Unannounced Care Inspection

Name of Establishment:	**Greerville Manor**
RQIA Number:	**1256**
Date of Inspection:	**19 February 2015**
Inspector's Name:	**Heather Sleator**
Inspection ID:	**INO17016**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Greerville Manor Care Home
Address:	192 Newtownbreda Road Belfast BT8 6QB
Telephone Number:	028 9064 4244
Email Address:	greerville.manor@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Healthcare (NI) Ltd
Registered Manager:	Ricardo Papa
Person in Charge of the Home at the Time of Inspection:	Ricardo Papa
Categories of Care:	NH - DE
Number of Registered Places:	60
Number of Patients Accommodated on Day of Inspection:	Dixon Suite - 27 Belvoir Suite - 15 Millbrook Suite - 16
Scale of Charges (per week):	£536.00
Date and Type of Previous Inspection:	Unannounced Primary Care Inspection and Pre-Registration Inspection 4 March 2014 09:10 – 17:50 5 March 2014 10:30 - 15:30
Date and Time of Inspection:	19 February 2015 09:45 – 17:15 hours
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: amend as relevant

- discussion with the Regional Manager
- discussion with the Registered Nurse Manager
- discussion with staff
- discussion with patients individually and to others in groups
- consultation with relatives
- 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
- review of the complaints, accidents and incidents records
- 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	**10 patients individually**
Staff	**11**
Relatives	**2**
Visiting Professionals	**0**

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

Issued To	**Number Issued**	**Number Returned**
Patients	**3**	**0**
Relatives/Representatives	**0**	**0**
Staff	**5**	**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

Greerville Manor Private Nursing Home is situated on the Newtownbreda Road with pleasant views over South-East Belfast. It is located beside a private housing development, Public transport facilities to Belfast and Lisburn are close by, and spacious car parking facilities are available in the grounds of the home. Four Seasons Healthcare Ltd are the registered provider and Ricardo Papa is the registered manager.

The home is a purpose built single storey residence. When the home opened it is divided into two units, the Dixon Suite consisting of 28 beds and the Barnett Suite consisting of 42 beds. In August 2013 a 15 bedded unit, Belvoir Suite was opened to provide care and accommodation for patients with a past or present alcohol dependency (NH-A). In March 2014 a 17 bedded unit, Millbrook Suite opened to provide care and accommodation for patients with a mental disorder excluding learning disability and dementia (NH-MP). The total number of registered places for the home reduced to 60 in March 2014.

MH – DE Dixon Suite, 28 patients
MH – MP Millbrook Suite, 17 patients
MH - A Belvoir Suite, 15 patients

Each of the units is self-contained, providing lounge and dining rooms, single bedrooms, some of which have en-suite facilities and the appropriate range and ratio of bathing/showering and toilet facilities.

The home's certificate of registration was appropriately displayed in the main reception area of the home.

The home is registered to provide care for a maximum of 60 persons under the following categories of care:

Nursing care

DE	dementia care
MP	mental disorder excluding learning disability or dementia
MP (E)	mental disorder excluding learning disability or dementia over 65 years
A	alcohol dependency past or present

8.0 Executive Summary

The unannounced care inspection of Greerville Manor was undertaken by Heather Sleator on 19 February 2015 between 09:45 and 17:15 hours. The inspection was facilitated by Ricardo Papa, registered manager, who was available for verbal feedback at the conclusion of the inspection. Lorraine Kirkpatrick, regional manager was present for part of the inspection and Stella Law, peripatetic manager, was present for 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 care inspection on 4 and 5 March 2014.

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

Summary

There was evidence that a continence assessment had been completed for the majority of patients. This assessment formed part of a comprehensive and detailed assessment of patient needs from the date of admission and was found to be updated on a regular basis and as required. The assessment of patient needs was evidenced to inform the care planning process.

Comprehensive reviews of both the assessments of need and the care plans were maintained on a regular basis and as required in the five records reviewed. A recommendation has been made to ensure that patients' bowel patterns are monitored and recording in the patients' progress records and evidence reference to the use of the Bristol Stool chart.

Discussion with the registered manager confirmed that some staff were trained and assessed as competent in continence care. A recommendation has been made for registered nurses to be provided with training in male/female catheterisation if this training has not been undertaken.

Policies, procedures and guidelines in the promotion of continence and the management of incontinence were available in the home.

