses receive a training update on care planning.

Review of three patients' care records revealed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient. These statements reflected wound and nutritional management intervention for patients as required.

Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patients' status or to indicate communication with other professionals/representatives concerning the patients.

Entries were noted to be 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 to enable the inspector to judge that the diet for each patient was satisfactory.

The inspector reviewed the care records of three patients identified of being at risk of inadequate or excessive food and fluid intake. This review confirmed that:

- daily records of food and fluid intake were being maintained
- the nurse in charge had discussed with the patient/representative their dietary needs
- where necessary a referral had been made to the relevant specialist healthcare professional
- a record was made of any discussion and action taken by the registered nurse
- care plans had been devised to manage the patient's nutritional needs and were reviewed on a monthly or more often basis.

Review of a sample of patients fluid balance charts evidenced that these charts were recorded appropriately.

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

Twenty four staff had attended training in nutrition and dysphagia during the period from 17 February 2014 to 23 September 2014.

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

Section F – The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives. Standard criteria 5.7 examined.

Please refer to criterion examined in Section E. In addition, the review of three patients' care records evidenced that consultation with the patient and/or their representative had taken place in relation to the planning of the patient's care. This is in keeping with the DHSSPS Minimum Standards and the Human Rights Act 1998.

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

Section G – The management and involvement of patients and/or their representatives in review of care. Standard criterion 5.8 and 5.9 examined.
Prior to the inspection, a patients' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that all the patients in the home had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014. The registered manager informed the inspector that patients' care reviews were held post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff preferably the patient's named nurse attends each care review. A copy of the minutes of the most recent care review was held in the patient's care record file. The inspector viewed the minutes of three care management care reviews which evidenced that, where appropriate, patients and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended an updated assessment of the patient's needs and a record of issues discussed. Care plans were evidenced to be updated post care review to reflect recommendations made where applicable.

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

Section H – Management of nutrition including menu choice for all patients. Standard criterion 12.1 and 12.3 examined.
A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance. There was a four 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 01April 2014. The inspector discussed the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients with the registered manager and a number of staff. Staff spoken with were knowledgeable regarding the individual dietary needs of patients and to include their likes and dislikes. Discussion with staff and review of the record of the patient's meals confirmed that patients were offered choice prior to their meals. Staff spoken with were knowledgeable regarding the indicators for onward referrals to the relevant professionals. e.g. speech and language therapist or dieticians. From a review of the menu planner and records of patients' choices and discussion with a number of patients, residents, registered nurses and care staff, it was revealed that choices were available at each meal time. The registered manager confirmed choices were also available to patients who were on therapeutic diets.

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

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

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

Review of training records revealed that 24 staff had attended training in dysphagia awareness. Twenty six staff had attended training in first aid. However examination of staff training confirmed that staff required a training update in Enteral Feeding Systems. A requirement is made in this regard.

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.

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

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

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11.0 Additional areas examined

11.1 Records required to be held in the nursing home

Prior to the inspection a check list of records required to be held in the home under Regulation 19(2) Schedule 4 of The Nursing Homes Regulations (Northern Ireland) 2005 was forwarded to the home for completion. The evidence provided in the returned questionnaire; and review of a selected sample of documents by the inspector confirmed that the required records were maintained in the home and were available for inspection.

11.2 Patients/residents under Guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) Order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection.

There were no patients/residents accommodated at the time of inspection in the home who were subject to guardianship arrangements.

11.3 Quality of Interaction Schedule (QUIS)

The inspector undertook a number of periods of enhanced observation in the home which lasted for 30 minutes each. The inspector observed the lunch meal being served in the dining room. The inspector also observed care practices in two of the sitting rooms following the lunch meal.

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

Total number of observations	Three
Positive interactions	All Positive
Basic care interactions	
Neutral interactions	
Negative interactions	

Observation of the lunch meal confirmed that meals were served promptly and assistance required by patients and residents was delivered in a timely manner. Staff were observed preparing and seating the patients and residents for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients and residents with their meal and patients and residents were offered a choice of fluids. The staff explained to the patients and residents their meal choice and provided appropriate assistance and support to the patients and residents.

