Unannounced Care Inspection

Name of Establishment:	**Mount Lens**
RQIA Number:	**1269**
Date of Inspection:	**11 November 2014**
Inspector's Name:	**Karen Scarlett**
Inspection ID:	**17106**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Mount Lens
Address:	166 Kings Road Belfast BT5 7EL
Telephone Number:	028 90485483
Email Address:	mount.lens@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Health Care Mr James McCall
Registered Manager:	Mr Paulo Leitao
Person in Charge of the Home at the Time of Inspection:	Mr Paulo Leitao
Categories of Care:	NH-I ,NH-PH ,NH-PH(E) ,NH-TI
Number of Registered Places:	34
Number of Patients Accommodated on Day of Inspection:	21 and 1 in hospital
Scale of Charges (per week):	£567 - £644
Date and Type of Previous Inspection:	18 March 2014, primary unannounced inspection
Date and Time of Inspection:	11 November 2014 09.30 – 15.30
Name of Inspector:	Karen Scarlett

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 Acting Nurse Manager
- Discussion with staff
- Discussion with patients individually and with 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	8 and with others in groups
Staff	7
Relatives	3
Visiting Professionals	0

Questionnaires were provided by the inspector, 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	2	2
Relatives/Representatives	3	3
Staff	10	10

6.0 Inspection Focus

Prior to the inspection, the acting manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the acting 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

Mount Lens Care Home is situated in the pleasant residential King's Road area of East Belfast. It is sited on the main road and is afforded privacy with hedges and trees to the sides and back of the home. A car park is available within the grounds of the home. Local bus services and main routes to and from Belfast are directly outside the home. The home is centrally located within the local community and is close to the main shopping areas and community services.

This purpose built home provides accommodation on two floors. Access to the first floor is via a passenger lift and stairs. The bedroom accommodation is provided in single bedrooms with en-suite bathroom facilities. There are two day rooms, a quiet room and a dining room on the ground floor. Bath/shower rooms and WC's are accessible to all communal and bedroom areas throughout the home. Laundry services are located on the ground floor and a hairdressing room is available on the first floor.

Mount Lens Care Home is registered to provide nursing care (NH) for up to 34 patients in the following categories of care

I	Old age not in any other category
PH:	Physical disability under 65 years of age
PH (E):	Physical disability over 65 years of age
TI:	Terminal illness

The RQIA certificate of registration was appropriately displayed in the entrance hall of the home. A variation has been submitted to change a bedroom into a treatment room and this is currently undergoing review with RQIA estates department. The home has current plans to build a new unit for patients with dementia on the ground floor so the majority of the ground floor bedrooms are currently not in use in anticipation of the commencement of works. The home currently accommodates 22 patients.

8.0 Executive Summary

The unannounced secondary inspection of Mount Lens was undertaken by Karen Scarlett on 11 November 2014 between 09.30 and 15.30. The inspection was facilitated by Paulo Leitao, acting manager, who was available throughout the inspection and for verbal feedback at the conclusion of the inspection.

A number of documents are required to be returned to the RQIA pre inspection and all the relevant documents were sent by the acting manager within the required timescale. These were reviewed prior to the inspection. A complaint was reported to RQIA in October 2014 and the RQIA were also notified of an ongoing Safeguarding of Vulnerable adults (SOVA) investigation. Further information is contained in section 9.1 of the report. The inspector is satisfied that the issues have been dealt with in the appropriate manner and in accordance with regional guidelines and legislative requirements.

The inspector spoke with eight patients individually and with the majority of others in groups. Two patients also completed questionnaires. The patients' comments were overwhelmingly positive about the care they received and no concerns were raised. Staff interactions with patients were observed throughout the period of inspection and were found to be positive, caring and respectful. Questionnaires were also completed by two patients' relatives and a visitor. One respondent stated that they felt the home could do with more staff in the mornings. An examination of the duty rotas, however, evidenced that staffing is in accordance with RQIA's staffing guidance for nursing homes. Refer to section 11.5 for further details about patients and relatives.