The inspector was informed that the registered manager is the continence link nurse in the home and was involved in the review of continence management and education programmes for staff.

Regular audits of the management of incontinence are undertaken and the findings acted upon to enhance already good standards of care.

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 was assessed as compliant and two recommendations have been made.

Additional Areas Examined

Care Practices
Complaints
Patient Finance Questionnaire
NMC Declaration
Patients and Relatives Comments
Environment

Details regarding the inspection findings for these areas are available in section 11.0, additional areas examined, of the report.

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

The inspector would like to thank the patients, registered manager, registered nurses, relatives 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	12 (1) (a) and (b)	The registered person shall provide treatment, and any other services to patients in accordance with the statement of purpose, and shall ensure that the treatment and other services provided to each patient- (a) meet his individual needs; (b) reflect current best practice	Staff had completed person centred care training from the last inspection. The training had been embedded in practice and was reflected in the care records reviewed in all units. Staff also verbalised how they delivered person centred care and felt the experience of the PEARL accreditation (positively enriching and enhancing residents' lives) was beneficial to patients, staff and the environment had improved.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	12.2	It is recommended that the registered manager ensures that efforts to involve patients and/or representatives in planning menus continue. Documentary evidence should be maintained.	Dining audits are regularly undertaken by senior staff. The audit information is reviewed by the regional manager during the monthly monitoring visit. The menu is discussed at patients meetings and suggestions made, as far as possible, are acted on. The dining experience for patients is also regularly reviewed as part of PEARL accreditation.	Compliant
2	32	It is recommended that the registered manager ensures that the following environmental improvements are fully implemented: • The number of way-finding landmarks in the Dixon Suit should be increased; • The programme of redecoration in Dixon Suite should be completed; • Corridor handrails should be repaired/replaced/provided as required; • The provision of magnetic door holders should be considered for all doors without this feature; • Lighting in the Dixon Suite should be reviewed and improved.	The environment was viewed as part of the inspection process. The following was observed: • Dixon suite had been visually enhanced with orientation landmarks for patients as part of PEARL; • redecoration of Dixon suite was in the final stage of completion; • corridor handrails had been repainted and were more visible; • magnetic door holders had been installed on all doors; and • lighting had been increased in Dixon suite and was more suitable for a dementia unit.	Compliant

3	1.1	It is recommended the values that underpin the standards inform the philosophy of care and staff consistently demonstrate the integration of these values within their practice. This recommendation relates to dementia practice within Dixon Suite.	Dixon suite is in preparation for PEARL accreditation. This had entailed enhancing the environment to improve the quality of life for persons with dementia through orientation cues, improved lighting and new colour schemes and flooring. Staff have completed person centred training and a personal activities leader has been appointed with sole responsibility for the Dixon suite.	Compliant
5	28.4	It is recommended that care staff complete training in the prevention of pressure ulcers.	Staff training records evidenced that 80% of staff had completed training in pressure ulcer prevention. The remaining 20% of staff were ancillary staff and were not required to complete the training.	Compliant
6	25.11	It is recommended a system is established to monitor, audit and review the progress of patients with wounds /pressure ulcers.	The registered manager is the link nurse for wound care management. Wound management audits are completed on a regular basis, when applicable. The information from the audit is recorded on the organisations clinical dashboard and is reviewed by the regional manager.	Compliant

7	5.1	It is recommended the assessment of need completed within 11 days of admission is detailed and comprehensive. The information within the needs assessment should correspond to the need for a care plan.	The registered manager audits patients care records systematically. The audit includes reviewing that the assessment of need for patients is completed within 11 days of admission and corresponding care plans are written in consultation with the patient and/or patient's representative. Audit information is reviewed by the regional manager on a monthly basis.	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 in 4 and 5 March 2014, RQIA have been notified by the home of ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues. The BHSCT and SEHSCT safeguarding team are managing the SOVA issues under the regional adult protection policy/procedures.

