Unannounced Care Inspection

Name of Establishment:	**Phoenix Clinic & Resource Centre**
RQIA Number:	**1281**
Date of Inspection:	**3 February 2015**
Inspector's Name:	**Karen Scarlett**
Inspection ID:	**16823**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 General Information

Name of Establishment:	Phoenix Clinic & Resource Centre
Address:	1 Lansdowne Road Newtownards BT23 4NT
Telephone Number:	028 91822111
Email Address:	phoenixclinic@hotmail.co.uk
Registered Organisation/ Registered Provider:	Phoenix Healthcare (N.I.) Ltd Mr Iain McCartney
Registered Manager:	Mrs Karen Lynda Edwards
Person in Charge of the Home at the Time of Inspection:	Mrs Karen Lynda Edwards
Categories of Care:	NH-PH, NH-PH(E)
Number of Registered Places:	36
Number of Patients Accommodated on Day of Inspection:	28
Scale of Charges (per week):	£650.34
Date and Type of Previous Inspection:	19 May 2014, secondary unannounced inspection
Date and Time of Inspection:	3 February 2015 11.00 – 16.30
Name of Inspector:	Karen Scarlett

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- Discussion with the Registered Nurse Manager
- Discussion with staff
- Discussion with patients individually and with others in groups
- Consultation with relatives
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- Review of a sample of care plans
- Observation during an inspection of the premises
- Evaluation and feedback

5.0 Consultation Process

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

Patients	5
Staff	5
Relatives	0
Visiting Professionals	0

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

Issued To	**Number Issued**	**Number Returned**
Patients	0	0
Relatives/Representatives	5	0
Staff	10	2

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

Phoenix Clinic and Resource Centre is situated on the outskirts of Newtownards, off the Comber Road. It is situated in a residential area and the local town can be accessed by taxi. The home provides a minibus which is funded by the home and used for day trips for patients.

Phoenix Clinic and resource centre is a purpose built facility and provides accommodation for thirty six patients. All patient accommodation is on the ground floor. All bedrooms have ensuite facilities. A number of communal lounge areas are available throughout the home and one lounge is in the process of being converted into a multi-sensory room for patients.

There are grounds to the rear of the building with an open area at the front, which is popular with patients.

The home provides a range of facilities including a physiotherapy room, a diversional therapy room and a hydro therapy pool.

The certificate of registration issued by the RQIA was displayed in the reception area of the home.

The home is registered to provide care for a maximum of 36 persons under the following categories of care:

Nursing care

PH	physical disability other than sensory impairment under 65
PH (E)	physical disability other than sensory impairment over 65 years

8.0 Executive Summary

The unannounced inspection of Phoenix Clinic and Resource Centre was undertaken by Karen Scarlett on 3 February 2015 between 11.00 and 16.30. The inspection was facilitated by Mrs Karen Edwards, registered manager, who was available for verbal feedback at the conclusion of the inspection.

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

A number of documents are required to be returned to RQIA prior to the inspection and these were returned within the specified timeframe and offered the required assurances.

The patients were well presented and appeared relaxed in their surroundings. Those spoken with were satisfied with their care and the staff. One patient raised concerns about their care and this was discussed with the registered manager. Interaction between staff and patients was observed to be relaxed and friendly with attention paid to patients' privacy and dignity. For further information regarding patients' views refer to section 11.5.

There was evidence that a continence assessment had been completed for most but not all patients. When completed, this assessment formed part of a comprehensive and detailed assessment of patient needs from the date of admission and was found to be updated on a regular basis and as required. The assessment of patient needs was evidenced to inform the care planning process. A recommendation has been made to ensure that continence assessments have been carried out for all patients who require continence management and support.

Comprehensive reviews of both the assessments of need and the care plans were maintained on a regular basis and as required in the records reviewed. It was evident from the care records examined that there was some confusion over the target fluid intake for each patient. It has been recommended that the individualised fluid target for each patient must be clearly recorded in their care records.