This inspection focused on the level of compliance with standard 19 of the Nursing Home Minimum Standards (2005) concerning continence care and further detail can be found in section 10.0 of the report. There was evidence that a continence assessment had been completed as part of a comprehensive assessment of patients' needs in the three care records examined. The risk assessments were updated on a regular basis as required and were evidenced to inform the care planning process.

However, it was noted on examination of the care records that nursing staff were not consistently signing and printing their name and designation nor recording the time and date of their entries in accordance with Nursing and Midwifery Council (NMC) guidelines. A recommendation has been made in this regard.

An excellent resource file with up to date guidance was available for staff. This contained a number of relevant policies on continence management. However, the majority of policies were in need of review. A recommendation has been made that these are reviewed and updated as required.

There was evidence of proactive quality monitoring of continence care practices within the home through monthly audit reports and regular staff meetings. Care staff were also receiving ongoing monthly supervision in order to improve practice.

Discussion with the registered manager confirmed that staff were trained and assessed as competent in continence care, male and female 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 was substantially compliant. Two recommendations have been made.

The inspector spoke with seven staff individually and ten completed questionnaires. Staff comments were very positive regarding the home, the staff team and the care given to patients and no concerns were raised. Refer to section 11.6 of the report.

The home was maintained to a high standard of decorative order and hygiene throughout. The ceiling in the laundry was water damaged and a recommendation has been made that this is repaired. Refer to section 11.7 of the report.

The inspector also reviewed and validated the home's progress regarding the recommendation made at the last inspection on 18 March 2014 and this was found to be compliant.

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

The delivery of care to patients was evidenced to be of a satisfactory standard and patients were observed to be treated by staff with dignity and respect. The inspector would like to thank the patients, acting manager, registered nurses and staff for their assistance and co-operation throughout the inspection process and to those who completed questionnaires.

9.0 Follow-Up on Previous Issues

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1.	28.4	It is recommended the percentage of staff who have completed training in the areas detailed below should increase; • safeguarding of vulnerable adults • deprivation of liberty • prevention of pressure ulcers/skin care (care assistants) Training statistics should evidence a significant increase within three months from the receipt of the report. **Ref: previous report**	A review of staff training records demonstrated a significant increase in the numbers of staff trained in the specific areas highlighted and that these had been sustained. This recommendation has been addressed.	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.

RQIA did receive a complaint through its duty system on the 13 October 2014 and had requested a follow up report from the regional manager which was duly submitted. On review of the complaints record and the care record of the patient concerned, on the day of the inspection, there was evidence that appropriate actions had been taken to respond to the issues raised.

Since the previous inspection on 18 March 2014, RQIA have been notified by the home of an ongoing investigation in relation to an alleged safeguarding of vulnerable adults (SOVA) issue. The incident was appropriately reported and is currently being investigated by the PSNI under the regional adult protection policy/procedures. RQIA is satisfied that the acting manager has dealt with SOVA issues in the appropriate manner and in accordance with regional guidelines and legislative requirements. Appropriate actions have been taken to safeguard patients.

