Secondary Unannounced Care Inspection

Name of Establishment:	**Nicholson House**
RQIA Number:	**1274**
Date of Inspection:	**8 January 2015**
Inspector's Name:	**Sharon McKnight**
Inspection ID:	**IN017211**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Nicholson House
Address:	8 Antrim Road Lisburn BT28 3DH
Telephone Number:	02892674126
Email Address:	nicholsonhousepnh@btinternet.com
Registered Organisation/ Registered Provider:	Nicholson House
Registered Manager:	Ruth Mary Johnston
Person in Charge of the Home at the Time of Inspection:	Pauline Adair, deputy manager
Categories of Care:	NH-I, NH-PH, NH-PH(E), NH-TI
Number of Registered Places:	32
Number of Patients Accommodated on Day of Inspection:	32
Date and Type of Previous Inspection:	6 February 2014 Primary Unannounced Inspection
Date and Time of Inspection:	8 January 2015 10 40 – 15 30 hours
Name of Inspector:	Sharon McKnight

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- Discussion with the deputy 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 care plans
- Observation during a tour of the premises
- Evaluation and feedback.

5.0 Consultation Process

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

Patients	**6 patients individually and with the majority generally**
Staff	**5**
Relatives	**5**
Visiting Professionals	**0**

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**0**	**0**
Relatives/Representatives	**0**	**0**
Staff	**6**	**1**

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

Nicholson House is a nursing home situated on the Antrim Road, a short distance from Lisburn city centre. The nursing home is owned and operated by Mr Andrew Johnston and Mrs Ruth Johnston, who is also the registered manager.

Nicholson House was original a domestic dwelling which has been adapted and extended to provide accommodation for patients on both floors of the home. Access to the first floor is via a passenger lift and stairs. Bedroom accommodation is provided in single and shared bedrooms. Communal lounges and dining areas are provided on the ground and first floor. A number of bathrooms and toilets are located throughout the home.

Car parking facilities are provided at the rear of the home. The home also provides for catering and laundry services on the ground floor.

The home is registered to provide care for a maximum of 32 persons under the following categories of care:

Nursing care

I	old age not falling into any other category…..if required… to a maximum of 31 patients
PH	physical disability other than sensory impairment under 65
PH(E)	physical disability other than sensory impairment over 65 years
TI	terminally ill

8.0 Executive Summary

This unannounced inspection of Nicholson House was undertaken by inspector Sharon McKnight on 8 January between 10 40 and 15 30 hours. The inspection was facilitated by Ms Pauline Adair, deputy manager who was available throughout the inspection and was provided with verbal feedback at the conclusion of the inspection. Ms McKnight was accompanied by Dr Alan Lennon, RQIA chairman, during the morning of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection of 6 February 2014.

As a result of the previous inspection four requirement and eight recommendations were issued. These were reviewed during this inspection and the inspector evidenced that one requirement has been complied with, two were assessed as moving towards compliance and one is assessed as not compliant. These three requirements have been stated for a second time. The eight recommendations have been fully complied with. Details can be viewed in the section immediately following this summary.

Inspection Focus

Review of patients' care records evidenced that bladder and bowel continence needs were assessed as part of the activities of daily living assessment. In three of the care records viewed an additional assessment entitled "Bladder function assessment" had been completed. This assessment contained greater detail of the patients' assessed needs. Areas for improvements were identified in the care records and a recommendation has been made.

Patients care records evidenced that assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The management 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.

The management of urinary catheters was reviewed. The frequency with which catheters were required to be changed was recorded in the care plan. Care records evidenced that catheters were changed regularly and in accordance with the recommended frequency. Staff spoken with on the day of the inspection were knowledgeable regarding the management of continence and urinary catheters. It is recommended that best practice publications on the management of bladder and bowel continence and catheter and stoma care should be readily available in the home to support and guide staff on best practice.

Discussion with staff and observation made during the inspection evidenced that there were adequate stocks of continence products available in the nursing home. A recommendation is made in regard to the management of continence pants.

