Unannounced Secondary Care Inspection

Name of Establishment:	**Parkdean**
Establishment ID No:	**1280**
Date of Inspection:	**19 June 2014**
Inspector's Name:	**Loretto Fegan**
Inspection ID:	**16996**

The Regulation And Quality Improvement Authority
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General Information

Name of Home:	Parkdean
Address:	44 Fortwilliam Park Belfast BT15 4AN
Telephone Number:	028 90370406
E mail Address:	parkdean-nh@hotmail.co.uk
Registered Organisation/ Registered Provider:	Mrs Emer Bevan
Registered Manager:	Ms Margaretha Erasmus (Acting)
Person in Charge of the Home at the Time of Inspection:	Ms Margaretha Erasmus
Categories of Care:	NH-I, NH-PH, NH-PH (E), NH-TI
Number of Registered Places:	64
Number of Patients Accommodated on Day of Inspection:	61
Scale of Charges (per week):	£581.00 per week A third party top-up of £50 is applicable to six bedrooms
Date and Type of Previous Inspection:	1 & 2 August 2013, Primary care unannounced inspection
Date and Time of Inspection:	19 June 2014 11.15 – 17.50 hours
Name of Inspector:	Loretto Fegan (bank inspector)

1.0 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.

1.1 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

1.2 Methods/Process

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

- discussion with registered provider
- discussion with the home manager
- discussion with staff
- discussion with patients individually and to others in groups
- 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

1.3 Inspection Focus

The main focus of the inspection was to follow-up the progress made in relation to the requirements and recommendations made during the previous inspection on 1 & 2 August 2013 and to establish the level of compliance being achieved.

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.

2.0 Profile of Service

Parkdean Nursing home is situated on the outskirts of Belfast in Fortwilliam Park off the Antrim Road.

The nursing home is owned and operated by Mrs E Bevan.

The home manager is Ms M Erasmus.

Accommodation for patients is provided in single bedrooms and one double bedroom is also available. Most bedrooms have en-suite facilities.

Access to all floors is via a passenger lift and stairs.

Communal lounge and dining areas are provided throughout the home.

The home also provides for catering and laundry services on the ground floor.

A number of communal bathroom / shower and sanitary facilities are available throughout the home. There is also a designated hairdressing room.

The home is surrounded by well- maintained gardens and there are car parking spaces to the front of the building.

The home is registered to provide care for a maximum of 64 persons under the following categories of care:

Nursing care

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

3.0 Summary

This summary provides an overview of the services examined during an unannounced secondary care inspection to Parkdean Nursing Home. The inspection was undertaken by Loretto Fegan on 19 June 2014 from 11.15 to 17.50 hours.

The inspector was welcomed into the home by Ms Margaretha Erasmus, home manager who was on duty throughout the inspection. However, as Ms Erasmus was required to provide direct nursing care to patients due to unforeseen staffing circumstances, the inspection was mainly facilitated by Mrs Bevan, registered provider, Mrs S Stanford, company director and Mr Macklin, company director. Ms Erasmus, home manager, was available to facilitate the latter part of the inspection, which included the review of care records. Verbal feedback of the issues identified during the inspection was given to Mrs Bevan, registered provider, Mrs S Stanford, company director and Ms M Erasmus, home manager.

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

As a result of the previous inspection conducted on 1 & 2 August 2013, three requirements and fifteen recommendations were issued. These were reviewed during this inspection. The inspector evidenced that two requirements and four recommendations were compliant. A further requirement and seven recommendations were substantially compliant and four recommendations were assessed as moving towards compliance. Details can be viewed in the section immediately following this summary.

The inspector evidenced that communication between staff and patients reflected that patients were treated courteously and with dignity and respect. All patients spoken with commented positively regarding their care in the home. Those patients who were unable to verbally express their views were observed to be well groomed, appropriately dressed and appeared relaxed and comfortable in their surroundings.

The inspector examined specific aspects in relation to three patients' care records. As significant areas for improvement were identified, recommendations previously issued in relation to care records have been made requirements. The home manager was in agreement with the issues raised.

