Secondary Unannounced Care Inspection

Name of Service and ID:	**The Graan Abbbey (1215)**
Date of Inspection:	**18 February 2015**
Inspector's Name:	**Heather Moore**
Inspection ID:	**IN016530**

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544

1.0 GENERAL INFORMATION

Name of Home:	The Graan Abbey
Address:	Derrygonnelly Road Enniskillen BT74 5PB
Telephone Number:	028 6632 7000
E mail Address:	graanabbey@yahoo.co.uk
Registered Organisation/ Registered Provider:	Carewell Homes Ltd Mrs Carol Kelly
Registered Manager:	Mrs Martina McGuiness (Registration Pending)
Person in Charge of the Home at the Time of Inspection:	Mrs Martina McGuiness
Categories of Care:	NH-I, NH-PH, NH-DE, NH-MP, NH-MP(E), RC-I, RC-PH, RC-MP, RC-MP(E)
Number of Registered Places:	86
Number of Patients and Residents Accommodated on Day of Inspection:	68 -Patients NH-I NH-PH 49 NH-DE 19 15 - Residents RC-I RC-PH RC-MP RC-MP(E) (Three patients in hospital on day of inspection)
Scale of Charges (per week):	£581.00 – Nursing £461.00 - Residential
Date and Type of Previous Inspection:	17 June 2014 Secondary Unannounced
Date and Time of Inspection:	18 February 2015: 8.35 am to 1.35 pm
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 are required.

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 METHODS / PROCESS

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

- Discussion with the registered provider
- Discussion with the manager
- Discussion with staff
- Discussion with patients /residents individually and to others in groups
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- Review of a sample of care records
- Observation during a tour of the premises
- Evaluation and feedback.

5.0 Consultation Focus

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

Patients/Residents	**10**
Staff	**10**
Relatives	**0**
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	**6**	**6**
Relatives / representatives	**0**	**0**
Staff	**8**	**6**

6.0 Inspection Focus

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

STANDARD 19 - CONTINENCE MANAGEMENT

Patients receive individual continence management and support.

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

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

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

7.0 Profile of Service

The Graan Abbey Private Nursing Home is situated in its own grounds off the main Enniskillen / Derrygonnelly Road in Co. Fermanagh.

The home comprises of two units;

The Inishview Unit comprises of 39 single en-suite bedrooms. There is one main sitting room, kitchen and dining room, bathroom, shower and toilet facilities, a nurses' station, a laundry, a designated smoking area for patients and residents, a staff room and treatment room.

The Cloisters Unit comprises of 35 single and six double en-suite bedrooms. There are a number of sitting rooms, quiet room, main kitchen, dining room, bathrooms, toilets, nurses' station, laundry, and staff accommodation.

The Inishview and Cloisters Units were re-registered on 13 June 2013 as one registration.

The home is registered in the following categories of care:

Nursing-I &PH - 44 patients
Nursing- DE - 20 patients (Primrose Unit)
Nursing –MP&MP (E) - seven patients
Residential-MP&MP (E) - six residents
Residential-I &PH - nine residents.

The grounds around the home are beautifully landscaped and provide secluded secure areas to enable patients and residents to relax in tranquil surroundings.

There are adequate car parking facilities at the front of the home.

8.0 Summary

This summary provides an overview of the services examined during an unannounced care inspection to The Graan Abbey. The inspection was undertaken by Heather Moore on 18 February 2015 from 8.35 am to 1.35 pm.

The inspector was welcomed into the home by Mrs Martina McGuiness, Manager who was also available throughout the inspection. Mrs Carol Kelly, Registered Provider was also available. Verbal feedback of the issues identified during the inspection was given to the registered provider and to the manager at the conclusion of the inspection.

Mrs Martina McGuiness has been recently appointed as manager and as yet has not been registered with the RQIA. For the purposes of this report she will be referred to as the manager.

During the course of the inspection, the inspector met with patients and residents examined a selection of records and carried out a general inspection of the nursing home environment as part of the inspection process.

