Unannounced Primary Inspection

Name of establishment:	**Richmond Nursing Home**
RQIA number:	**1288**
Date of inspection:	**24 July 2014**
Inspector's name:	**Lyn Buckley**
Inspection number:	**17859**

The Regulation And Quality Improvement Authority
9th Floor, Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 90 517 500 Fax: 028 890 517 501

1.0 General information

Name of establishment:	Richmond
Address:	19 Seafront Road Cultra BT18 0BB
Telephone number:	028 90426558
Email address:	office@richmondnursinghome.co.uk
Registered organisation/ Registered provider / Responsible individual	Richmond Nursing Home Ltd Mr Robin Francis Bryans
Registered manager:	Ms Sharon Ruth Radcliff -Bryans
Person in charge of the home at the time of inspection:	Ms S Radcliffe-Bryans
Categories of care:	NH-I ,NH-PH ,NH-PH(E) ,NH-TI
Number of registered places:	35
Number of patients accommodated on day of inspection:	26
Scale of charges (per week):	£650 - £795
Date and type of previous inspection:	20 March 2014 Unannounced secondary care inspection
Date and time of inspection:	24 July 2014 07:35 – 16:30 hours
Name of inspector:	Lyn Buckley

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 is required.

This is a report of an unannounced primary care inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were 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.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

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

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the DHSSPS Nursing Homes Minimum Standards 2008.

The inspection process has three key parts; self-assessment (including completion of self- declaration), pre-inspection analysis and inspection visit by the inspector.

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

- review of any notifiable events submitted to RQIA, in accordance with Regulation 30 of the Nursing Homes Regulations (NI) 2005, since the previous inspection
- analysis of pre-inspection information submitted by the registered person/s
- discussion with the registered manager
- review of the quality improvement plan (QIP) issued at the last care inspection
- observation of care delivery and care practices
- discussion with staff on duty at the time of the inspection
- examination of records pertaining to the inspection focus/themes
- consultation with patients individually and with others in groups
- tour of the premises
- evaluation and feedback.

5.0 Consultation process

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

Patients	8 patient individually and with the majority of others in smaller groups
Staff	7
Relatives	1
Visiting Professionals	2 staff from the Trust visited the home during this inspection. However, given the reason for their visit the inspector only spoke briefly with them regarding this specific area.

Questionnaires were provided, during the inspection, to patients, their representatives and staff seeking their views regarding the service. Concerns raised in the questionnaires were addressed by the inspector either during the course of this inspection or by telephone after the inspection. Refer to sections 9.5 and 12.7 for details.

Issued to	Number issued	Number returned
Patients/residents	5	4
Relatives/representatives	0	0
Staff	9	2

6.0 Inspection focus

The inspection sought to establish the level of compliance achieved regarding selected DHSSPS Nursing Homes Minimum Standard criterion.

The theme/s for the inspection year April 2014–March 2015 are:

- Standard 5: Patients receive safe and 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 regular reviewed;
- Standard 11 (selected criterion): Management of wounds and pressure ulcers;
- Standards 8 and 12 (selected criterion): Management of nutritional needs of patients and weight loss; and
- Standard 12 (selected criterion); Management of dehydration.

The inspector will also consider the management of patients' human rights during this inspection.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Guidance - Compliance statements	**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

Richmond Private Nursing Home is situated on the seafront at Cultra with panoramic views over Belfast Lough. The home is convenient to shopping areas and community services in nearby Holywood Co Down.

The nursing home is owned and operated by Richmond Nursing Home Ltd. Mr R F Bryans and Ms S R Radcliffe-Bryans are the owners of the home. The registered nurse manager is Ms Radcliffe-Bryans and Mr Bryans is registered as the responsible individual for the home.

Communal lounges and a main dining area are provided. Toilets and assisted bathroom/shower rooms are located throughout the home and are clearly signed for ease of identification. A passenger lift ensures that facilities are accessible to all patients and visitors.

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

The home is registered to provide care for a maximum of 35 persons under the following categories of care:

Nursing care (NH)

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.

8.0 Summary of inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Richmond Nursing Home. The inspection was undertaken by Lyn Buckley on 24 July 2014 from 07:35–16:30 hours.