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

11.0 Additional Areas Examined

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

Details regarding the inspection findings for these areas are available in the main body of the report.

Conclusion

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

A total of three requirements are restated for a second time following this inspection and three recommendations were made as a result of this inspection.

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

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	12(1) (a)	It is required that the registered person shall ensure that the treatment provided to each patient meet their individual need. Each patient must have a comprehensive assessment completed to accurately identify what their individual needs are.	**Review of six patients care records evidenced that this requirement has been complied with.**	**Compliance**
2	17 (1)	It is required that the registered person shall ensure that audits are completed on all care records and the outcomes of any deficits identified are addressed. The audit process must be an ongoing process to ensure care records are maintained in keeping with regulatory requirements.	**The deputy manager informed the inspector of the audit process within the home. However there were no records available on the day of inspection to evidence the audit processes.** **This requirement is assessed as moving towards compliance and is stated for a second time.**	**Moving towards compliance.**
3	19(2) schedule 4(12) (b)&(c)	It is required that incidents of pressure ulcers, grade 2 and above, must be reported to RQIA in accordance with best practice guidelines.	**Notifications of pressure ulcers grade 2 and above had not been notified to RQIA.** **Retrospective notifications were sent to RQIA on 8 January 2015. This requirement is assessed as moving towards compliance and is stated for a second time.**	**Moving towards compliance**

4	19(1)(a), schedule 3, 2(k)	The registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence the care delivered. Repositioning charts must contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning.	**Review of repositioning charts evidenced that they were not consistently completed and did not evidence regular repositioning or that a skin inspection of pressure areas has been undertaken at the time of each repositioning.** **This requirement is assessed as not compliant and is stated for a second time.**	**Not compliant**

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	29.4	Ensure all staff receives formal supervision sessions on at least a six monthly basis and that policies, procedures and training are in place to support this arrangement.	**The supervision policy dated 1 October 2012 was reflective of DHSSPS guidance.** **The deputy manager confirmed that a system to deliver formal supervision within the home had been established. There was documented evidence of completed supervision sessions which had been undertaken.** **This recommendation is assessed as compliant.**	**Compliant**
2	30.4	Ensure the competency and capability assessments are further developed to reflect all the duties and responsibilities of the registered nurse in charge of the home in the absence of the registered manager. It is recommended that the records should be dated and signed following the assessment of staff competency.	**Completed competency and capability assessments reviewed were reflective of the duties and responsibilities of the registered nurse in charge of the home in the absence of the registered manager.** **The records were dated and signed.** **This recommendation is assessed as compliant.**	**Compliant**

3	20.3	It is recommended that a resuscitation policy, in line with the Resuscitation Council (UK) guidelines, and including a section on ethical/legal issues, 'Do not resuscitate' situations and the review of resuscitation decisions is drawn up to guide and direct staff.	**The policy "cardio pulmonary resuscitation" included a section on DNAR which included review.** **This recommendation is assessed as compliant.**	**Compliant**
4	25.13	The quality of services provided is evaluated on at least an annual basis, a report prepared and follow-up action taken. Key stakeholders are involved in the process. It is recommended that systems are developed to evidence that patients and relatives have access to this report.	**The inspector was informed that the report for 2014 was due for completion by 31 January 2015.** **A copy of the annual report was received by RQIA on 29 January 2015.** **The deputy manager informed the inspector that patients and relatives would be made aware of the report and copies would be available in the home for them to view.** **This recommendation is assessed as compliant.**	**Compliant**
5	16.9	Refresher training on the protection of vulnerable adults is provided for all staff at least every three years.	**Review of training records evidenced that this recommendation has been complied with.**	**Compliant**
6	5.3	It is recommended that care plans are updated to reflect the recommendations of visiting healthcare professionals.	**Review of care records evidence that this recommendation has been complied with.**	**Compliant**

7	11.4	A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.	**Review of care records evidenced that this recommendation has been complied with.**	**Compliant**
8	1.1	It is recommended that care records are written in a patient centred manner. The use of the word 'resident' does not recognise a person's uniqueness and should cease.	**Generally care records reviewed contained the name of the patient and not the term "resident". This recommendation is assessed as compliant.**	**Compliant**

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

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

Since the previous inspection on 6 February 2014, there have been no investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues.