Further to reviewing a sample of complaints, incidents and accidents recorded by the home, the inspector requested that one complaint and an event recorded should be referred to the Health Care Trust to be considered under the Safeguarding Vulnerable Adults (SOVA) procedure. Further communication to RQIA from the registered provider has confirmed that this correspondence has taken place following the inspection. RQIA should also receive notification in accordance with Regulation 30 regarding incidents / complaints which identify any potential safeguarding issue. Requirements are made in this regard.

The accident / incident records were on occasions not recorded in date order, all records should be recorded contemporaneously and all incidents recorded centrally. A requirement is made in this regard.

Ms Erasmus was undertaking a dual role of home manager and registered nurse providing direct patient care on the day of inspection. Mrs Bevan explained that this situation had arisen due to the absence of a registered nurse at short notice. Information relating to assessed patient dependency levels and staffing levels indicated that the home met the DHSSPS's recommended minimum staffing guidance for nursing homes. However, as deficits were identified during the inspection in relation to specific governance arrangements as detailed in the report, the home manager must have sufficient time in a supernumerary capacity to ensure that all governance arrangements are maintained in accordance with best practice.

The inspector observed the general environment in the nursing home to be well maintained. An issue regarding lighting in one area of the home is currently being addressed and there is on-going correspondence with RQIA in this regard.

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. The patients were observed to be treated with dignity and respect.

Areas for improvement were identified with regard to care records, recording of incidents and onward referral of potential safeguarding of vulnerable adult (SOVA) to the designated safeguarding officer. Requirements have been made accordingly.

The home's general environment was well maintained. An issue was identified with regard to lighting in one area of the building; RQIA has received ongoing correspondence with regard to rectifying this issue.

Therefore seven requirements and two recommendations were made as a result of this inspection, in addition to a restated requirement and seven restated recommendations. The requirements and recommendation are detailed throughout the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, registered provider, members of the management team, home manager and staff for their assistance and co-operation throughout the inspection process.

4.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1.	29 (3) and (4)	Where the registered provider is an individual, but not in day to day charge of the nursing home, he shall visit the home in accordance with this regulation. The visits shall take place at least once a month and be unannounced. The person carrying out the visit shall interview, with their consent and in private, such of the patients and their representatives and persons working in the nursing home as appears necessary in order to form an opinion of the standard of nursing provided in the home. The person carrying out the visit shall also inspect the premises of the nursing home, its record of events and record of any complaint. Reports should be anonymised and state the time of commencing and finishing the visit.	Examination of three Regulation 29 reports confirmed that the company director Mrs S Stanford carried out the Regulation 29 visits on a monthly basis in accordance with the Nursing Homes Regulations (NI) 2005. A recommendation has been made that consideration is given to how the identity of patients, relatives and staff is redacted in reports made available to patients / their representatives. It is acknowledged that the time of commencing the visit was recorded on the report; however it is recommended that the finishing time of the visit is also stated.	Compliant

2.	17 (1), (2) and (3)	The registered person shall introduce and ensure systems are maintained for reviewing the quality of nursing and other service provision in the nursing home. A report is to be written on an annual basis and evidence consultation with patients and their representatives. It is recommended the annual quality report includes, for example, evidence of consultation with patients, representatives and staff, outcome and action taken in response to patients/representatives satisfaction questionnaires, action taken to address any deficits identified through audit or consultation.	There was evidence that systems were in place to review the quality of nursing and other service provision in the home. This included audits undertaken in relation to falls, pharmacy and infection control. Discussion took place with Mrs Bevan and Ms Erasmus how the auditing process should be further developed to ensure that action plans with timescales are consistently put in place and re-audit takes place on a timely basis. It is required that care records are also audited. A recent "root cause analysis" was undertaken in relation to pressure ulcer development and learning was identified. An annual quality report was not available on the day of inspection. Mrs Bevan, registered provider advised that the responses to the most recent patients' / representatives' satisfaction questionnaire were being analysed at present and the outcomes will be incorporated into the annual quality report which will be available by July 2014. **This requirement will be stated for a third and final time. Further non-compliance will lead to enhanced enforcement action.**	Substantially compliant