Observation of care practices in the sitting rooms revealed that staff initiated conversations with patients and residents and listened to their views and were respectful in their interactions with them. Overall the periods of observation were positive in regard to the care of patients and residents in the home.

11.4 Complaints

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

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

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

11.5 Patient/ resident finance questionnaire

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

11.6 NMC declaration

Prior to the inspection the registered manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC.

11.7 Questionnaire findings

11.7.1 Staffing levels and staff comments

Discussion with the registered manager and review of the nursing and care staff duty roster for three weeks evidenced that the registered nursing and care staffing levels were satisfactory and in line with the RQIA's recommended minimum staffing guidelines for the number of patients and residents accommodated in the home during the inspection.

During the inspection the inspector spoke to10 staff. The inspector was able to speak to a number of these staff individually and in private. Ten staff completed questionnaires.

The following are examples of staff comments during the inspection and in questionnaires.

- "I love my work here; we work well as a team."
- "I had an induction when I commenced work."

- "I think we provide a good standard of care here."
- "The residents are all well looked after."
- "I am working in Springlawn for approximately eight years and the residents are all well looked after."
- "I am happy to say that all the patients are all well looked after, there is a high standard of care here."
- "I have had training in wound management."
- "Yes I have had training in Dysphagia."
- "Everyone works well together here as a team."
- "Sometimes it's very busy; I would like more staff on."

11.7.2 Patients/residents and relatives comments

During the inspection the inspector spoke with 10 patients/residents individually and with the majority of others in smaller groups.

Patient spoken with and the questionnaire responses confirmed that patients were treated with dignity and respect, that staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home.

The following are examples of patients and residents comments during the inspection and in the questionnaires.

- "This is a great place, I am happy here."
- "I have access to drinks throughout the day."
- "The staff here are very good."
- "Sometimes when they are busy, I have to wait for the staff to answer my buzzer."
- "I am happy here."
- "I am well looked after."

The inspector spoke with two relatives during the inspection and one relative completed a questionnaire at the end of the inspection. Relatives' responses included:

- "I am happy with the standard of care in the home."
- "My mother would like to go for a walk outside occasionally, and sometimes she has to wait for a member of staff to answer her buzzer."

11.8 Environment

The inspector undertook a tour of the home environment and viewed a number of patients/ residents bedrooms, communal areas, dining rooms, and toilet and bathroom facilities.

The home presented as warm, clean and comfortable. However a requirement is made that the identified patients' bedroom carpet and the identified bedroom doors and architraves are refurbished.

12.0 Quality Improvement Plan

The details of the quality improvement plan appended to this report were discussed with Mrs Sharon Colhoun, Registered Manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider / manager is required to record comments on the quality improvement plan.

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

Enquiries relating to this report should be addressed to:

Heather Moore
The Regulation and Quality Improvement Authority
Hilltop
Tyrone and Fermanagh Hospital
Omagh
Co Tyrone
BT70 0NS

_____ _____

Heather Moore **Date**
Inspector / Quality Reviewer

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**
On admission an inital risk assessment is carried out using information recieved from pre- admission assessment and care management team, a validated tool is used. Full holistic assessment is completed within 11 days of admission. MUST sreening tools are used on each patient & updated monthly. Assessment such as Braiden scale, incontinence, MUST,risk and skin inspections are used to assess patients risk of pressure ulcers.	Compliant