The inspection sought to establish the level of compliance achieved regarding the selected DHSSPS Nursing Homes Minimum Standards. The following are the standard/s and selected standard criterion examined as part of this inspection focus/theme:

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. (Selected criteria)

Standard 8: Nutritional needs of patients are met. (Selected criteria)

Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)

Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria).

The inspector was welcomed into the home by Ms S Radcliffe-Bryans, registered manager, who was on duty and remained in the home throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Ms Radcliffe-Bryans and Ms R Wilson, senior nurse, throughout and at the conclusion of the inspection.

Prior to the inspection, the registered person/s completed a self-assessment using the criteria outlined in the standards inspected. The comments provided by the registered person/s in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector spoke with patients and staff. Two visiting healthcare professionals from the Trust also visited during the inspection. However, the inspector only spoke briefly with them in respect of a specific area. Comments made by patients, staff and one visitor during discussions were positive regarding the management of the home, staff attitude toward patients and families, delivery of care and the cleanliness of the home. There were no issues or concerns raised with the inspector during this inspection. The inspector also observed care practices, examined a selection of records, issued patient and staff questionnaires and carried out a general inspection of the nursing home environment as part of the inspection process.

In addition to the general observations carried out, the inspector also spent one extended period observing staff and patient interaction. These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool was designed to help evaluate the type and quality of communication which takes place in the nursing home. Refer to section 12.3 for details.

As a result of the previous inspection conducted on 20 March 2014 one requirement and three recommendations were issued. These were reviewed during this inspection. The inspector evidenced that the requirement and recommendations issued previously had been fully complied with. Details can be viewed in section 11.

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

Planned staffing levels, as discussed with the registered manager, were confirmed to meet RQIA's staffing guidance for the number of patients resident in the home.

The home's environment was well maintained with a high standard of décor observed throughout the home. There were no issues identified in this regard.

9.0 Summary of inspection findings

9.1 Management of nursing care – Standard 5

The inspector can confirm that at the time of the inspection there was evidence to validate that patients received safe and effective care in accordance with their assessed needs.

There was evidence of comprehensive and detailed assessment of patient needs from the date of admission. This assessment was found to be updated on a regular basis and as required. A selection of relevant risk assessments were also used to supplement the general assessment tool. The assessment of patient need was evidenced to inform the care planning process.

Reviews of the assessment of need, risk assessments and the care plans were maintained on at least a monthly basis or as required. Details were also retained in relation to discussion with patients and their representatives regarding care plans.

There was also evidence that the referring health and social care trust (HSCT) maintained appropriate reviews of the patient's satisfaction with the placement in the home, the quality of care delivered and the services provided. There was evidence that the registered manager was proactive in ensuring care reviews were conducted by the HSCT.

Discussion with the registered manager, review of patient care records and the submitted self-assessment evidenced that there was management processes in place to ensure the delivery of safe and effective care.

Compliance level: Compliant

9.2 Management of wounds and pressure ulcers – Standard 11 (selected criteria)

The registered manager informed the inspector at the start of the inspection that there were no patients in the home who required treatment for a pressure ulcer. However, there were patients requiring wound care.

The inspector evidenced that wound management in the home was well maintained.

There was evidence of appropriate assessment of the risk of development of pressure ulcers. Registered nurses spoken with demonstrated that they were aware of when referral to tissue viability specialist nurses (TVN) for guidance was required.

Care plans for the management of risks of developing pressure ulcers and wound care were maintained to a good standard and in accordance with professional guidance.

Compliance level: Compliant.

9.3 Management of nutritional needs and weight loss – Standard 8 and 12 (selected criteria)

The inspector reviewed the management of nutrition and weight loss within the home.

Richmond Nursing Home is a participant in the SEHSCT nutritional project for patients in nursing homes requiring dietetic input. The inspector reviewed records pertaining to monthly screening and the ‘virtual ward round' undertaken by the home and Trust.

Registered nurses were knowledgeable of patients' nutritional risk and requirements. The senior nurse explained that since the beginning of the project use of nutritional supplements had been virtually eliminated with patients eating their meals which were fortified to provide the required calories and nutrients. The data produced from the results of nutritional screening evidenced that patient weights had stabilising and/or some patients were gaining weight. The benefits of having direct access to an ‘expert' was having a positive effect in managing weight loss in the home.