3.	16 (1)	The registered person shall ensure that a written plan is prepared by a nurse in consultation with the patient or patient's representative as to how the patient's needs in respect of his health and welfare are to be met.	There was evidence that a written plan was prepared by a nurse in consultation with the patient or patient's representative (where bedrails were in place) as to how the patient's needs in respect of his health and welfare were to be met. However, other issues identified in relation to care records are highlighted elsewhere in this report (see section 4 and section 5.3 of this report) Separate requirements have been made in relation to the issues identified.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1.	28.1	It is recommended individuals induction training record should be validated by the registered manager on completion.	The inspector can confirm that the two staffs' induction training records examined were validated by the registered manager on completion.	Compliant
2.	28.8	It is recommended staff maintain a reflective learning log following the receipt of any training. The effect of training on practice should be evaluated as part of quality improvement. The reflective log should identify areas of learning for the individual.	The home manager confirmed that supervision, appraisal, observation of practice and staff maintaining a reflective learning log are all used to evaluate the effect of training on practice in the home. A supervision planner was in place.	Compliant
3.	29.1 and 29.4	It is recommended the templates used for formal supervision and appraisal evidence the participation and agreement of both parties and identifies areas of continued professional development and/or support.	The inspector can confirm that the more recently developed templates for formal supervision and appraisal are designed to include the participation and agreement of both parties. They also provide a prompt to identify areas of continued professional development and/or support.	Compliant

4.	25.11	It is recommended a system to re-evaluate any shortfalls noted during audits undertaken in the home is introduced. The registered manager should confirm shortfalls have been addressed in a timely manner.	There was evidence that systems were in place to review the quality of nursing in the home. This included audits undertaken in relation to falls, pharmacy and infection control. Discussion took place with Mrs Bevan and Ms Erasmus how the auditing process should be further developed to ensure that action plans with timescales are consistently put in place and re-audit takes place on a timely basis. It is required that care records are also audited. This recommendation will be stated for the second time and compliance followed up during the next care inspection.	Substantially compliant

5.	25.13	It is recommended the information supplied in patients/representatives questionnaires be collated, an action plan developed and a report written and made available for patients and representatives information.	A report was not available for inspection with regard to the collation / analysis of a previous patients/representatives satisfaction questionnaire. Mrs Bevan, registered provider advised that the responses to the most recent patients' / representatives' satisfaction questionnaire were being collated and analysed at present. Mrs Bevan, registered provider confirmed that an action plan will be developed if any deficits are identified and a report will be written and made available for patients and representatives information. Mrs Bevan also informed the inspector that the outcomes will be incorporated into the annual quality report which will be available in July 2014. This recommendation will be stated for the third time and compliance followed up during the next care inspection.	Moving towards compliance
6.	26.6	It is recommended policies and procedures will be dated when issued, reviewed or revised.	The inspector can confirm that two recently reviewed policies / procedures were dated when revised/ issued and a further review date was recorded.	Compliant

7.	5.6	It is recommended 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. This recommendation is in relation to: • evaluations of care should be meaningful and accurately reflect the patients response to planned care interventions, for example wound care; and • a consistent and agreed approach to care planning and recording is implemented and adhered to by all staff	The inspector examined a range of nursing records including daily progress notes, food and fluid charts, fluid intake and output charts, repositioning charts and incident/ accident records. These were in the main recorded contemporaneously however, specific examples were highlighted with the nurse manager and registered provider when • statements were provided in relation to care given rather than a meaningful evaluation of the care • intake and output charts were not consistently totalled over the 24 hour period • the repositioning charts did not always document the condition of the skin • there were variations in the recording of food and fluid charts The specific issues identified with regards to evaluation of care will be incorporated into a new requirement made for the first time. It was highlighted that a consistent and agreed approach to care planning and recording should be fully implemented and adhered to by all staff, therefore this part	Substantially compliant

			will remain a recommendation to be followed up during the next care inspection.	
8.	26.1	It is recommended the policy on quality assurance for the home includes information/arrangements for the regulation 29 monthly monitoring reports and the completion of the annual quality report. Information should also be detailed that these reports are available in the home and patients and/or their representatives may read the reports if they so wish.	The inspector reviewed the home's policy on quality assurance and can confirm that it includes information/arrangements for the regulation 29 monthly monitoring reports. However, the completion of the annual quality report is not included in the policy. Information is detailed that the regulation 29 monthly monitoring report is available in the home and patients and/or their representatives may read the reports if they so wish. However, this should also include the availability of the annual quality report for patients and/or their representatives to read. This recommendation will be stated for the second time and compliance followed up during the next care inspection.	Substantially compliant