As a result of the previous inspection conducted on 17 June 2014 two requirements and one recommendation were issued. These were reviewed during this inspection. The

inspector evidenced that these requirements and recommendation had been complied with. Details can be viewed in the section immediately following this summary.

Discussion with the manager, a number of staff, patients and residents and review of four patients care records revealed that continence care was well managed in the home.

Staff were trained in continence care on induction. Mrs Carol Kelly Registered Provider informed the inspector that further training on Continence Awareness was planned for all staff on19 March 2015.

Examination of four patients care records revealed that one care record contained no care plan on continence care. It is acknowledged that a continence assessment was in place. A requirement is made that this shortfall is addressed.

A regular review of the management of patients and residents who were incontinent was not undertaken in the home. A recommendation is made that monthly audits are undertaken and the findings acted upon to enhance continence care in the home.

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

One requirement and one recommendation are made. These are detailed in the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, and residents, registered provider, 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 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	20 (3)	The registered person shall ensure that at all times a nurse is working at the nursing home and that the registered manager carries out a competency and a capability assessment with any nurse who is given the responsibility of being in charge of the home for any period of time in her absence.	Inspection of registered nurses competency and capability assessments confirmed that these assessments were undertaken on an annual basis.	Compliant
2	13 (7)	The registered person shall ensure that disposable gloves and aprons are stored appropriately.	Observation on the day of inspection confirmed that disposable gloves and aprons were stored appropriately.	Compliant

No.	Minimum Standard Ref.	Recommendation	Action Taken – As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	30.1	It is recommended that the Activity Therapists hours are reviewed and increased to ensure that the patients receive adequate stimulation to improve their mental health needs.	Discussion with the registered provider and examination of the staff duty roster confirmed that since the previous inspection the activity hours had been increased to 66 hours per week.	Compliant

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

Since the previous inspection RQIA had received one anonymous complaint, this complaint was investigated and is now closed. One incident is currently being investigated by the Adult Safeguarding Team.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support.	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of three patients' care records revealed that bladder and bowel continence assessments were undertaken for these patients. Inspection of four care records revealed the absence of one specific care plan on continence care was not available in the patient's care record. A requirement is made that this shortfall is addressed. The promotion of continence, skin care, fluid requirements and patients' and the resident's dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients and residents were referred to their GPs as appropriate. Review of care records revealed that there was written evidence held of patient/resident and their relatives' involvement in developing and agreeing care plans. Discussion with staff and observation during the inspection revealed that there were adequate stocks of continence products available in the home.	Substantially Compliant
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place; • continence management / incontinence management • stoma care • catheter care.	Compliant

The inspector can also confirm that the following guideline documents were in place; • Nice Guidelines on Faecal incontinence • Nice Guidelines on urinary incontinence. Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not applicable.	Not Applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the senior nurse and review of the staff training records revealed that staff were trained in continence care on induction. The registered provider informed the inspector that further training on continence awareness was planned for 19 March 2015. Discussion with the manager revealed that currently in the home there were no patients that required assistance with stoma appliances, female catheters or male catheters. Currently there were no audits undertaken of patients or residents who were incontinent. A recommendation is made that regular audits are undertaken and the findings acted upon to enhance continence care in the home.	Substantially Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

During the inspection the staff were noted to treat the patients and residents with dignity and respect. Good relationships were evident between patients, residents and staff.

Patients and residents were well presented with their clothing suitable for the season.

Staff were observed to respond to patients' and residents' requests promptly.

The demeanour of patients and residents indicated that they were relaxed in their surroundings.

11.2 Patients' and Residents' Comments

During the inspection the inspector spoke to 10 patients and residents individually and to others in groups. Six patients and residents also completed questionnaires. These patients and residents expressed high levels of satisfaction with the standard of care, facilities and services provided in the home. A number of patients and residents were unable to express their views verbally. These patients and residents indicated by positive gestures that they were happy living in the home.

Examples of patients' and residents' comments were as follows:

- "The staff are all very good."
- "The food is very good."
- "The staff are all very kind."
- "I have no complaints everything is perfect."