Therefore, robust systems were evidenced with risk assessments and appropriate referrals to General Practitioners (GP's), speech and language therapists (SALT) and dieticians being made as required.

The inspector also observed the serving of the lunch time meal and can confirm that patients were offered a choice of meal and that the meal service was well managed and supervised by registered nurses. Refer to section 12.3 for more detail regarding the inspector's observation of this meal time.

The inspector reviewed care charts relating to the management of food and fluids. Recommendations were made regarding the content of these records and how they were completed. Refer to section 12.8 and the quality improvement plan (QIP) for details.

Compliance level: Compliant

9.4 Management of dehydration – Standard 12 (selected criteria)

The inspector examined the management of dehydration which evidenced that fluid requirement and intake details for patients were recorded and maintained for all patients.

Daily fluid intake targets were agreed for each patient using guidance provided by the malnutrition universal screening tool (MUST) and dieticians. The registered manager was aware of the recently revised Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes, April 2013; and a copy was available in the home.

Patients were observed to be able to access fluids with ease throughout the inspection. Staff were observed offering patients additional fluids throughout the inspection. Fresh drinking water, various cordials, milk, tea and coffee were available to patients in lounges, dining rooms and bedrooms.

The inspector reviewed care charts relating to the management of food and fluids. Recommendations were made regarding the content of these records and how they were completed. Refer to section 12.8 and the QIP for details.

Compliance level: Compliant

9.5 Patient, representatives and staff questionnaires

Some comments received from patients:

“This is a lovely home and the staff are lovely”
“I enjoy the food; always can get a cup of tea…when I want”
“Love it here”

Some comments received from staff:

“We have lots of training provided for us”
“I like working here”
“Good support and encouragement from management”
“I feel this home provides an extremely high standard of care…”
“All staff members work well together…”

9.6 Additional areas examined

- Records required to be held in the nursing home
- patient and staff quality of interactions (QUIS)
- complaints
- patient finance pre-inspection questionnaire
- NMC registration declaration
- staffing levels
- comments from representatives/relatives and visiting professionals
- environment.

Details of the findings in the above areas can be viewed in section 12 of this report.

10.0 Inspection 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 inspector was satisfied that the management team had processes and systems in place to ensure compliance with the themes and standard criteria inspected. However, areas for improvement were identified in relation to record keeping and that staff must not wear jewellery when on duty in accordance with infection prevention and control regional guidance.

As a result of this inspection one requirement and four recommendations were issued. Details of the inspector's findings can be found throughout this report and in the quality improvement plan (QIP).

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

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

11.0 Follow-up on the requirements and recommendations issued as a result of the previous inspection conducted on 20 March 2014.

No	Reference	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 Article 40(1)	The Regulation and Improvement Authority may at any time require a person who carries on or manages an establishment or agency to provide it with any information relating to the establishment or agency which the Regulation and Improvement Authority considers it necessary or expedient to have for the purposes of its functions. The registered provider / manager must ensure that the self-assessment documentation submitted to the Authority prior to inspection, provides comprehensive details of how the home is achieving the required standard,	The registered person/s submitted the completed self-assessment for the inspection year 2014/15. The inspector reviewed this self-assessment on 15 July 2014. There content provided comprehensive detail of how the home was achieving each criteria to be inspected.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	10.7	It is recommended that the registered manager review and update the documentation used in respect of pressure mats	Review of three patient care records and discussion with the registered manager and other registered nurses confirmed that documentation in respect of pressure mats was reviewed on a regular basis and updated as required.	Compliant
2	23.1	It is recommended that the registered manager review the current accident / falls risk assessment to ensure that the tool used appropriately guides staff on the risk of falls and the action to be taken following a fall. The fall risk assessment must be updated on a monthly basis plus following any fall.	The inspector review the content of patient falls risk assessment in three patient care records. The registered manager confirmed that this tool had been introduced following the previous inspection. The records evidenced that registered nurses were reviewing the risk assessment on a regular basis and following a fall.	Compliant

3	8.1	It is recommended that the registered manager ensures that the MUST calculation considers weight loss over the previous 3-6 months to ensure accuracy of scoring.	The participation of the home in the SEHSCT's nutritional project has ensured that all patients are weighed regularly and 'screened' by registered nurses in the home and by the Trust's nutritional team via 'virtual ward rounds' conducted at least monthly. Where weight loss or a risk of weight loss is highlighted a care plan is implemented in consultation with the dietician.	Compliant

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

Since the previous inspection in March 2014 RQIA have not been notified, by the home or the Trust of any investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues.