9.	5.3	It is recommended the registered manager ensures patients and representatives are aware of the individuals named nurse.	The home manager confirmed that every patient is allocated a named nurse. Ms Erasmus, home manager informed the inspector that the named nurse attends the care management review of their named patients and that information pertaining to the allocation of the named nurse is displayed in the nurses' office. Discussion took place with Ms Erasmus with regard to putting in place a process to ensure that all patients and/or their representatives are informed regarding their nominated named nurse. This recommendation will be stated for the second time and compliance followed up during the next care inspection.	Substantially compliant
10.	25.12 and 25.13	It is recommended patients and their representatives should be made aware of the availability of the regulation 29 reports and the annual quality report in the home, should they wish to read them.	It was confirmed during the inspection that patients and their representatives are made aware of the availability of the regulation 29 reports, however they should also be informed regarding the annual quality report when it becomes available in the home. This recommendation will be stated for the second time and compliance followed up during the next care inspection.	Substantially compliant

11.	10.7	It is recommended that: • completed risk assessments should clearly evidence if bedrails are required or not; • care records should evidence whether consultation has taken place with the patient and/or representative regarding the use of bedrails	• The inspector examined two care records in this regard and can confirm that the completed risk assessments evidenced if bedrails were required or not. The care records also evidenced that consultation had taken place with the patients' representatives regarding the use of bedrails.	Compliant
12.	10.4	It is recommended nursing staff undertake training on restraint, restrictive practices and physical interventions. The training should include the procedures to follow regarding the use of restrictive practice in accordance with RCN guidelines	Ms E Erasmus, home manager informed the inspector that nursing staff have not yet undertaken training on restraint, restrictive practices and physical interventions. Ms E Erasmus confirmed that a plan was in place to have this undertaken. This recommendation will be stated for the second time and compliance followed up during the next care inspection.	Moving towards compliance

13.	5.3,11.6 and 11.3	It is recommended in relation to wound care management; • a care plan in relation to pain management should be developed where need has been assessed as present • the wound observation chart each time the wound is dressed • care plans should reflect the current advice of the tissue viability specialist • weight loss or gain must be diligently recorded in patients' care records. • Evidence of timely referrals to healthcare professionals should also be in evidence • the frequency of dressing of the wound should be clearly stated in documentation • regular photographic evidence of the wound should be present in the patient's care records; and • information leaflets regarding wound management and skin care should be available in the home and given to patients and/or representatives, where appropriate.	The inspector examined two care records in this regard and the following was evidenced: a care plan in relation to pain management was developed for one patient where need was been assessed as present, however this was only partly addressed in respect of the other patient a wound observation chart was not in place each time wounds were dressed in respect of either patients the care plan of one patient reflected the current advice of the tissue viability specialist, the home manager advised that the other patient did not require tissue viability specialist input Recording of weight was not transferred from a communal record for May and June 2014 to one patient's care record. There was no evidence of analysis / evaluation in relation to a significant difference in weight (gain) over a three week period in respect of this patient. It was not clear if the discrepancy in weight highlighted during the inspection resulted from a defect in the weighing scales. This reading if incorrect may have resulted in the patient's	Moving towards compliance

			Malnutrition Universal Screening Tool (MUST) being calculated incorrectly. The home manager agreed to address this issue as a matter of urgency. There was evidence of timely referrals to healthcare professionals such as the dietician for one patient. Depending on the outcome of the weight discrepancy, a dietician referral may be required for the other patient also. The frequency of dressing of the wound was clearly stated in the documentation pertaining to one patient but this required to be updated with regard to the other patient. There was no regular photographic evidence of the wounds present in either patients' care records Information leaflets regarding wound management and skin care were not available in the home for patients and/or representatives, where appropriate.	