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 five patients' care records evidenced that bladder and bowel continence assessments were completed. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. There was evidence in five 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 review of patients' progress records evidenced nursing staff reference the Bristol Stool chart when recording patients' bowel motions however this was not completed by all staff in a consistent manner. Nursing staff should monitor patients' bowel motions and accurately reflect this using the Bristol Stool chart. A recommendation has been made. 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 five 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.	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 Inspected
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 nursing staff revealed that not all the registered nurses in the home had undertaken training in female/male catheterisation and the management of stoma appliances. A recommendation has been made in this regard. The review of staff training records evidenced nursing and care staff had completed training in bowel management and caring for a patient with a urinary catheter. This is good practice. The registered manager is the continence link nurse and was involved in the review of continence management and education programmes for staff. Regular audits of the management of incontinence are undertaken and the findings acted upon to enhance already good standards of care.	Substantially 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 and Relatives Comments

During the inspection the inspector spoke with 10 patients individually and with the majority of others in smaller groups.
Patient spoken with 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 inspector met with the relatives of one patient. Positive comments were made regarding the standard of care afforded and the attitude and approach of staff. Comments made included:

"staff are very accommodating"
"delighted to see how well cared for my ….is"
"we have nothing but good to say about Greerville and the staff"

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 and all areas were maintained to a high standard of hygiene.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ricardo Papa, 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**
Prior to admisssion to Greerville Manor Care Centre the Home Manager or a designated nurse from the home carries out a Pre-admission Assessment. Information is obtained from the resident/representative (where possible), the care records and information from the Care Management Team informs this assessment. Risk Assessments such as the Braden tool are carried out if possible at this stage. Following a review af all the information obtained ,a decision is made in regard to Parkviews ability to meet the needs of the resident. If an emergency admission is required and it is	Substantially compliant

not possible to carry out a Pre-admission assessment in the residents current location then the Pre-admission Assessment is carried out over the telephone with written comprehensive, multidisciplinary information regarding the resident being faxed, e mailed or delivered to the home. Only when the Manager is satisfied that the home can meet the needs of the resident will the admission take place.. On admission to the Home an identified Nurse completes the initial assessments using a person centred approach. The Nurse communicates with the resident and/or representative, refers to the Pre-admission Assessment and to the information received from the Care Management Team to assist them in theis process.Two assessments are completed within twelve hours of admission- A Needs Assessment which includes photography consent, record of personal effects and records of 'My Preferences' and also a Needs Assessment which includes 16 areas of need - the additional comments section within each of the 16 sections includes additional necessary information that is required to formulate a Person Centred plan of care for the Resident. In additioin to these two documents the nurse completes Risk Assessments immediately on admission. These include a Skin assessment using the Braden Tool, a Body Map, an Initial wound assessment (if required), a Moving and Handling assessment, a Falls Risk assessment, Bed Rail assessment, a Pain assessment and a nutritional assessment which includes the MUST stool, FSHC nutritional and Oral assessment. Other risk assessments which are completed within seven days of the Residents admission are a continence assessment and a bowel assessment. Following discussion with the resident/representative, and using the Nurse's clinical judgement , a plan of care is developed to meet the resident's needs in relation to identified risks , wishes and expectations. This can be evidenced in the care plan and consent forms. The Home Manager and Regional Managers will complete audits on a regular basis to quality assure this process.	