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 six patients' care records evidenced that bladder and bowel continence needs were assessed as part of the activities of daily living assessment. In three of the care records viewed an additional assessment entitled "Bladder function assessment" had been completed. This assessment contained greater detail of the patients' assessed needs. The care records did not contain details of the specific continence aids the patient required. It is recommended that: • The "Bladder function assessment" is completed for all patients who have identified continence needs in their activity of daily living assessment • The type of continence pad and size of pants are recorded in the patient's care records. Patients care records evidenced that assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The management 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. The management of urinary catheters was reviewed. The frequency with which catheters were required to be changed was recorded in the care plan. Care records evidenced that catheters were changed regularly and in accordance with the recommended frequency. Review of patient's care records evidenced that patients and/or their representatives were informed of changes to patient need and/or condition and the action taken by staff in response to need.	Compliant

Discussion with staff and observation made during the inspection evidenced that there were adequate stocks of continence products available in the nursing home. The management of continence pants was discussed with staff who informed the inspector that these items of clothing were not personalised but managed communally. It is recommended that, in the interest of patient dignity, each patient should have continence pants supplied solely for their personal use.	
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:	
A policy for the management of continence was in place to guide staff regarding the promotion of bladder and bowel continence and management of incontinence. The inspector discussed the availability of best practice guidance documents within the home. None were available at the time of this inspection. It is recommended that publications on the management of bladder and bowel continence and catheter and stoma care are readily available in the home to inform and guide staff on best practice.	Substantially compliant
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:	
Staff spoken with on the day of the inspection were knowledgeable regarding the management of urinary catheters and the frequency with which the catheters required to be changed. Currently there were a number of	Compliant

registered nurses who undertake male catheterisation. Information received following the inspection evidenced that registered nurses attended training updates for male catheterisation provided by the local health and social care trust. Further dates have been arranged in March 2014 with the local health and social care Trust for those nurses who have not attended a recent update. There were no patients resident in the home at the time of this inspection who had a stoma appliance.	

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.

Review of bed side charts evidenced that those patients who were being nursed in bed, and unable to summon help, were attended by staff on a regular basis.

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 managed.

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) and that the registration status of all nursing staff was checked at the time of expiry.

11.5 Patients Comments

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

Patient spoken with confirmed that staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner and that the food was good. Patients were aware of who to speak to if they had concerns and wanted to make a complaint.

There were no issues or concerns raised with the inspector about care delivery in the home.

11.6 Relatives Views

Five relative, spoken with during the inspection, commented positively regarding the attitude of staff and the care their loved one received. They confirmed that the staff were vigilant regarding charges in their loved ones health and contacted the relevant healthcare professionals in a timely manner. Relatives were satisfied that they were kept informed of changes to patient need and/or condition.

There were no issues or concerns raised by relatives with the inspector during this inspection.

11.7 Staff Comments

During the inspection the inspector spoke with five staff including registered nurses, care staff and housekeeping staff. Staff spoken with commented positively in regard to the care delivery in the home, management and the support and training available. Staff were knowledgeable regarding individual patient need.

One completed staff questionnaire was received following the inspection. Staff responses indicated that they had received an induction, completed mandatory training, completed additional training in relation to the planned primary inspection focus and were very satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

11.8 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 Ms Pauline Adair, deputy 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.

Where the inspection resulted in no recommendations or requirements being made the provider/manger is asked to sign the appropriate page confirming they are assured about the factual accuracy of the content of the report.