14.	11.7	It is recommended all registered nurses undertake training in wound management.	The home manager confirmed that 75% (9/12) of the registered nurses had undertaken training in wound management. The inspector reviewed the training records in relation to two registered nurses which confirmed that they had undertaken training in wound management. This recommendation will be stated for the second time and compliance followed up during the next care inspection.	Substantially compliant

15.	30.4	It is recommended the competency and capability assessment for the nurse in charge of the home, in the absence of the registered manager reflects: • all sections of the assessment have been completed • both parties sign and date the completed assessment • there is a final statement of competency validated by the registered manager • wound management safeguarding vulnerable adults procedures should be included in the competency and capability assessment	Ms E Erasmus, home manager informed the inspector that the competency and capability assessment for the nurse in charge of the home, in the absence of the registered manager needs to be completed / updated. Ms E Erasmus confirmed that a plan was in place to commence the completing / review of these the week following the inspection.	Moving towards compliance

4.1 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 there is considered to be a breach of regulation as stated in the Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

Since the previous care inspection on 1 & 2 August 2013, RQIA have received nil notifications of safeguarding of vulnerable adult (SOVA) incidents in respect of Parkdean Nursing Home.

During this inspection, the inspector reviewed a sample of complaints, incidents and accidents recorded by the home. The inspector requested that one complaint and an event recorded should be referred to the Health Care Trust to be considered under the Safeguarding Vulnerable Adults (SOVA) procedure. The initiation of any investigation /decision regarding the “screening out” of suspected or alleged abuse should always be determined by the designated safeguarding officer in Trust. Further communication to RQIA from the registered provider has confirmed that correspondence with the safeguarding team has since taken place following the inspection in this regard. RQIA should also receive notification in accordance with Regulation 30 regarding incidents / complaints which identify any potential safeguarding issue. Requirements are made in this regard.

5.0 Additional Areas Examined

5.1 Care practices

The inspector observed care practices which included the assistance provided to patients while mobilising. Communication between staff and patients evidenced that patients were treated courteously and with dignity and respect.

5.2 Patients' views

The inspector spoke with fifteen patients individually and with others in groups. All commented positively with regard to staff attitude, care provided and the cleanliness of the home. The patients spoken with were very satisfied were the quality of the meals provided in the home. Those patients who were unable to verbally express their views were observed to be well groomed, appropriately dressed and appeared relaxed and comfortable in their surroundings.

5.3 Care Records

The inspector examined specific aspects in relation to the care records of three patients and the following issues were identified for improvement in addition to those highlighted in section 4 (follow-up on previous issue) :

- A discrepancy was observed by the inspector in relation to the recording of one patient's weight over a three week period. The home manager agreed to ensure that the correct weight was ascertained and if required the Malnutrition Universal Screening Tool (MUST) should be amended accordingly. A referral to the dietician may need to be considered for this patient on reviewing the MUST score.
- The care plan in respect of one patient requires to be reviewed regarding pressure ulcer /moisture lesion management in response to the current assessed classification of the wound. The care plan should also include the specific care related to the prevention of any further deterioration of skin integrity to include the pressure relieving / reducing equipment in use
- Repositioning of the patient should take place in accordance with assessed need as prescribed in the care plan and records should be made contemporaneously in relation to this activity. One patient's repositioning chart evidenced that there were deficits in recording this activity of up to 4-5 hours on two occasions. However on the morning of the inspection clarity was provided that the patient had been repositioned in the interim, although this was not recorded.
- One patient's care plan should reflect the dietician's advice
- Food and fluid charts were found to be inconsistently recorded in respect of one patient. This should be addressed in line with the home's recording system i.e. codes used in relation to amount taken.
- There were occasions when the daily fluid intake and output chart were not totalled over the 24 hour period. This should be addressed.
- One patient had a MUST score completed in March 2014 and this was not evaluated subsequently. It was agreed with the home manager that this would be done as a matter of urgency.

- The progress notes for one patient stated that a specific treatment was used for a skin care condition; however a different treatment was prescribed by the GP. This matter has been referred to the RQIA pharmacy inspector. Registered nurses should ensure that only prescribed treatments are used.

