Secondary Unannounced Care Inspection

Name of Establishment:	**Parkside**
RQIA Number:	**1250**
Date of Inspection:	**16 December 2014**
Inspector's Name:	**Heather Sleator**
Inspection ID:	**INO10712**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1.0 General Information

Name of Establishment:	Parkside
Address:	4 North Circular Road Lisburn BT28 3AH
Telephone Number:	(028) 9267 4943
Email Address:	pauline@parksidenursing.co.uk
Registered Organisation/ Registered Provider:	Mr Arthur Dodds Parkside Private Care Ltd
Registered Manager:	Ms Paulene Rogers
Person in Charge of the Home at the Time of Inspection:	Ms Paulene Rogers
Categories of Care:	NH-I ,NH-PH ,NH-PH(E) ,NH-TI
Number of Registered Places:	29
Number of Patients Accommodated on Day of Inspection:	29
Scale of Charges (per week):	£537 - £577
Date and Type of Previous Inspection:	4 March 2014 10:15 – 13:30
Date and Time of Inspection:	16 December 2014 10:30 – 15:30
Name of Inspector:	Heather Sleator

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 Nurse Manager, Paulene Rogers
- discussion with staff
- discussion with patients 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 plans
- observation during a tour of the premises
- evaluation and feedback

5.0 Consultation Process

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

Patients/Residents	Eight patients individually and with the majority of patients generally
Staff	4
Relatives	0
Visiting Professionals	0

6.0 Inspection Focus

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

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

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

Standard 19 - Continence Management

Patients receive individual continence management and support.

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

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

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

7.0 Profile of Service

Parkside Nursing home is situated adjacent to the railway station and Wallace Park in Lisburn, Co. Antrim. The nursing home is owned and operated by Parkside Private Care Ltd and the responsible person is Mr Arthur Dodds. The current registered manager is Ms Paulene Rogers.

Parkside Nursing Home, originally a private residence, has been adapted and extended to provide nursing home accommodation over three floors. There are a range of bedrooms providing single and double room accommodation, some with ensuite facilities. Bath/shower rooms and WCs are assessable to all communal and bedroom areas. Access to the first and second floors is via a passenger lift.

Communal lounge and dining areas are provided on the ground floor.

The home also provides for catering services on the ground floor. Laundry facilities are located in a building outside the home.

The home is registered to provide care for a maximum of 29 persons under the following categories of care:

Nursing care

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
PH (E)	physical disability other than sensory impairment over 65 years
TI	terminally ill

The Home's RQIA 'Certificate of Registration' was appropriately displayed in the hall of the home.

8.0 Executive Summary

The unannounced inspection of Parkside Nursing Home was undertaken by Heather Sleator on 16 December 2014 between 10:30 and 15:30 hours. The inspection was facilitated by Ms Paulene Rogers, registered manager, who was available for verbal feedback at the conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection of 4 March 2014.

As a result of the previous inspection two requirements and two recommendations were issued. These were reviewed during this inspection and the inspector evidenced that the requirements and recommendations have been fully complied with. Details can be viewed in the section immediately following this summary.

The inspector can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a good standard and patients were observed to be treated by staff with dignity and respect. Good relationships were evident between staff and patients. Patients were well groomed, appropriately dressed and appeared comfortable in their surroundings. Those patients who were unable to verbally express their views were also observed to be well groomed, appropriately dressed in clean matching attire and were relaxed and comfortable in their surroundings.

The inspector reviewed assessments and care plans in regard to management of continence in the home. Review of patient's care records evidenced that patients and/or their representatives were informed of changes to patient need and/or condition and the action taken. Areas for improvement were identified with the care records and two recommendations have been made.

Nursing staff spoken with on the day of the inspection were knowledgeable regarding the management of urinary catheters and the frequency with which the catheters within the home required to be changed. Discussion with staff and review of training records confirmed that there were staff trained and assessed as competent in urinary catheterisation.

From a review of the available evidence, discussion with relevant staff and observation, the inspector can confirm that the level of compliance with the standard inspected is compliant.

Additional Areas Examined

- Care Practices
- Complaints
- Patient Finance Questionnaire
- NMC Declaration
- Patients Comments
- Environment

Details regarding the inspection findings for these areas are available in the main body of the report. There were no areas for improvement identified with the additional areas examined.