RQIA is satisfied that the registered manager and registered nurses, in charge of the home in the absence of the registered manager, are aware of their role and responsibilities in relation to the management of potential or alleged safeguarding allegations.

12.0 Additional areas examined

12.1 Records required to be held in the nursing home

Prior to the inspection a check list of records required to be held in the home under Regulation 19(2) Schedule 4 of The Nursing Homes Regulations (Northern Ireland) 2005 was forwarded to the home for completion. The evidence provided in the returned questionnaire; and review of a selected sample of documents, by the inspector, confirmed that the required records were maintained in the home and were available for inspection.

12.2 Patients/residents under guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) Order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection.

There were no patients, at the time of inspection, in the home who were subject to guardianship arrangements.

12.3 Quality of interaction schedule (QUIS)

The inspector undertook one period of enhanced observation in the home which lasted for 25 minutes in the ground floor dining room during the serving of the lunchtime meal.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area.

Total number of observations	15
Positive interactions	9
Basic care interactions	3
Neutral interactions	2
Negative interactions	1

The inspector evidenced that the quality of interactions between staff and patients was in the main positive (60%).

A description of the coding categories of the Quality of Interaction Tool is appended to this report.

One negative interaction was observed. This referred to a member of staff who was observed to wipe a patient's mouth with their napkin without asking the patient's permission or giving the patient a 'warning' that they were going to do this. Feedback was provided to the registered manager and senior nurse regarding the detail of the QUIS session. Both stated that this tool and the observations were beneficial and would improve awareness and practices.

A recommendation is made that the registered person ensures that all staff are aware of the importance of seeking permission/consent before undertaking tasks for or to patients. This is also in the interests of dignity and respect.

12.4 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 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.

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

The inspector discussed the management of complaints with the registered manager and reviewed relevant records. The inspector was satisfied that complaints were investigated in a timely manner and in accordance with legislative requirements.

12.5 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.

12.6 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.

12.7 Staffing levels and staff comments

Discussion with the registered manager and review of the nursing and care staff duty roster evidenced that the registered nursing and care staffing levels were in line with the RQIA's recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection.

The registered manager informed the inspector that the home did not have any staff vacancies.

Staff were provided with a variety of training, including mandatory training, since the previous inspection. Attendance at mandatory training was required by the management team and actively managed by the registered manager. Review of records, discussion with the registered manager and staff evidenced that a robust system was in place to ensure all staff undertook mandatory training.

During the inspection the inspector spoke with seven staff. The inspector was able to speak to a number of these staff individually and in private. Two other staff returned completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

See comments made in section 9.5.

12.7.1 Patients'/relatives comments

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

Patients spoken with and the questionnaire responses confirmed that patients were treated with dignity and respect, that staff were polite and respectful, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home.

The inspector did have the opportunity to speak with one visitor during the inspection. The visitor came to the home on a regular basis and believed that the care was good. There were no concerns raised.

See comments made in section 9.5.

12.7.2 Professionals' comments

Two healthcare professionals visited the home during the inspection. As previously stated the inspector only spoke briefly with them in relation to a specific area.

12.8 Record keeping

Review of three patient care records and selected care charts evidenced that generally a good standard of record keeping was maintained. However, a number of areas for improvement were identified as follows:

- the inspector found difficulty in retrieving information relating to the dressing of a patient's wound. The information was recorded in the wound observation record and care plan review but no mention was made in the daily progress notes that the wound had been dressed. In addition fluid intake records should be clear and accurate as to the intake over a specified 24 hour period and not recorded to the side of the daily evaluation record.

  It is recommended that care records and charts are clear and accurate in relation to the information recorded. Registered nurses should make use of specific and measurable data when describing care delivery evaluations/outcomes and avoid duplicating information which can cause confusion.

- The inspector reviewed a selection of food and fluid intake charts. This review indicated that these charts were not always used to record food intake as a number recorded the frequency and use of 'nutrilis'.

  It is recommended that charts clearly specify/define what has to be recorded. For example, food charts record food intake.