Requirements in relation to care records and medicine management have been made with regard to the issues identified in the care records.

5.4 Staffing

Discussion took place with the registered provider and home manager regarding the staffing levels on the day of inspection. Ms Erasmus was undertaking a dual role of home manager and registered nurse providing direct patient care on the day of inspection. Mrs Bevan explained that this situation had arisen due to the absence of a registered nurse at short notice. The inspector was provided with the duty rota for the following week which confirmed that the home manager would be supernumerary.

The registered manager advised the inspector that the home had experienced recent difficulty with regard to recruitment and retention of registered nurses and confirmed that an on-going recruitment process was in progress and the home are currently using agency staff as and when required.

As deficits were identified during the inspection in relation to record keeping, the updating of the competency assessment in relation to registered nurses taking charge of the home in the absence of the manager and audit processes, the home manager must have sufficient time in a supernumerary capacity to ensure that these governance arrangements are maintained in accordance with best practice.

The inspector requested Ms Erasmus to submit one week's duty rota with the corresponding patients' assessed dependency levels using Rhys Hearn scoring system to RQIA for analysis. The information submitted to RQIA indicated that the staffing arrangements met the DHSSPS's recommended minimum staffing guidance for nursing homes.

5.5 Incident / Accident Reporting

It was identified during the inspection that staff only record accidents and not incidents in a central recording system. Discussion took place with Mrs E Bevan, registered provider regarding this practice. Mrs Bevan was of the understanding that as incidents are recorded in the patients' individual care records this should suffice. The inspector explained that all incidents must be recorded centrally and be available for RQIA inspections and that the record of incidents should inform the monthly Regulation 29 visit by the registered provider /nominated person. The accident records were on occasions not recorded in date order; all records should be recorded contemporaneously. A requirement is made in this regard.

5.6 General Environment

As part of the inspection process, the inspector observed the general environment in the nursing home. This included viewing twenty-one bedrooms, three lounges, two dining rooms and bathroom / toilet facilities. The home was warm and comfortable and all areas were maintained to a high standard of hygiene.

However, the lighting on the first floor corridor was not working at the time of inspection and Mr S Macklin; company director confirmed that this was being addressed. There has been subsequent on-going correspondence between the RQIA estates inspector and another company director Mr Bevan regarding this matter. Mr Bevan has confirmed that all of the bulbs that were not working have been changed as a temporary measure pending the completion of the permanent solution by the electrical contractor as a matter of urgency. The RQIA estates inspector has requested that a daily check should be carried out to these areas and the outcome documented and staff, particularly night staff should be vigilant in relation to checking these corridor areas. A requirement has been made in this regard.

As there was ambiguity regarding the recording of one patient's weight, a recommendation has been made to confirm that all weighing scales used by patients are re-checked and if necessary re-calibrated in accordance with the manufacturers' instructions by a suitably qualified person.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs E Bevan, registered provider, Mrs S Stanford, company director and Ms M Erasmus, home manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

Loretto Fegan
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Quality Improvement Plan

Unannounced Secondary Inspection

Parkdean

19 June 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 Mrs E Bevan, registered provider, Ms M Erasmus, home manager and Mrs S Stanford, company director 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), (2) and (3)	The registered person shall introduce and ensure systems are maintained for reviewing the quality of nursing and other service provision in the nursing home. A report is to be written on an annual basis and evidence consultation with patients and their representatives. It is recommended the annual quality report includes, for example, evidence of consultation with patients, representatives and staff, outcome and action taken in response to patients/representatives satisfaction questionnaires, action taken to address any deficits identified through audit or consultation. **This issue is raised for a third and final time. Further non-compliance will lead to enhanced enforcement action.** **Ref – Section 4, Follow-up on Previous Issue**	Three	The annual quality report was prepared and written by previous Registration Manager for year ending 2013. Unfortunately the Manager is no longer employed by Parkdean Nursing Home and the report cannot be located The annual quality report has been prepared to date for 2014 and can be viewed on request.	From date of inspection
2.	14 (4)	The registered person must make arrangements by training staff or by other measures, to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse by	One	It has been reiterated to all registered nurses to report to management any potential safeguarding issues. A flow chart has been produced to	From date of inspection