RQIA are not part of the investigatory process. However, RQIA have been kept informed at all stages of the investigations by the acting manager.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of three patients' care records evidenced that bladder and bowel continence assessments were undertaken for all three patients. 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 three 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 care plans reviewed addressed the patients' assessed needs in regard to continence management. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken as required and patients were referred to their GPs as appropriate. Review of three 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. However, the records evidenced that nursing staff were not consistently signing and printing their name and designation nor were they consistently recording the date and time of the entry. In a number of entries a stamp of the name and designation was used but the entry not signed, timed and dated. In other entries only the month and year of the entry was recorded when reviewing care plans. Nurses must ensure their record keeping practice is in accordance with Nursing and Midwifery Council (NMC) guidelines. A recommendation has been made. 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 (2007) • Ileostomy and colostomy care (2009) • Catheter care (2013) • Bowel management (2009) • Digital rectal evacuation (2007) However, only the Catheter care policy was evidenced to be up to date. A recommendation is made that the remaining specified policies are reviewed and updated as appropriate. The inspector can also confirm that an excellent and comprehensive resource file was available to staff with the following guideline documents 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 • NICE guidelines on the management of urinary tract infections in men There was further evidence in the staff training folder that staff had been made aware of these policies, procedures and guidelines.	Substantially 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 Acting Manager and review of training records confirmed that staff had received training in continence care in February and that further training was planned for December. There was also training planned in November for bowel care and the administration of rectal medicines. Discussion with the manager confirmed that designated registered nurses were competent in female and male catheterisation. However, there were no patients with catheters in the home on the day of the inspections. An examination of the care records and discussion with a registered nurse demonstrated competence in the management of stoma appliances. Individual discussion with five staff members confirmed that they had received training and supervision in continence care. All staff were knowledgeable about the important aspects of continence care including the importance of dignity, privacy and respect as well as skincare, hydration and reporting of any concerns. The Acting Manager had carried out a recent unannounced night visit to the home in response to whistleblowing by a staff member who had concerns about the continence care at night. The staff member's concerns had been substantiated and regular monthly supervision with care staff has been carried out in response. There was evidence of regular supervision of all staff to include important elements of continence care including adequate fluid intake, infection control, use of pads as outlined in the care plans, constipation and lower bowel dysfunction. There was evidence in the staff meetings folder that staff were able to raise any concerns regarding continence care and that these were proactively addressed. Monthly quality monitoring also takes place within the home including an audit of care records which the inspector was assured would identify any continence care issues.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

During the inspection staff were noted to treat the patients with dignity and respect. For instance, the staff respectfully observed the two minutes silence for Armistice Day along with the patients. Good relationships were very 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

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.

The RQIA have received one complaint in relation to the home and have been notified of one ongoing SOVA investigation as outlined in section 9.1 of the report.

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 complaints record was reviewed and discussed with the acting manager. 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 acting 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

The inspector spoke with eight patients individually and with the majority of others in smaller groups. Two patients kindly completed questionnaires. Other patients were unable to respond verbally but all smiled and were observed to be contented and relaxed. All patient spoken with and the questionnaire responses confirmed that patients were treated with dignity and respect, that staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home. Patients commented:

> "The staff are lovely here"
> "You get a choice (of food)"
> "It's always very clean"

Two patients' relatives and one visitor completed questionnaires. The responses were very positive and included:

> "My mother is very contented at Mount Lens."
> "Staff are very attentive."
> "The laundry service is exceptional."
> "I could not complain about anything."

One respondent was concerned that staff were very under pressure in the mornings. However, following an examination of the staff duty rotas evidenced that staffing is in accordance with RQIA's staffing guidance for nursing homes.

The inspector also noted a compliment in the home records which stated:

> "The warm, helpful, caring attitude of staff has created a family like environment for mum."

11.6 Staff Comments

The inspector spoke with seven staff including a registered nurse, a senior care assistant, four care assistants and a domestic assistant. The inspector was able to speak to four staff individually and in private. Ten staff completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

Examples of staff comments were as follows;

> "I really enjoy my work."
> "Our home is a home from home."
> "I think the care in our home is very good."
> "The patients are always treated with tender loving care by staff."

11.7 Environment

An inspection of the premises was undertaken and the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas were viewed. The home was comfortable and all areas were maintained to a high standard of hygiene. The laundry ceiling was found to be water damaged and in need of repair. A recommendation has been made in this regard.