Conclusion

The inspector can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a good standard and patients were observed to be treated by staff with dignity and respect. Good relationships were evident between staff and patients. Patients were well groomed, appropriately dressed and appeared comfortable in their surroundings. Those patients who were unable to verbally express their views were also observed to be well groomed, appropriately dressed in clean matching attire and were relaxed and comfortable in their surroundings.

As a result of this inspection two recommendations were made. Details of the recommendations can be found in the quality improvement plan (QIP) of this report.

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

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	29 (4) (c)	It is required that a written report is prepared each month in accordance with Regulation 29 and made available to patients and their representatives.	The inspector verified that this requirement had been addressed. The inspector reviewed the monthly monitoring reports of May, June and July 2014 and evidenced the monthly visits and reports had been completed in accordance with regulation 29 The Nursing Homes Regulations (Northern Ireland) 2005.	Compliant
2.	15 (2) (a) and (b)	Registered nursing staff should develop a care plan where pressure damage is observed, in order to provide clear guidance on the treatment and care the patient requires and also to provide a traceable history and aetiology of pressure damage/ulcer.	The inspector verified that this requirement had been addressed. The inspector reviewed the care plan of a patient requiring wound care management. Evidence was present to validate the care plan had been developed and reviewed in accordance with professional and clinical standards.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	25.12	It is recommended the annual quality report should evidence consultation with patients and representatives. Further information regarding the format of the report is listed in section E of the Primary Unannounced Inspection Report 16 May 2013.	The inspector verified that this recommendation had been addressed. The annual quality report and the monthly monitoring reports are being completed in consultation with patients and representatives.	Compliant
2.	20.1	It is recommended that the patient's resuscitation status is recorded in the patient's care plan and monitored monthly by the patient's named nurse.	The inspector verified that this recommendation had been addressed. The inspector selected four patients' nursing care records for review. Evidence was present of the patient's resuscitation status in the nursing care records reviewed.	Compliant

9.1 Follow-Up on any Issues/Concerns Raised with RQIA since the Previous Inspection such as Complaints or Safeguarding Investigations

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

Since the previous inspection on 4 March 2014, RQIA have been notified by the registered manager of ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues.

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

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of four patients' care records evidenced that bladder and bowel continence assessments were undertaken for four patients. A recommendation has been made that the outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. A recommendation has also been made that the continence assessment in use is revised. The assessment viewed by the inspector was not comprehensive and did not evidence the decision making processes used to identify the continence needs of the individual. This was discussed with the registered manager who agreed to source a more comprehensive continence assessment tool. There was evidence in four patients care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. Review of four patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. The care plans reviewed addressed the patients' assessed needs in regard to continence management. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Substantially Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place: • continence management / incontinence management • stoma care • catheter care The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines • British Geriatrics Society Continence Care in Residential and Nursing Homes • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not 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 registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the registered manager revealed that four registered nurses in the home were deemed competent in female catheterisation, male catheterisation, suprapubic catheterisation and the management of stoma appliances. Care staff completed training in continence care in March 2014. The promotion of continence and the management of incontinence is completed at the time of induction. The review of three staff induction training records evidenced this training had been completed and had been validated by the registered manager. Regular audits of the management of continence products are undertaken by the senior care assistant.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

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

Patients were well presented with their clothing suitable for the season. Staff were observed to respond to patients' requests promptly. The demeanour of patients indicated that they were relaxed in their surroundings.

11.2 Complaints

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

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

11.3 Patient Finance Questionnaire

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

11.4 NMC Declaration

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

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

11.5 Patients' Views

During the inspection the inspector spoke to eight patients individually and to others in groups. These patients expressed high levels of satisfaction with the standard of care, facilities and services provided in the home. A number of patients were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients' comments were as follows:

"I am very happy with everything here."
"very nice people here"
"give you good food here"
"staff are helpful and always have time for a few words"