		• Referring any potential safeguarding issue to the designated safeguarding officer in the health and social care trust in accordance with regional guidance **Ref – Section 4, (4.1)**		assist in this regard.	
3.	30 (1) & (2)	The registered person must give notice to RQIA without delay regarding any potential safeguarding issue. **Ref – Section 4, (4.1)**	One	Registered Provider and Registerd Manager will continue to give notice to RQIA regarding any potential safeguarding issue.	From date of inspection
4.	15 (2) (a & b)	The registered person must ensure that the assessment of the patient's needs is kept under review and revised at any time when it is necessary to do having regard to any change of circumstances by : • recording the wound observation chart each time a wound is dressed • weight loss or gain must be diligently recorded and analysed in patients' care records. • ambiguity regarding the accuracy of one identified patient's weight should be addressed as a priority • food and fluid charts should be consistently recorded in line with the home's recording system (the codes used in relation to amount taken). • regular photographic evidence of wounds should be present in the	One	Patients have a wound chart for each wound. The wound is measured each time dresing is renewed and therefore staff do not feel the need for photographic evidence. All staff nurses have recieved training in wound assessment. Ambiguity of residents weight has been addressed. Codes are no longer used when recording amounts of food, the actual amount of spoonfuls are recorded. Daily fluid intake and output charts have totals calculated at 7pm and 7am and totals are recorded in daily notes. All staff nurses are aware of the need to update MUST score on	From date of inspection

		patient's care records • the daily fluid intake and output chart should be totalled over the 24 hour period. • MUST scores should be re-assessed monthly **Ref – Section 4 & section 5, (5.3)**		a monthly basis.	
5.	16 (2) (b)	The registered person must ensure that care plans are kept under review and the following information is recorded: • a care plan in relation to pain management should be developed where need has been assessed as present • the frequency of wound dressings should be clearly stated • information leaflets regarding wound management and skin care should be given to patients and/or representatives, where appropriate and same recorded. • the care plan in respect of one patient should be reviewed in response to the current assessed classification of the wound. • care plans should include the specific care related to the prevention of any further deterioration of skin integrity to include the pressure relieving / reducing equipment in use • repositioning of patients should take place in accordance with assessed need as prescribed in the care plan and records should be made	One	Patients with wounds now have a care plan in relation to pain management in place. This is located in the medication kardex. A pain asssessment chart is also in place for all patients on regular pain relief and those with wounds. A wound assessment tool is in place for the relevant patients and this states the frequency dressings should be changed. Information leaflets relating to wound care are contained in patients care records and these can be offered to patients and their representatives. The care plans indicate the grade of wound and the pressure relieving equipment in place to prevent further deterioration. The care plan and daily reports and repositioning charts reflect timing of repositioning and condition of patient's skin.	From date of inspection

		contemporaneously in relation to this activity. • one patient's care plan should reflect the dietician's advice. • a referral to the dietician may need to be considered for another patient on reviewing the patient's weight and MUST score. • evaluations of care should be meaningful and accurately reflect the patient's response to planned care interventions **Ref – Section 4 & section 5, (5.3)**		Dietician advice has been included in the care plan identified. Referral to a dietician has been made for identified patient. It has been reitertated to all staff nurse the importance of recording meaningful and accurate information in response to planned care interventions.	
6.	13 (4) (b)	The registered person must ensure that medicine which is prescribed is administered as prescribed to the patient for whom it is prescribed (this requirement relates to topical treatment) **Ref –Section 5, (5.3)**	One	The Registerd Person will continue to ensure that medication is admisistered to the patient for whom it is prescribed.	From date of inspection
7.	19 (2), schedule 4 (12) (b)	The registered person must maintain in the nursing home the records of any incident which is detrimental to the health or welfare of the patient. Accident /incidents records should be recorded contemporaneously in date order. **Ref – Section 5, (5.5)**	One	Registered Manager now ensures incidents are recorded on an incident form for topics not covered by Form 1a. It has been reiterated to all nursing staff the importance of recording incidents/ accidents in contemporaneously date order.	From date of inspection