There are plan to build a new unit for patients with dementia on the ground floor. As a result the majority of ground floor bedrooms are vacant in anticipation of the commencement of works. There are a number of patients accommodated on the ground floor and there is a day room, dining room and a quiet room in use.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Paulo Leitao, 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
Before admission, the Home Manager or Sister carries out a pre admission assessment. The resident is visited personally and information is taken from them and/or their representative where possible. Care records are viewed and reports are requested from the Care Management/Hospital team. Risk assessments such as the Braden Tool are carried out, if possible, at this stage. Following a review of all this information, a decision is made in regard to the Homes ability to meet the needs of this resident. On admission to the Home, an identified nurse completes initial assessments using a patient centred approach. The nurse consults all the information gathered throughout the pre admission assessment whilst communicating with the resident and/or their representative. There are two documents completed within twelve hours of admission – an "Admission Assessment" which includes photography consent, record of personal effects and a record of "My Preferences" - and 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 addition to these documents, the nurse completes the following risk assessments on admission. 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 nutritional assessments including the MUST tool, FSHC nutritional and oral assessment. A continence assessment and bowel assessment is completed within 7 days of admission. Following discussion with the resident and/or representative, and using the nurses clinical judgement, a plan of care is developed to meet the residents' 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 Manager will complete audits on a regular basis to quality assure this process.	Compliant

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

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
A named nurse completes a comprehensive and holistic assessment of the residents' needs using the assessment tools as cited in Section A, within 7 days of admission. The named nurse devises care plans to meet the identified needs, in consultation with the resident and/or their representative. The care plans demonstrate the promotion of maximum independence and focuses on what the resident can do for themselves, as well as what assistance is required. Any recommendations made by other members of the multidisciplinary team, are included in the care plan The care plans have goals that are realistic and achievable. Registered nurses in the home are fully aware of the process of referral to a TVN where necessary. The nurses can either make a referral through the GP or can refer directly through the Call Management system. The contact details of Call Management are widely available in the home. Referrals are also made via this process in relation to residents who have lower limb or foot ulceration to either TVN or podiatry. If necessary, a further referral is made to a vascular surgeon by the GP, TVN or podiatrist. When a resident is assessed as being "at risk" of developing pressure ulcers, 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 due consideration to advice received from other multi disciplinary members. The treatment plan is agreed with the resident and/or their representative, Care Management and relevant members of the Multidisciplinary Team. The Regional Manager is informed via the monthly report and during their 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 contact the GP and request that a referral is made. The dietician may contact the Home before they visit and offer advice. All advice, treatment or recommendations are recorded on the Multidisciplinary team form with a subsequent care plan being compiled or current care plan being updated to reflect the advice and recommendations. The care plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in the home and other members of the Multidisciplinary team are kept informed of any changes.	Compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The Needs Assessment, risk assessments and care plans are reviewed and evaluated at a minimum of once a month or more often if there is a change in the residents' condition. The care plan 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 on-going daily basis with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the Home Managers attention. The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.	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,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 E.P.U.A.P. 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 on-going wound assessment and care plan evaluation form is completed at each dressing change. The care plan is adjusted to include any changes to the dressing regime as required. There are up to date Nutritional Guidelines such as "Promoting Good Nutrition", "RCN – "Nutrition Now", PHA – "Nutritional Guidelines and Menu Check list for Residential and Care Homes" and NICE guidelines –" Nutrition Support in Adults, available for staff to refer to on an on going basis. Staff also refer to FSHC policies and procedures in relation to nutritional care, diabetic care, care of subcutaneous fluids and care of percutaneous endoscopic gastrostomy (PEG)	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 special 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 using a FSHC food record booklet or fluid record booklet. These charts are recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. The nurse utilises the information contained in these charts in their daily evaluation. Any deficits are identified with appropriate action being taken and with referrals made to the relevant Multidisciplinary team member as necessary. Any changes to the residents plan of care is discussed with them and/or their representative. Care records are audited on a regular basis by the Home Manager with an action plan compiled to address any deficits or areas for improvement – this is discussed during supervision sessions with each nurse as necessary.	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care delivered is 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 of care or more frequently if there is a change in the residents' condition or if there are recommendations made by any member of the Multidisciplinary team. Residents and/or their representatives are involved in the evaluation process.	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 6-8 weeks post admission and annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident and/or representative. The Trust are responsible for organising these reviews and inviting the resident and/or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the reviews are sent to the resident, representatives and a copy is held in the residents' file. Any recommendations made are actioned by the Home, with care plans reviewed to reflect these changes. The resident and/or representative is kept informed of progress towards the agreed goals	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
The Home follows FSHC policy and procedures in relation to nutrition and follows best practise guidelines as cited in Section D. Registered nurses fully assess each residents' dietary needs on admission and review on an on-going basis. The care plan reflects the type of diet, any special 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 recommendations made by the Dietician or Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more frequently if required. The Home has a 3 weekly menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with the residents and/or their representatives, residents meetings, one to one meetings and food questionnaires. The PHA document "Nutrition and Menu Checklist for Residential and Nursing homes" is used to ensure the menu is nutritious and varied. . Copies of instructions and recommendations from the dietician and speech and language therapist are made available to the kitchen staff, along with a diet notification form which informs the kitchen staff of each residents specific dietary needs. Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want a meal from the daily menu, an alternative 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 recorded on the daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. Daily menus are displayed in each dining room. The 3 weekly menu is displayed in a folder in the foyer	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Training and supervision on dysphagia and enteral feeding techniques (PEG) was given to Staff. 3RN, 2SCA and 1CA attend to dysphagia training on 15/05/14.New guidelines from Speech and language were given to staff and Kitchen and incorporated on Nutrition file. A dedicate file was created for kitchen. Home Manager had FSHC Peg training on 04/03/14 and did supervision to all RN.. 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 "	Substantially compliant