  The inspector reviewed an overview record which recorded the fluid intake/output for all patients in the home (as required). This record measured the patient's progress at 12 hour intervals and was considered by the inspector to be a useful overview record. However, the inspector noted that staff had altered the data recorded using correction fluid.

  It is recommended that any alterations to records are dated timed and signed and made in such a way that the original entry can still be read.

12.9 Infection prevention and control

Observations made by the inspector during this inspection confirmed that infection, prevention and control measures were in place with one exception; the majority of staff on duty (all grades) were observed to be wearing stoned earrings, stoned rings, bracelets, wrist watches and stoned necklaces. As these items cannot be effectively decontaminated staff must not wear them when on duty and in accordance with regional guidance. A requirement is made in this regard.

13.0 Quality improvement plan

The details of the quality improvement plan appended to this report were discussed with Ms A Mitchell, 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:

Lyn Buckley
The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Appendix 1

<table>
<tr><th colspan="2">Section A</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>On admission, Assessment of Daily Living is carried out by R.N. for all new residents, using the Roper, Logan & Tierney Model of Nursing. Resident's temperature, pulse, respiration, blood pressure and weight are taken and recorded on the initial care plan. The content of the Daily Living Assessments are based on information supplied by Care Management on admission,when applicable and our pre-admission assessment information obtained by visiting the resident at home or in hospital, where possible.</td><td>Compliant</td></tr>
</table>

Within 11 days of admission, a comprehensive full Care Plan is drawn up by R.N. using validated assessment tools e.g. Braden Scale, M.U.S.T. Nutritional Assessment, Continence Assessment, Fall Risk Assessment, Bed Rail Risk Assessment, Bristol Stool Assessment and Moving & Handling Assessment. Additional risk assessments will be included in the Care Plan if R.N./Management assess they are appropriate. On admission, along with a M.U.S.T. Nutritional Assessment, residents and relatives are asked for details of resident's dietary requirements i.e. diabetic diet, vegetarian, S.A.L.T. Also if resident appears underweight or dehydrated a Food/Fluid intake sheet will be kept for 1-2 weeks in order for an accurate assessment of the resident's needs to be obtained and Care Plan amended as necessary. Where possible, prior to admission or on admission, all residents have a Pressure Ulcer Risk Assessment completed. This includes M.U.S.T. Nutritional Assessment Tool, Braden Scale and Continence Assessment and where relevant to resident's condition, a Pain Score Indicator. Where appropriate, wounds are photographed on admission. Residents are assessed to ascertain if a pressure relieving mattress or cushion is necessary.	

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**
As per the Home's policy,each resident is allocated a Named Nurse and Named Carers who are responsible for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual residents and their representatives.	Compliant

The Pre-Admission assessment from the relevant Health Professionals forms the Nursing Care Plan. The Nursing Care Plan monitors and measures the progress of the resident. Advice and recommendations from relevant healthcare professionals such as Tissue Viability Specialist Nurse, Speech & Language Therapist, Occupational Health and Physiotherapist is taken into account and used to promote maximum independence and rehabilitation where appropriate in the Nursing Care Plan. Care Plan Audits and Wound Care Audits are completed each month and any identified areas for improvement are actioned. RNs grade pressure ulcers in accordance with the European Pressure Ulcer Advisory Panel (EPUAP) and NICE/RCN guidance for practitioners. A Tissue Viability Nurse is assigned by the S & E Trust and arrangements are in place to obtain advice, support and wound care management when required. When a patient is assessed as "at risk" of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme is drawn up and agreed with relevant healthcare professionals such as District Nursing Service for arranging delivery of Pressure Relieving Mattresses and Tissue Viability Nurse when advice and support is required. As the residents' condition changes, the surface they are nursed on should reflect the change. Staff's clinical judgement and residents' wishes are an important part of the decision making process. Richmond works in partnership with Dieticians from S&E Trust, who have undertaken a project to test a new model to support the nutritional management of all residents with or at risk of malnutrition. Dietary information from all our residents, M.U.S.T. scores and gradings of any current wounds are given monthly to Dietician involved and she recommends if a new or adjusted Nutritional Treatment Plan is required. The Dietician's monthly recommendations form part of the residents' Nutritional Care Plans.	