11.6 Environment

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

12.0 Quality Improvement Plan

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

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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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**
At Parkside Nursing Home we carry out a comprehrensive assessment prior to admission to the home. All potential patients and their relatives are invited to visit the home and speak to the staff, relatives and other patients. Information will be obtained from the Trust and the Care Manager about the needs and the requirements of the patient, a medical assessment, risk assessments, social assessments and any ongoing specialized treatment will be continued as required. A designated qualified Nurse will visit the patient either at their own home or hospital setting. The	Compliant

designated Nurse will speak with the patient, family members or their representatives and the relevant multi-disciplinary teams. All relevant documentation will be observed. After consultation with the patient, staff, relatives or representatives and the multi-disciplinary team together we will ensure that Parkside is the appropriate placement for this patient. Prior to and on admission Nutritional screening is carried out using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST). All Nurses have received training on how to use the MUST tool effectively and to raise any concerns and refer on to the appropriate multi-disciplinary teams such as the SLT and Dietitician this is evidenced in care plans Prior to admission and on admission there is evidence that all patients have ulcer risk assessment, pain assessments and continence assessments carried out with reference to Crest Guidelines and a referral made to appropriate multi-disciplinary teams such as TVN, Dietitician, SLT, OT, GP and Physio. Pressure releiving mattress and relevant equipment provided where necessary In the event of an emergency admission information is obtained from Care Management team, providers of care at the time and the multi-disciplinary team either via e-mail, telephone or fax and if possible if the patient is at home a Nurse in charge will be able to visit the patient	

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**
Prior to admission and on admission to Parkside Nursing Home a Named Nurse will carry out a pre-admission assessment based on holistic needs of the patient. The named Nurse will carry out an initial Risk assessment using the Roper Logan and Tierney model, Manual Handling assessment, Braden score, Risk assessment for use of bed	Compliant

rails and if they are necessary or required, MUST tool and last recorded weight, Food and Fluid chart and Food chart for likes and dislikes. This information will be obtained from the patient if and where possible and their wishes taken into account first and foremost. Information will also be obtained from the Care Management Team, their relatives or representatives and all other multi-disciplinary teams involved with the holistic care of the patient. If a patient is assessed as 'at risk' of developing a pressure ulcer a documented care plan is drawen up with reference to Crest and local guidelines. A referral is made to relevant multi-disciplinary teams including TVN, Dietitician, SLT, GP, Care Manager (Trust), podiatrist if necessary, pressure releiving quipment put in place, OT also if necessary and Pysio. Relatives also kept informed if required and patient informed at all times of ongoing treatment plan. Holistic care plan put in place by the Named Nurse within references to all recommendations from relevant health professionals and all staff are informed of or made aware of any changes	

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
On admission to Parkside a Named Nurse is delegated to the patient to discuss, plan and agree Nursing interventions to meet the assessed needs of the patient with the assistances of the relatives and or representatives based on this and the information received from Care Management Team, trust and other multi-disciplinary teams and current providers a Person Centred Care Plan is developed. We at Parksaide are committed to Person Centred Care and to provide the highest individual tailored evidence based care to our patients We are also dedicated to maintaining the independence and social skills to all who live here Contemporaneous records maintained in accordance with NMC guidelines of all Nursing Care, activities and procedures are carried out in the home All validated forms, risk assessments and Tools are completed and if care needs change these are amended daily or whenever a change should occur all relevant staff kept informed.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
We have a named Nurse system in place within the home. Care records reflect advice provided by health care professionals such as tissue viability specialist nurses (TVN), dieticians, speech and language therapists, physiotherapists, occupational therapsits and community psychiatric nurses (CPN's). All nursing interventions, activities and procedures are supported by research evidence and guidelines provided by the above multi-disciplinary teams, local Trust guidelines, Crest Guidelines. Information and advice is sought from TVN and current guidelines to form a validated grading tool (Braden Tool) to assess those at risk of pressure ulcer damage and care plans are put in place to ensure appropriated plan implemented for the individual patient. Patients weights are recorded on admission and on at least a monthly basis or more often if required. Patients nutritional status is also reviewed on at least a monthly basis or more often if required Daily records are maintained regarding patients daily food intake and fluid intake. Patients recommended daily fluid intake including the action to be taken if targets not being achieved.	Compliant

Nutritional guidelines are in use by staff on a daily basis and referred to by kitchen staff when updating menus. All staff receive training on Nutririon.	