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 Speech and Language therapist recommendations and this is kept on file for reference by the kitchen. Special dietary requirements are displayed on a white board in the dry store. Meals are served at the following times: Breakfast 9.00am – 10.00am Morning tea – 11am Lunch – 1pm Afternoon tea – 3pm Evening tea – 5pm Supper 7.30pm – 9pm 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 residents who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedrooms, 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, consistent 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 on the residents 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 that is suitable to them. Appropriate aids such as plate guards and specialised cutlery are available as necessary and indicated in the plan of care. Each nurse has completed an education e-learning module on pressure area care. All CA were requested to do the model not mandatory for them.The Home had a link nurse who had received enhanced training, to provide support and education to other nurses within the home on an ad hoc basis. Home Manger are doing this rool based on her own	

large experience and programing an up date traing for a link nurse. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the Home 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**
	Compliant

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Care Inspection

Mount Lens

11 November 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 the acting manager during 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.	6.2	All entries in case records are to be contemporaneous; dated, timed and signed, with the signature accompanied by the name and designation of the signatory. **Ref: Section 10.0 of report**	One	Supervision has been conducted with all the nursing staff. This will monitored by the Home Manager and Regional Manager as part of the Regulation 29 report.	From date of inspection
2.	26.6	The following specified policies must be reviewed and updated as required and ratified by the responsible person: • Continence Care • Ileostomy and colostomy care • Digital rectal evacuation • Bowel Care **Ref: Section 10.0 of report**	One	These policies have been referred to Four Seasons Health Care Corporate Policy Manager. a review of these policies will be undertaken and revised draft policies will be available by February 2015.	From date of inspection
3.	32.1	Water damage on the laundry ceiling should be repaired. **Ref: Section 11.7 of report**	One	The water damage to the laundry ceiling will be repaired in January 2015.	From date of inspection

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	Janice Brown
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall Carol Cousins CAROL COUSINS DIRECTOR OF OPERATIONS

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	YES	J Scarlett	5/1/15
Further information requested from provider			