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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9th Floor
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Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
At admission of a new Resident using the Roper ,Logan, Tierney model an initial assessment of daily living is documented by a Senior Nurse, most often the Nurse Manager or the Deputy Manager. Information from the Care Manager is requested prior to admission. (However this does not always arrive in home until after admission has taken place.) A copy of the home's statement of purpose and patient guide are provided on admission to Resident and their relative / representative. A comprehensive and holistic assessment of the Residents care needs are completed within 11 days of admission. In	Substantially compliant

the Residents notes the validated assessment tools used are: Braden for pressure ulcer risk, MUST for malnutrition risk. Bed rail risk assessment, Falls risk assessment, Continence assessments, Moving & Handling assessment and Wound assessment (if required) are also documented. Usually where risks are identified they are reflected in the care plan problems. On admission Residents have a base line weight recorded and a risk assesment carried out using the Malnutrition Universal Screening Tool (MUST). A nutritional asssesment is also detailed in Residents notes (adpated from NI Hospice Dec 2010 by kind permission.) If Resident identified as at risk the an appropriate care plan is developed and reviewed The Braden scale which incorporates nutrition & continence assessment is used to assess all Residents on admission to the home. Where a prospective Resident is identified at high risk by staff who are looking after them in current setting then a Braden score will be requested from staff. on a monthly basis or more frequently if required. A policy on Nutrition, nutritional assesment & hydration is in place.	

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
Nursing interventions to identify assessed needs for the individual Resident are documented in the careplan. If another health professional gives advice or recommendations these are usually incorporated into the care plan. With each new Resident admitted a named nurse is allocated and a list of the named nurses is kept in the daily report file Referral arrangements to dietitians are requested if necessary through the Residents GP. Where a Resident is identified as being at risk of malnutrition then a careplan is developed and reviewed on at least a monthly basis. Referral arrangements to Vascular specialist are requested if necessary through the Residents GP. Where a Resident is identified as being at risk of lower limb or foot ulceration then a careplan is developed and reviewed on at least a monthly basis. There are referral arrangements in place to avail of the expertise of the Tissue Vuability Nurse and Podiatrist in the local Trust. Where Residents score on Braden scale is deemed at risk then an appropriate careplan is drawn up to reflect Residents needs. If a Resident is in high risk category then we will liase with other health professional such as Tissue Viability Nurse and GP to draw up appropriate treatment plan for Resident.	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**
Daily evaluation of care delivery is carried out as a minimum twice in a 24 hour period. Re- assessment of careplans is ongoing and aims to be carried out on changing needs of Resident although this is not always met. Careplans are aimed to be reviewed monthly to ensure that they remain current and relevant to the Resident's needs	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**
Nursing interventions as detailed in careplan aim to have up to date and best practice from guidelines such as CREST, GAIN & NICE . This is ongoing work. Nutritional Guidelines 2013 are in use and easily accesible to all Staff. A nutrition file including up to date guidance is located at the Nurses Station. The validated pressure ulcer grading tool in use is from the NPUAP-EUAP guidelines. An appropriate careplan is implemented for all Residents who have skin damage detected.	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**
Contemporaneous nursing records are kept of all nursing care of the Resident. The records are wrtitten as soon as possible after any intervention. Time is used as real time and the 24 hour clock time is documented. Nursing records are signed with the signature of the nurse and also printed name and designation. Any referral to other health professional is documented either in progress report or in daily evaluation chart The cook records the meals served at each meal time. Nutritional Guidelines are in use and easily accesible to all Staff. A nutrition file including up to date guidance is located at the Nurses Station. If a Resiednts caeplan requires and Resident is at risk then a food chart may be recorded for a period of time to	Substantially compliant

ascertain if referral is required. This is then documented in Residents notes and careplan developed if action identified by other professional such as dietitian or Speech and language therapist	