Discussion with the registered manager confirmed that staff were trained and assessed as competent in continence care. Registered nursing staff were also competent in female and suprapubic catheterisation in order to meet the needs of current patients.

A policy on continence care and management was available in the home but a recommendation has been made that this is updated to reflect current best practice guidelines. It was further recommended that a policy on catheter care and management is developed.

The inspector was informed that a continence link nurse was working in the home and this good practice is commended.

From a review of the available evidence, discussion with relevant staff and observation, the inspector can confirm that the level of compliance with the standard inspected was substantially compliant. Three recommendations have been made in relation to this standard. For further information refer to section 10.0.

The inspector spoke with five staff individually and there were no concerns raised. Staff were positive about working in the home and confirmed that they had received the relevant training.

The home was generally well decorated and presented to a good standard of hygiene throughout. Work was currently underway to convert one of the lounges into a multi-sensory room for patients. One set of bathroom doors in cranberry zone were found to be damaged and one specified patient's bedroom was found to be in need of repainting. A requirement has been made in this regard.

An examination of the care records identified the need for improvement to the documentation concerning the management of wounds and pressure ulcers. A recommendation has been made in this regard. For further information refer to section 11.8.

The inspector can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a satisfactory standard and patients were observed to be treated by staff with dignity and respect.

Details regarding these areas are contained in section 11.0 of the report.

The inspector reviewed and validated the home's progress regarding the three recommendations made at the last inspection on 19 May 2014 and confirmed compliance outcomes as follows: two recommendations were compliant and one regarding record keeping was not compliant and has been stated for a third time.

As a result of this inspection, one requirement and five recommendations, one restated, were made.

Details can be found under Section 10.0 and 11.0 of the report and in the quality improvement plan (QIP).

The inspector would also like to thank the staff who completed questionnaires.

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

9.0 Follow-Up on Previous Issues

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	10.7	It is recommended that care plans relating to the use of lap belts are updated to clearly state who prescribed the use of lap belts, when the lap belts are to be applied, who is responsible for checking the lap belts when in use and a review date should be stated.	Care plans clearly demonstrated that discussion had taken place between the patient, their representative, the physiotherapist and nurses regarding the use of lap belts. The care plans clearly stated when these were to be released and the registered manager confirmed that these were released when the patient received personal care and when repositioning. The repositioning charts were found to be kept accurately. This recommendation has been addressed.	Compliant
2.	10.7	The record of discussion with the relative, relating to the use of any form of restraint, should be more specific to evidence that there has been a consultation process relating to each method of restraint in place for the safety and wellbeing of the patient, rather than the phrase “any other specialized equipment”.	There was evidence in three out of the four records examined that the proformas had been updated to reflect the specific form of restraint used. The registered manager assured the inspector that the old form found in one record would be updated that day. Patients or their representative had signed the consent / discussion forms as appropriate. This recommendation has been addressed.	Substantially compliant

3.	6.2	Registered nurses must sign and date each entry made on care records and the actual date the patient was weighed should be documented in the patient's care records.	An examination of four care records could not evidence that a specific date and time had been recorded for when the patient had been weighed. Similarly, the monthly bed rail checks recorded only the month and year of the checks instead of the full date and time in accordance with NMC record keeping guidelines. This recommendation has been stated for the third time.	Not 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 19 May 2014 RQIA have been notified of no ongoing 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 four patients' care records evidenced that bladder and bowel continence assessments were undertaken for three patients. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. However, there were observed to be two different continence assessment forms in use and one patient did not have a continence assessment completed. A recommendation has been made that one continence assessment is used and that this assessment is completed for all patients. There was evidence in four patients care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. The care plans reviewed addressed the patients' assessed needs in regard to continence management. Review of four patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. There was some confusion evident in the records as to individual fluid intake targets. These were not always accurately specified or recorded in the care plans and one patient had two different targets specified. On discussion with the registered manager she confirmed that this had been discussed with the GP and a fluid target set for all patients. A recommendation has been made that this is recorded accurately on each patient's care plan.	Substantially compliant

Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector can confirm that the following policy and procedure was in place; • continence management / incontinence management This policy was dated from 2010 and a recommendation has been made that this be updated and reviewed in accordance with best practice guidelines. It is also recommended that the home develop a policy on catheter care and management in order to meet the needs of current patients. The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines • RCN guidelines for management of bowel dysfunction • NICE guidelines on the management of urinary incontinence Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not applicable.	Not applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the registered manager and staff and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the manager revealed that all the registered nurses, except for two newly registered nurses, were deemed competent in female and suprapubic catheterisation. More training is planned for the newly registered nursing staff. A continence link nurse is working in the home and this good practice is commended. Regular audits of the management of records are undertaken to include continence care and the findings acted upon to enhance already good standards of care.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

During the inspection staff were noted to treat the patients with dignity and respect. Good relationships were evident between patients and staff. Staff took great care to protect the privacy and dignity of the patients in their care. Efforts had been made to enable patients to communicate effectively, including the use of technology.

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

11.2 Complaints

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

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

The inspector discussed the management of complaints with the registered manager and was assured that complaints were managed in a timely manner and in accordance with legislative requirements.

11.3 Patient Finance Questionnaire

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

11.4 NMC Declaration

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

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

11.5 Patients' Comments

The inspector spoke with five patients individually and with the majority of others in smaller groups. The feedback from the patients was generally very positive. One patient complained that they were not listened to and did not feel involved in their care. On discussion with the registered manager she was aware of a number of issues affecting this patient and she was in the process of arranging an urgent care review with the relevant care manager, the patient and their representative.

A number of patients were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients' comments were as follows:

"The staff are very good to me."
"I am very happy here."

11.6 Staff Comments

The inspector spoke with five staff including registered nurses, care assistants and domestic staff. The inspector was able to speak to a number of these staff individually and in private. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes. No issues of concern were raised by staff.

Examples of staff comments were as follows:

"The staff work as a team."
"The care staff ensure the best possible care for residents."

11.7 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. Damage to the bathroom doors in Cranberry zone was noted and one patient's bedroom needs re-painted. A requirement has been made in this regard.

A number of individually labelled ointments and other medicinal products were found in other patients' rooms. On discussion with two registered nurses and the registered manager it was ascertained that this issue had been identified in an audit undertaken the day before and new products had been ordered from the pharmacy. They were awaiting delivery and assurances were given that this would be addressed as soon as replacement products were available. They also confirmed that care staff had been spoken to regarding this.

11.8 Care Records

The care records were generally maintained to a high standard with evidence of regular review of patients' needs. There was some improvement required in the assessment and management of wounds. The Braden risk assessment was carried out but the total score was not always accurately recorded. One patient was found to be at high risk of pressure ulceration and no care plan was in place to manage this risk. Although repositioning charts were generally well completed there were no individualised timeframes for repositioning recorded on the chart or in the care plans examined.

There were wound care charts in place which is good practice. However, if there was more than one wound being dressed at a time the record did not always reflect which wound was being treated. In addition, the wound care charts and care plans were not always updated to reflect the recommendations made by the nursing staff or the tissue viability nurse. A recommendation has been made in this regard.

12.0 Quality Improvement Plan

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

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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

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**
A nurse carries out an initial assessment using Roper, Tierney Logan 'Activities of Living' and draws up a plan for immediate care. This is based on information from the Care Managemnet Team and Nurse Managers assessment. A comprehensive assessment of patients needs is completed within 11 days of admission. All residents have a 'MUST' assessment completed on admission. A pressure ulcer assessment including nutrtional, pain and continence assessments is carried out on all patients on admission by nurse, and if poosible prior to admission by Nurse Manager.	Compliant