8.	27(4)(p) 27(4)(q)	The Registered Persons should keep RQIA up to date with progress in relation to resolving the corridor lighting issue. In the interim until the permanent solution to this issue has been achieved, staff should remain vigilant and the corridors should be checked daily. A record for these checks should be kept in the home available for review during future inspections. **Ref – Section 5, (5.6)**	One	This issue has been addressed. Bulbs are continually replaced along the corridors until a permanent solution has been reached.	Ongoing

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.	25.12	It is recommended that the following is addressed in relation to Regulation 29 visit reports • consideration is given to how the identity of patients, relatives and staff is redacted in reports made available to patients/ their representatives. • the time of commencing and finishing the visit is stated. **Ref – Section 4, Follow-up on Previous Issue**	One	This issue has been addressed. A number key is now used on the reports and the fininshing time is recorded on report.	From date of inspection
2.	25.11	It is recommended a system to re-evaluate any shortfalls noted during audits undertaken in the home is introduced. The registered manager should confirm shortfalls have been addressed in a timely manner. **Ref – Section 4, Follow-up on Previous Issue**	Two	An audit tool to capture shortfalls noted during audits has been developed. This will be used by Registered Manager and shorfalls will be addressed in a timely manner.	From date of inspection
3.	25.13	It is recommended the information supplied in patients/representatives questionnaires be collated, an action plan developed and a report written and made available for patients and representatives information. **Ref – Section 4, Follow-up on Previous**	Three	Information supplied in patient / representatives questionnaires have been collated and report produced. Any recommendations, shortfalls identified in the report will be addressed in due course.	By 31 July 2014

		Issue			
4.	5.6	It is recommended a consistent and agreed approach to care planning and recording is implemented and adhered to by all staff **Ref – Section 4, Follow-up on Previous Issue**	Two	It has been reiterated to all staff the importance of a consistent and agreed approach to care planning. An audit tool has been produced to identify any shortcomings and this will be addressed with the relevant nurse.	From date of inspection
5.	26.1	It is recommended the policy on quality assurance for the home includes information/arrangements for the regulation 29 monthly monitoring reports and the completion of the annual quality report. Information should also be detailed that these reports are available in the home and patients and/or their representatives may read the reports if they so wish. **Ref – Section 4, Follow-up on Previous Issue**	Two	This issue has been addressed. Policy now includes information on regualtion 29 monitoring reports and the completion of the annual quality report. It also specifies that these reports are available for viewing by patients and their representatives.	By 31 July 2014
6.	5.3	It is recommended the registered manager ensures patients and representatives are aware of the individual's named nurse. **Ref – Section 4, Follow-up on Previous Issue**	Two	It will be communicated to patients and their representatives the name of patient's primary nurse.	From date of inspection
7.	25.12 and 25.13	It is recommended patients and their representatives should be made aware of the availability of the regulation 29 reports and the annual quality report in the home, should	Two	A notice is now displayed on the patient / visitor notice board indicating the availability of regulation 29 reports and	By 31 July 2014

		they wish to read them. **Ref – Section 4, Follow-up on Previous Issue**		annual quality report.	
8.	10.4	It is recommended nursing staff undertake training on restraint, restrictive practices and physical interventions. The training should include the procedures to follow regarding the use of restrictive practice in accordance with RCN guidelines **Ref – Section 4, Follow-up on Previous Issue**	Two	We have contacted Belfast Trust and the Beeches Management Centre and are awaiting confirmation of the dates.	By 30 September 2014
9.	32.8	Confirm that the weighing scales used by patients have been re-checked and if necessary re-calibrated in accordance with the manufacturers' instructions by a suitably qualified person **Ref – Section 5, (5.6)**	One	Weighing scales were re calibrated in September 2013 and are due for examination September 2014.	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 and return to nursing.team@rqia.org.uk

Name of Registered Manager Completing Qip	R Erasmus
Name of Responsible Person / Identified Responsible Person Approving Qip	E Bevan

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	√	Loretto Fegan	8/8/14
Further information requested from provider			