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

professionals. There are arrangements in place for referrals to tissue viability nurses. Where a patient has been assessed as being at risk a pressure prevention programme is put in place, putting needs and comfort as priority, equipmentbis utilised and opinions of all health care professionals sought. There are referral arrangements in place for tissue viability nurses. There are referral arrangements in place for dietician involvement and plans of care are drawn up. This plan is drawn up taking account of recommendations from other health care professionals and these plans are adhered to.	
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 daily and all assessments and careplans are updated monthly or sooner if needs change.	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 are supported by good practise & evidence based care. Nurses are registered with yhe NMC & care staff with Social Care Council. A grading tool is used to screen patients with skin damage & appropiate plan implemented, NICE guidelines available. Up to date nutitional guidelines & menu checklist, DHSSPS- promoting good nutrition etc on premises and used by staff daily.	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**
All nursing records are in accordance with NMC guidlines, all Intervention, activities and procedures documented with outcomes in a contemporous manner. Meals record is kept daily. Records are held of all patients who have reduced nutritional input, referrals are sent to appropriate heatlh care professtionals in relation to dietary issues and a record is kept and careplans 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**
Care is monitored and recorded minimum 8AM & 8PM with handover to other staff. Interventions and visits by GP etc.may be recorded during the course of the day or night as appropriate.	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**
Patients are encouraged and facilitated to participate, attend and contribute in review meetings. All review reports are held in clients notes and all changes agreed with patient/ representative are updated in their careplans and outcomes discussed.	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**
Patients are provided with a varied nutritional diet which takes into account dietary needs and preferences of patients & also any heatlh care professional involement, records of same are held on premises and updated regularly. Menus within the home are based on a four weekly routine,two or more choices are given at each meal time with the optition of an alternative meal if different chioce is preferred . A record is held of all specific and therapeutic dietsof individual patients.	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**
All staff attend training in relation to feeding and swallowing yearly and records are kept for all patients who are under the care of speech & language therapists and all instrutions followed. All meals areprovided at conventional times with optition for other times to suit specific patient needs. Snacks ,hot and cold drinks and water is available at all times throughout the day. Care plans are in place and all staff are ware of any patients who have dietary concerns ie. assistance,specialist equipment or risks.	Compliant

Staff attend TVN training and have access to specialist TVN nurses for all wound care management.	

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

Primary Announced Care Inspection

Springlawn

30 September 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 Sharon Calhoun, Registered Manager** either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	16 (1)	The registered person shall ensure that a specific care plan on pain management is in place for patients who require analgesia. **Ref: Section B**	One	This has been addressed.	From the date of this inspection
2	15 (2) (b)	The registered person shall ensure that the assessment of the patient's needs is reviewed at any time where it is necessary to do so having regard to any change of circumstances and in any case not less than annually. This review should fully reflect the patient's assessed needs. **Ref: Section C**	One	This has been addressed.	From the date of this inspection
3	20 (1) (c) (i)	The registered person shall ensure that registered nurses receive training in the following areas: • Enteral Feeding Systems including the use of specific pump equipment • Care planning. **Ref: Section E and Section I**	One	This has been booked for November 2014 + staff identified to attend.	Two Months (Process shall commence immediately)

4	27 (2) (d)	The registered person shall ensure that the identified patient's bedroom carpet is replaced. Identified bedroom doors and architraves should also be refurbished. **Ref Section 11 point 11.8 (Additional Areas Examined)**	One	This has been discussed with the Home Owners & will be addressed.	Two Months

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.3	It is recommended that the patients' pressure relieving equipment in use on the patients' beds and when sitting out of bed be addressed in patients care plans on pressure area care and prevention. **Ref: Section B**	One	This is being included in Care Plans.	One week
2	5.3	It is recommended that a pain assessment be maintained in patients care records and that the assessment be recorded appropriately. **Ref: Section A**	One	This will be addressed.	One week
3	5.3	It is recommended that written evidence is maintained in patients and residents care records to indicate that discussions had taken place with patients, residents, and/or their representatives in regard to planning and agreeing nursing interventions. **Ref: Section B**	One	This will be addressed as fully as possible where representatives available.	One Month
4	5.3	It is recommended that the roles and responsibilities of named nurses and key	One	This has been addressed.	One Month

		workers be recorded in the Patient's Guide. **Ref: Section B**			

The registered provider / manager is required to detail the action taken, or to be taken, in response to the issue(s) raised in the Quality Improvement Plan. The Quality Improvement Plan is then to be signed below by the registered provider and registered manager and returned to:

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

Mrs Colhoun on annual leave.

SIGNED: T McGarvey

NAME: T. McGarvey
Registered Provider

DATE 4-11-2014

SIGNED: [signature]

NAME: staff nurse J. McMullen
Registered Manager

DATE 4.11.14

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	07 November 2014
Further information requested from provider			