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

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
A named nurse completes a comprehensive and holistic assessment of the residents needs using the assesment tools outlined in Section A within seven days of admission. The named Nurse devises care plans to meet the identified needs in consultation with the resident/representative. The care plans demonstrate the promotion of maximum independence and focuses on what the resident can do for themselves, as well as what level of assistance is required. Recommendatons made by other members of the multidisciplinary team are included in the care plan. The care plans set realistic and achievable goals. All registered nurses in the home are fully aware of the process of referral to a TVN when nesessary. In The Belfast Trust The TVN can be contacted directly via the Quality Assurance department and provide a lot of support for the nursing home staff. Referals are also via this process in relation to residents who have lower limb or foot ulcerations to either TVN or Podiatry, if required a further referal can be made to a vascular surgeon by the GP,TVN or Podiatrst. Where a resident is assessed as being 'at risk' of developing pressure sores, a Pressure Ulcer Management and Treatment Plan is commenced. A care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. the care plan will give consideration to advice received from other members of the multidisciplinary team. The treatment plan is agreed with the resident/representative, Care Management and relevant member of MDT. The Regional manager is informed via a monthly report and during the Reg 29 visit. The registered nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Staff request referral to the dietician via the residents GP. The dietician is also available to give advice over the telephone until they are able to visit the resident. All advice, treatment or recommendations are recorded in the multidisciplinary communication sheet. The care plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in Greerville Manor and other members of the MDT are kept informed of any changes.	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**
Residents Needs Assessment, Risk Assessments and Care Plans are reviewed and aaaevaluated a minimum of once a month or more frequently if any change occurs in the resident's condition. The Plan of Care dictates the frequency of review and re-assessment, with the agreed time interval recorded on the plan of care. The resident is assessed on an ongoing daily basis with any changes recorded in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the home manager's attention. The Home Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.	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**
The Home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to. The validated pressure ulcer grading tool used by the Home to screen residents who have skin damage is the EPUAP grading system. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission, then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime, or if the condition of the pressure ulcer changes. There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', 'RCN- Nutrition Now', 'PHA- Nutritional Guidelines and Menu Checklist for Residential and Care Homes' and 'NICE Guidelines- Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in relation to nutrutional care, diabetic care, care of subcuteanous fluids.	Substantially 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
Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are contemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines- Record keeping: Guidance for nurses and midwives. Records of the meals provided for each resident at each mealtime are recorded on a daily menu choice form. The Catering Manager also keeps records of the food served and includes any specialist dietary needs. Residents who are assessed as being 'at risk' of malnutrition, dehydration or eating excessively have all their food and fluids recorded in detail on a daily basis on the touch screen food and fluid section . The fluid intake is totalled at the end of the 24hr period, and the nurse utilises this information. If any deficits are found appropriate action is taken and this is recorded in the residents notes . If a referral is required to a member of the MDT the nurse informs the resident and their representative and thisis recorded in the residents notes .	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**
Care delivered and outcomes are monitored and recorded on a daily basis on the daily progress notes, with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan on the plan of care or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their representatives are involved in the evaluation process.	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**
Care Management Reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the residents file. Any recommendations made are actioned by the Centre, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals.	Substantially 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**
Greerville Manor Care Centre follows FSHC policies and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and receommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if required. Greerville Manor has a 3 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives- residents meetings, one to one meetings and food questionaires. The PHA document- 'Nutritional and Menu Checklist for Residential and Nursing Homes' is used to ensure that the menu is nutritious and varied. Copies of instructions and recommendation from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs.	Substantially compliant

Residents are offered a choice of two meals and desserts at each meal time, if a resident does not want anything from the daily menu, an alternative meal of their choice is provided. The menu offers the same choice, as far as possible, to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room.	

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**
Registered nurses and care staff have received training on dysphagia this year and also on enteral feeding administration and management .The Speech and Language therapist and dietician also give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines- 'Nutrition Support in Adults' and NPSA document- 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for feeding, equipment to use and assistance required. The kitchen receive a copy of the SALTs recommendations and	Substantially compliant

this is kept on file for reference by the kitchen. Special diets are displayed in the kitchen and on meal record charts. Meals are served at the following times; Breakfast- 08.30 - 10.00 Morning Tea- 11.00 Lunch-12.30 - 13.00 Afternoon Tea- 15.00 Dinner- 17.00 Supper- 20:00 - 21.00 There are variations to the above if a resident requests to have their meals outside of these times. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. There are foods available outside of these times for those residents who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedroom, these are replenished on a regular basis. Any matters concerning a residents eating and drinking are detailed on each individual care plan- including for e.g. likes and dislikes, type of diet, consistency of fluid, any special equipment required and if assistance is required. A diet notification form is completed for each resident with a copy given to the kitchen and one held in the care file. Meals are not served unless a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Appropriate aids such as plate guards and specialised cutlery are available as necessary and as indicated in the plan of care. Each nurse has completed an education e-learning module on pressure care. The Home has a link nurse who has received enhanced training, to provide support and education to other nurses within the Home and on an ad hoc basis. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the Centre have a competency assessment completed. Competency assessments have a quality assurance element built into the process.	

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Care Inspection

Greerville Manor

19 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 Ricardo papa, registered manager, at the conclusion of the inspection.

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	A consistent approach should be in evidence to the recording and monitoring of patients' bowel patterns. The progress recording in patients care records should reference the use of the Bristol Stool chart. **Ref: 19.1**	One	This has been addressed-staff now make reference to the Bristol Stool chart in patients care records in order to evidence the recording and monitoring of patients' bowel patterns.The Registered Manager is monitoring this through care profile audits monthly.	One month
2	19.4	Training in respect of male/female catheterisation should be undertaken by registered nurses. **Ref: 19.4**	One	Training in respect of male/female catheterisation has been planned for May 2015 for all trained staff to attend.	Four months

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	Ricardo Papa
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall CAROL COUSINS

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	X	Heather Sleator	11/05/15
Further information requested from provider			