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**
Contemporaneous nursing records are kept in accordance with NMC guidelines within the home. Record keeping is maintained appropriately and in accordance with legislative requirements, minimum standards and professional guidance. All care plans and records provide holistic care and outcomes for all patient's. Monthly audits are carried out by the manger to relect any action to be taken to address any deficits and areas for improvement evaluations include outcomes for patients. Care is monitored on a daily basis and care plans are altered as required to ensure that care delivered is appropriate and evidenced based. Care delivered is reflective of holistic care for the patient and involve input from the patient/representative. Daily records are kept and maintained regarding patients' daily food and fluid intake. Patients' recommended daily	Provider to complete

intake including action to be taken are recorded in care plans Any patient not meeting the requirements required for nutritional intake or over eating are referred to Dietician/SLT and recorded any action to be taken in care plans. Daily record is kept then of all food/fluid intake	

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**
Reassessment is an on-going assessment and is carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff record evaluations in daily progress notes on the delivery of care daily. Care plans are reviewed and updated as care needs of the patients' change. Manger carries out monthly audits Patients' have yearly care reviews from Care Management teams or more frequently if required when relatives and representatives are invited to be present Monthly resdients meetings are held and relatives are invited to participate if they so wish	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**
The registered manager adopts a management approach that creates an open, positive and inclusive atmopshere. The home works closely with all multi-disciplinary teams to ensure the best evidenced based care for our patients'. At Parkside all our Patients' views are taken very seriously and they are encouraged to participate along with relatives or representatives to discuss their daily care and needs at anytime they so wish, any changes are recorded and documented well in their care plans Six weeks after admission there is a formal meeting with the Care Manager and by invitation their Associate Nurse/Named Nurse, General Practitioner, Family Representative and Home Representative. Any queries, recommendations or requested changes to care will be altered immediately if required. Care management reviews can also be arranged in response to changing needs such as expression of dissatisfaction with care or at the request of their representative	Compliant

Patients and their representatives are kept updated and informed of the progress toward agreed goals	

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**
On admission to Parkside the patients' dietary needs and requirements are clearly documentated and all staff informed An individulised care plan is put in place that clearly demonstrates the capabilities of the patient, their likes/dislikes, any special dietary requirements whether they require thickened/purreed or soft foods, and whether they have a large or small appetite Meals are served at appropriate intervals throughout the day and in keeping with best practice contained within the Nutritional Guidleines and Menu Checklist for Residental and Nursing Homes for Older People and for those providing community meals and Promoting Good Nutrition: A Strategy for Good Nutritional Care For Adults in all care settings in Northern Ireland 2011 -2016: DHSSPS A choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements/therapeutic diets are provided daily choice of fluids also offered throughout the day at intervals The menu offers patients' a choice at each mealtime and an alternative is offered if the patient does not want this.Patients on a altered or therapeutic diet are also offered a choice and the meal is served in a manner that allows	Compliant

different foods and flavours to be recognised	

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**
On admission patients' are identified if they are in the 'at risk' caterogy and care plans are put in place to minimise the risk. Referrals are made to the General Practitioner, Speech and language therapist and the Dietician. These recemmendations are recorded in their care plans a copy given to the kitchen staff, relatives informed and all staff	Compliant

Staff receive relevant training in First Aid and are aware what to do in the event of a patient choking and on how to feed a patient correctly, the signs and symptons of aspiration. All staff have attended swallow awareness training Any speicial equipment required for eating or is recommended will be provided Staff have also received training in the use of fluid thickeners Holistic care plans are provided and assistances and support given with meals where required A choice of hot and cold drinks and snacks are available throughout the day. Choice of fluids, fresh drinking water were available Information from the referring Trust confirms 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 Registered Nurses receive yearly training on the update and management of pressure ulcer/wounds Registered nurses utilise the information from these assessment tools to inform their clinical judgement when developing care plans to manage patients' assessed needs Referral is always made to the Tissue Viability Nurse, Dietician, Speech and Language Therapist and GP. Local policy/formulas on the use of wound care products are available and adhered to with the advice of the TVN	

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

Quality Improvement Plan

Secondary Unannounced Care Inspection

Parkside Nursing Home

16 December 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 Ms Paulene Rogers, registered manager, at the conclusion of 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.

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	19.1	It is recommended the continence assessment is revised to provide comprehensive and detailed assessment information. **Ref: criterion 19.1**	One	New comprehenisve and detailed assessment put in place	Three months
2	19.1	It is recommended continence care plans detail the type of continence product to be used and the details of the patient's toileting programme. **Ref: criterion 19.1**	One	All care plans now detail the type of continence products to be used and the details of a toileting programme in place	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	Paulene Rogers
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Arthur Dodds

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	x	Heather Sleator	8 June 2015
Further information requested from provider			