11.3 Staffing/Staff Comments

On the day of inspection the number of registered nurses and care staff rostered on duty were in line with the RQIA's recommended minimum staffing guidelines for the number of patients and residents currently in the home.

The inspector spoke to a number of staff during the inspection. Six staff completed questionnaires. No issues or concerns were brought to the attention of the inspector.

Examples of staff comments were as follows:

- "I enjoy my work here."
- "We have enough continent products for the patients."
- "The food is very good here."
- "There is good team work here."
- "The residents are well looked after."

11.4 Environment

The inspector undertook a tour of the premises and viewed the majority of the patients' and residents' bedrooms, sitting areas, dining rooms, bathroom, shower and toilet facilities.

The home was found to be clean warm 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 Mrs Carol Kelly, Registered Provider and Mrs Martina McGuiness, Manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
A pre admission assessment is carried out for all proposed admissions with the exception of emergency admissions. This enables initial risks to be identified and appraisal of individual needs to occur. On admission further assessment of need is undertaken using the Roper,Tierney and Logan Model to form a care plan to reflect the patients care needs.The Care Manager`s assessments, other allied Health Professional assessments and family input contributes to planning of care needs. All nutritional needs are assessed using the MUST tool on admission and monthly thereafter or more often depending on patient needs. Pressure risk assessment using the Braden Scale tool is carried out when	Compliant

completing the pre-admission assessment and a body map completed on admission. On admission a variety of assessment tools are used to evaluate the care requirements of individual patients these include Continence, Braden Scale,Falls Risk Assessment and Manual Handling Assessment . Comprehensive assessment of the patient will take place over the period of eleven days following admission. This will be signed and dated as appropriate.	
Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
Each patient is allocated a named nurse who will plan and agree nursing interventions to meet the pateints assessed needs. The patient, care manager and relatives are informed who the named nurse is.The patients condition is evaluated on a daily basis and reviewed monthly and any referrals required to promote maximum independence and rehabilitation will be implemented. Referrals for any tissue advice to Heather Ogle TVN are processed through the RMA system. When a patient is identified as at risk of pressure ulcers, a care plan is implemented to meet the persons need.The care plan indicates action to be taken,outlines pressure relieving devices used,repositioning regime and any identified skin treatments.Referrals as required are sent to other members of the multidisciplinary team e.g. Dietician, G.P., Tissue viability. These are documented in the care plan and recommendations are recorded. Daily evaluations of skin condition are recorded. All patients have a monthly MUST assessment to identify any weight loss/gain. In the event of a 10% weight loss over a six month period or if a person presents with a low BMI,then a referral is made to the dietician.While awaiting the dieticians assessment the patient is commenced on food fortification measures. A copy of the dietician`s recommendations is kept on file and included in the care plan. All staff including kitchen staff are made aware of the patients dietary requirements.	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.