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

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
We have a 'named' nurse system in place. The named nurse plans the care with the involvement from the resident and family if possible, and involving advice from 'MDT'. Residents are referred to TVN as required. When a resident is assessed as 'at risk' of developing pressure sores, a prevention and treatment programme is drawn up and agreed with relevant healthcare professionals. If we had any residents with lower limb or foot ulcration they would be referred to the appropriate health professionals. The Community Dietician works closely with us and residents are referred to her/him if necessary.	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**
Reassesment is on-going and is carried out daily and at agreed time intervals as recorded in nursing Careplans.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
We use research based evidence and guidelines by professional bodies to support all interventions. We use the 'EPUAP' grading for pressure ulcers. Both 'Promoting Good Nutritional Guidelines and Menu Checklist' are avalible for all staff on a daily basis.	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 interventions. A food diary and fluid chart is kept for all those requiring it. A record is kept of all food consumed and/or refused. Referrals are made if necessary and records kept of action taken.	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care delivered is evaluated daily and in addition there are full evaluations of care notes monthly and as required with involvement from patients and their representatives if possible.	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**
Residents are encouraged to be involved in all reviews and to contribute to reviewing outcomes of care if appropriate. The result of reviews and minutes of review meetings are recorded and changes made to care plan. Where appropriate patients and their family are kept informed of the progress towards agreed goal.	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**
Phoenix provides a varied and balanced diet taking into account patients individual needs and preferences and with advice from 'Nutritional Guidelines and Advice Checklist'. All Sp+L and Dieticion recommendations are displayed and adhered to. A choice is offered to all residents other than the daliy menu.	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 document all instructions drawn uo by Speech and Language therapists and they are recorded in careplans and displayed in kitchen. Meals are provided at conventional times and hot and cold drinks are avalible at customary times, and fresh water at all times. There are adequate numbers of staff present at meal times to provide assistance necessary, and to reduce risk. When a patient requires wound care, nurses use the 'Northern Ireland Wound Care Formulary' to help assess wound care, choose appropriate dressing, refer to TUN, GP etc as necessary. Staff have attended recent 3 day wound care course and made literature avalible for all staff. Also TUNworks closely with us.	Compliant

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

Quality Improvement Plan

Unannounced Care Inspection

Phoenix Clinic & Resource Centre

3 February 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Karen Edwards, registered manager during the inspection visit.

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

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

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

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

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.	27 (2) (b) (d)	The registered person must ensure that the following matters are addressed: • Repair / replacement of damaged bathroom doors in Cranberry zone • Repainting of a specified patient's bedroom is undertaken **Ref: section 11.7**	One	Door has been repaired, and specified patients' bedroom is booked to be painted	3 May 2015

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	6.2	Registered nurses must sign and date each entry made on care records and the actual date the patient was weighed should be documented in the patient's care records. **Ref: section 9.0**	Three	Weight charts have been changed from Jan-Dec to actual Date to ensure this is corrected immediately.	3 April 2015
2.	19.1	A standardised continence assessment should be completed for each patient who requires individualised continence management and support. **Ref: section 10.0**	One	A standardised continence assessment is in place for each patient who requires individualized continence management and support.	3 May 2015
3.	26.6	The continence care policy must be reviewed and updated as required and ratified by the responsible person. In addition, a policy should be developed to address catheter care and management. **Ref: section 10.0**	One	The Continence Care policy has been updated, and a policy has been developed to address catheter care and management.	With the return of the QIP
4.	5.3	The recommended target fluid intake for each patient should be clearly recorded in the patient care record. **Ref: section 10.0**	One	The recommended target fluid intake for each patient is now recorded in Patient Care records.	3 April 2015

5.	11.3	Documentation in the care records in relation to pressure area/ wound care should include the following: • the total score of the Braden risk assessment • individualised timeframes for repositioning in the care plan and repositioning charts • if a risk of pressure ulceration is identified a care plan for prevention and management must be put in place • the care plan should be updated to reflect changes / recommendations of nurses and specialists • when there is more than one wound at a time the wound care chart should reflect the number of the wound to which it refers. **Ref: section 11.8**	One	Wound Care update for all staff is booked with TVN for March. Care Records in relation to pressure area/wound care have been updated.	3 April 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	Karen Edwards
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Iain McCartney

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Karen Scarlett	27/3/2015
Further information requested from provider			