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**
Outcomes of care delivered are recorded in daily evaluation. Care reviews are carried out with Residents and their relatives by appointment. We meet with families to discuss advanced care planning for their relatives. There has been positive feedback from families when given this opportunity. This is an ongoing work.	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 reviews are carried out with Residents and their relatives by appointment. The time scale is usually determined by the availability of the Care manager. Ideally the home would hold a Care review within 8 weeks of a new Resident being admitted and thereafter annually or sooner if the family or home request. Minutes of all Care reviews are filed in Residents notes Care review outcomes are documented in Residents notes and if required changes are made to the nursing care plan. Minutes of Care review meeting are held in Residents file	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**
On admission a nutrition assessment is documented with the Resident and relative / representative to ascertain likes/ dislikes and what the Resident would have usually eaten prior to admission. Any advice sheets from dietitian or Speech and language therapist will be placed in notes and cook , kitchen and care staff informed of this.GAIN guidelines for for Clinical Standards of Care for people with Diabetes in Care Homes Feb 2010 are available in nutrition file The menu is varaible to allow for choice of meal at each meal time. If a Resident does not wish to have the meal on the menu an alternative is offered. There is also a choice for Residents who have therapeutic diets.	Substantially 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**
Nurses have attended training delivered by Speech and Language therapists pertaining to managing feeding techniques. Care assisitants have also attended training with regard to Dysphagia, use of MUST tool and use of thickeners Meals are provided at timely intervals throughtout the day. Fresh drinking water and juices are availalble throughout the day . Between main meals hot drinks and home made cakes etc.are served. Residents are also offered meals outside arranged times if they so wish	Substantially compliant

All care staff are informed of Residents individual needs with regard to risks identified, assistance required and any necessary aids or equipment required. Staff are allocated to assits Residents with their meals. Staff are always seated beside a Resident to maintain eye contact during a meal and fully inform the Resident as to their meal choice. Staff assist with applying clothes protectors, plate guards etc. and observing and closely supervising Residents to ensure maximum independence but also adequate nuttritional intake. All nurses in home are deemed as competent to carry out wound assessment and appplication of dressings.Training in tissue viability and wound care is availablefor Nurses and learning is ongoing.	

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

Quality Improvement Plan

Secondary Unannounced Care Inspection

Nicholson House

8 January 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 Ms Pauline Adair, deputy manager, either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	17 (1)	It is required that the registered person shall ensure that audits are completed on all care records and the outcomes of any deficits identified are addressed. The audit process must be an ongoing process to ensure care records are maintained in keeping with regulatory requirements. **Re section 9**	Two	Audits on Care records are included in section 12 of Home audit. Audit process is ongoing.	By the end of February 2015.
2	19(2) schedule 4(12) (b)&(c)	It is required that incidents of pressure ulcers, grade 2 and above, must be reported to RQIA in accordance with best practice guidelines. **Ref section 9**	Two	Incidents of pressure ulcer grade 2 and above will be reported in line with best practice guidelines.	Ongoing from the day of inspection
3	19(1)(a), schedule 3, 2(k)	The registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence the care delivered. Repositioning charts must contain	Two	All staff informed of requirement to complete all nursing charts etc. with up to date care delivered. Also informed that skin inspection to be documented at each repositioning time.	By the end of February 2015.

		documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning. **Ref section 9**			

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	The "Bladder function assessment" should be completed for all patients who have identified continence needs in their activity of daily living assessment The type of continence pad and size of pants are recorded in the patient's care records. **Ref section 10, criterion 9.1**	One	All Residents notes 'bladder function assessment' updated for continence needs.	By the end of February 2015
2	1.1	In keeping with patient dignity, each patient should have continence pants supplied solely for their personal use. **Ref section 10, criterion 19.1**	One	Manager to source ID naming for continence pants.	By the end of February 2015.
3	19.2	Publications on the management of bladder and bowel continence and catheter and stoma care should be readily available in the home to inform and guide staff on best practice. **Ref section 10, criterion 19.2**	One	Up to date guidance available.	By the end of February 2015.

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	Ruth Johnston
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	X	Sharon McKnight	9-04-15
Further information requested from provider			