Criterion 5.4

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

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

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
The nurse evaluates care on a daily basis. Patient care is reviewed on a monthly basis or more often if required.	Substantially 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 practice, interventions and procedures are evidence based and National guidelines e.g. NICE, Crest, DHSSP, and Public Health. We have a rolling training programme for all staff and all staff are encourage to continuously update their skill and knowledge base. We have appointed link nurses for Palliative Care,Diabetes, Tissue Viability and Infection Control. A validated pressure ulcer grading tool is used to identify level of skin damage. In conjunction with advice and guidance with other health professionals e.g. TVN and Dietician, a treatment plan is developed and implemented. Up to date recent nutritional guidelines are available within the home for both care and kitchen staff to facilitate meeting the varying dietary needs of the patients.	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**
Up to date, clear and concise records in accordance with NMC guidelines are maintained for all nursing interventions and procedures for each patient. A record is kept of all meals provided to each resident. Individual dietary needs are catered for.eg. diabetic, pureed, fortified and soft diet. Any change of habit is recorded in the daily notes and monitored to ascertain if a pattern is developing. Care plans are updated to reflect any change in dietary habit. Where a change in dietary intake is identified, a 3 day fluid and food chart is kept and referral made to Dietician and G.P. for advice. Where a patient is identifed as having a weight loss of 10% or more within a six month period a referral is made to the dietician and food fortification is commenced. Advice will also be sought from the G.P. All interventions and assessments and action required are recorded in the individual careplan and monitored at monthly intervals or more often as required.	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.	
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**
Patients care delivery is evaluated on a daily basis in the nursing notes. Monthly reviews and evaluations are carried out on a monthly basis of all patient assessments and careplans,or more often if required. An annual care review is held with the patient, care manager and relatives and nursing staff to update, reflect and monitor the patients needs and continued appropriaetness of the placement.	Substantially 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**
All care managed patients are reviewed on an annual basis. Patients are invited and encouraged to attend. Next of kin are also invited to attend and offer their opinion in the review of care delivery, outcomes achieved and setting future goals,alongside the patient and care manager. Minutes of the review are kept in the patients care plan and any updating of the plan occurs following review. All staff are informed of any changes to agreed plan of care resulting from annual review.	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 offered a nutritious and varied menu with account being taken of personal choice and preferences.Prior to admission during the pre admission assessment information is gathered on nutritional needs, likes,dislikes and any previous assessments by Speech and Language or the Dietician and supplementary therapy noted. Any food allergies	Compliant

will also be noted. Up to date Nutritional guidelines are available within the home to both nursing and catering staff to assist with giving good nutrition. The menu includes an alternative choice for each mealtime.Where the patient does not wish to partake of any of the planned menu their preference is sought and an alternative is provided. Menus take account of Dietician and Speech and Language recommendations.A variety of nutritious snacks are available throughout the day.	
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 have up to date knowledge and skills to manage patients with swallowing difficulties to include consistency of food and fluids, and feeding techniques for each particular patient which reflects their degree of swallowing problems. Instructions by the SALT team are incorporated into the care plan and are adhered to and if any deterioration/improvement is noted a review of the assessment is requested. All staff are positively encouraged to attend Dysphagia training and to keep their skills updated. Meals are provided at conventional times. Hot and cold drinks and snacks are provided throughout the 24hour period at preset times and on request. Fresh drinking water is available throughout the day in all the day rooms and bedrooms. A choice of juices is also available. Where possible patients are encouraged to eat and drink themselves with some supervision or assistance. Where this is not possible the patient is fully assisted with eating and drinking. Staff are encouraged to make all mealtimes an enjoyable and pleasurable experience for patients. Specialist tools if required are available. 11.7 Nurses have up to date skill in carrying out wound assessments and wound management in terms of choosing and applying dressings, monitoring progress and obtaining further advice from Tissue Viability Nurse.Training sessions are provided by the Trust and Tissue Viability Nurse and staff are encouraged to update their skills on a regular basis. There are two tissue viability link nurses withih the home to advise and guide staff.	Substantially compliant

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

Quality Improvement Plan

Unannounced Secondary Inspection

The Graan Abbey

18 February 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Carol Kelly, Registered Provider and Mrs Martina McGuiness, Manager either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirement	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	16 (1)	The registered person shall ensure that a specific care plan on continence care is contained in the patients /residents care records **Ref:19.1**	One	A specific care plan relating to a residents continence care has been included in the care records and will be updated as necessary.	One Week

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	19.4	It is recommended that audits are undertaken of patients and residents who are incontinent and the findings acted upon to enhance continence care in the home. **Ref 19.4**	One	A nurse has been appointed to oversee continence care within the home. A second nurse has been identified to also take on this role upon return from maternity leave. These continence care nurses will attend the Trust Continence Care Link Nurses meetings (first of which will be on 16 April 2015). Audits to commence April 2015 and monthly thereafter.	One Month

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	Martina McGuinness
Name of Responsible Person / Identified Responsible Person Approving Qip	Carol Kelly

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Bridget Dougan	17 April 2015
Further information requested from provider			