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**
RN in charge ensures that the Care Plan is reassessed daily and amended as changes in the patient's needs occur. In line with the Home's procedure relating to care plans, the Named RN reviews and evaluates all nursing interventions on a 4-weekly basis to ensure that the care plan is up to date and relevant to the on-going needs of the patients.	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**
All nursing interventions, activities and procedures are supported by research evidence and recorded in Resident's Care Plan. They are based on guidelines from documents such as National Institute for Health and Clinical Excellence (NICE) and Enteral Tube Feeding in Adults. Nutritional interventions are based on the M.U.S.T. - Nutritional Risk Assessment Tool. Medical device alerts are checked online weekly and relevant alerts are printed, filed and actioned if applicable. Residents who have skin damage are screened for pressure ulcers using the National and European Pressure Ulcer Advisory Panel (EPUAP) annd NICE/RCN guidance as well as using the Braden grading tool. An appropriate plan of treatment is formulated and implemented as required. The "Nutritional Guidelines and Menu Checklist" as per Registered Community Dieticians, NI, March 2006 document is readily available for all staff in the nurses' office and for catering staff in the kitchen.	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, in accordance with NMC guidelines, detailing all nursing interventions, activities and procedures are recorded in the resident's care plan as per procedure SOP037 - Care Plans of Residents. Outcomes are reviewed and evaluated 4-weekly or more often as appropriate - such as Record of Wound Care Progress Charts. The activities co-ordinator keeps her activities records which will also detail outcomes for residents involved in activities. Record keeping training is provided for staff and also receives focus during individual supervision sessions. Menus are dated and a copy kept in menu file in kitchen. Evening meal choices and variations to daily menu for residents' specific requests are recorded on same.	Compliant

Carers report any problems at mealtimes i.e. resident overeating, refusing to eat or that they appear unable to eat or drink, immediately to RN in charge. Problem is noted and recorded on resident's daily statement and further encouraged intake is closely monitored. If action is required the R.N. will discuss same with the GP and if deemed appropriate Dietician and Speech and Language Therapist.	

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
RN's Daily Statement on evaluation form is used to record outcomes on day-to-day basis of resident's care delivery. Residents and their representatives are invited to contribute to the review and evaluation of care and care planning at the Care Management Review meetings. The open management format within Richmond enables residents and their representatives to discuss care issues informally on a daily basis. All care delivery, review/outcomes are subjected to review and evaluation at documented times - as reflected in procedure SOP037 - Care Plans of Residents, and any deficits in the processes addressed by the nurse manager/deputy manager.	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**
On admission, residents and relatives are invited to contribute to the content of their Care Plan. These outcomes of care and evaluation of same are reviewed with the residents and relatives and their Care Manager at the Care Management Review meetings as organised by the local HSC trusts. The documented outcomes from their plan of care are recorded in the HSC trust care management review forms. Any recommendations following the Care Management Review meeting are recorded on the resident's Daily Statement, verbally reported to all relevant staff at handover and resident's Care Plan amended to reflect same. Following a Care Management Review meeting, the Care Manager will send recorded minutes to the Home. These are filed in the resident's medical notes and the resident and/or their representative also receive a copy of the minutes. Progress towards agreed goals is recorded in appropriate section of Care Plan and reviewed by named R.N. at 4-weekly intervals. The resident and their representatives are kept informed of all progress and changes. Communication with residents and their representatives is recorded in communication column on daily evaluation sheet.	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**
Menus are devised to meet "Nutritional Guidelines and Menu Checklist" as per Registered Community Dieticians, NI, March 2006 and are planned on a 3 week cycle and changed seasonally. Where possible, ingredients are sourced locally and all meals prepared and cooked on the premises. Menus are displayed at the entrance to Dining Room. Individual preferences and requirements are recorded on admission and a copy is sent to the kitchen. Daily preferences and requirements are discussed between RN, chef and residents; these are recorded with the Daily Menu sheets. While there is a menu planned for each day, residents, including those on therapeutic or specific diets, are always given an opportunity to discuss an alternative of their choice with the chef. Alterations to the daily menu are recorded on same in the Kitchen.	Compliant

<table>
<tr><th colspan="2">Section I</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>Nurses obtain up to date knowledge and skills in managing feeding techniques for residents who have swallowing difficulties by attending training days provided by the Trust and various Nutritional Supplement Reps. Instructions drawn up by the Speech and Language Therapist are incorporated into the appropriate Care Plans, updated feeding instructions are cascaded to nursing, care and kitchen staff so that all records may be updated.</td><td>Compliant</td></tr>
</table>

Meal times in Richmond are as follows: Breakfast – 0800 – 0900 Morning Tea/Coffee – 1030 – 1100 Lunch – 1300 – 1400 Afternoon Tea/Coffee – 1500 – 1530 Evening Meal – 1700 – 1800 Supper – 1900 – 1930 Residents have fresh cold water (in vacuum jugs) in their rooms on a daily basis. Fluids are offered to residents who are awake during the night time checks. Hot and cold drinks and light snacks are available 24 hours a day. Residents who are on therapeutic and specific diets are also offered appropriate light snacks over a 24 hour period Specific concerns regarding residents' nutritional needs are recorded in their individual care plan and also verbally communicated to staff at each handover. RN in Charge ensures she is present to supervise Carers assisting at mealtimes in dining room. Catering staff ensure that tables and trays are set with appropriate cutlery and aids i.e. plate guards and adapted cutlery. Trays are provided for those residents who choose to remain in their bedrooms to eat. Trays are delivered promptly to ensure food is served hot, the meals and desserts are covered prior to leaving the kitchen and the trays are appropriately set and include condiments. Care staff ensure that resident is positioned appropriately prior to beginning their meal. Senior 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 as per current Trust guidelines. Staff attended a Tissue Viability Seminar on 5 September 2013 and knowledge cascaded to all RN staff.	

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

Appendix 2

Explanation of coding categories as referenced in the Quality of Interaction Schedule (QUIS)

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic care: (BC) – basic physical care e.g. bathing or use if toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.**
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc. (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away • Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an	Examples include: Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

individual's care in front of others	
Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (NS) – communication which is disregarding of the residents' dignity and respect.**
Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions • Not showing interest in what the patient or visitor is saying	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness') • Seeking choice but then ignoring or over ruling it • Being angry with or scolding older patients • Being rude and unfriendly • Bedside hand over not including the patient

References

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.

Quality Improvement Plan

Unannounced Primary Care Inspection

Richmond Nursing Home

24 July 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with the registered manager either during or after the inspection visit.

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

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

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

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

Statutory Requirements This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on the HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and the Nursing Homes Regulations (NI) 2005					
No.	**Regulation Reference**	**Requirements**	**Number of Times Stated**	**Details Of Action Taken By Registered Person(S)**	**Timescale**
1.	13 (7)	It is required that the registered persons shall make suitable arrangements to minimise the risk of infection and toxic conditions and spread of infection between patients and staff. **Ref: 12.9**	One	Auditing Staff training Daily inspection at commencement of each shift.	From the date of this inspection with full compliance by end of August 2014.

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.	7	It is recommended that the registered person ensures that all staff are aware of the importance of seeking permission/consent before undertaking tasks for or to patients. This is also in the interests of dignity and respect. **Ref: 12.3**	One	Observation Staff training Reminding staff on an ongoing basis	From the date of this inspection with full compliance by end of August 2014.
2.	5.6	It is recommended that care records and charts are clear and accurate in relation to the information recorded. Registered nurses should make use of specific and measurable data when describing care delivery evaluations/outcomes and avoid duplicating information which can cause confusion. **Ref: 12.8**	One	Staff training provided to discuss and address the duplication of recording care delivery and ensuring that specific and measurable data is always included in same.	From the date of this inspection with full compliance by end of August 2014.
3.	27.4	It is recommended that charts clearly specify/define what has to be recorded. For example, food charts record food intake. **Ref: 12.8**	One	Staff training Monitoring of recording	From the date of this inspection with full compliance by end of August 2014.

4.	6.3	It is recommended that any alterations to records are dated timed and signed and made in such a way that the original entry can still be read. **Ref 12.8**	One	Staff training delivered on importance of adjustments to record keeping so that the original entry can still be viewed.	From the date of this inspection with full compliance by end of August 2014.

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	Sharon Radcliffe-Bryans
Name of Responsible Person / Identified Responsible Person Approving Qip	Robin Bryans

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Jackie Callan	14/10/2014
Further information requested from provider			