Secondary Unannounced Care Inspection

Name of Establishment:	**Saintfield Lodge**
RQIA Number:	**1291**
Date of Inspection:	**8 January 2015**
Inspector's Name:	**Heather Sleator**
Inspection ID:	**INO16995**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Saintfield Lodge
Address:	4 Old Saintfield Road Belfast BT8 8EY
Telephone Number:	(028) 9081 4010
Email Address:	saintfield.lodge@fshc.co.uk
Registered Organisation/ Registered Provider:	Mr James McCall Four Seasons Health Care
Registered Manager:	Ms Melanie Reyes
Person in Charge of the Home at the Time of Inspection:	Ms Melanie Reyes
Categories of Care:	NH-MP
Number of Registered Places:	51
Number of Patients Accommodated on Day of Inspection:	51
Date and Type of Previous Inspection:	28 October 2013 30 October 2013 Primary Unannounced Inspection
Date and Time of Inspection:	8 January 2015 10:00am–4.30pm
Name of Inspector:	Heather Sleator

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- discussion with the Registered Nurse Manager, Melanie Reyes
- discussion with staff
- discussion with patients individually and to others in groups
- consultation with relatives
- review of a sample of policies and procedures
- review of a sample of staff training records
- review of a sample of staff duty rotas
- review of a sample of care plans
- review of the complaints, accidents and incidents records
- observation during a tour of the premises
- evaluation and feedback

5.0 Consultation Process

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

Patients	10 individually and the majority of others in small groups
Staff	5
Relatives	1
Visiting Professionals	0

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	0	0
Relatives/Representatives	0	0
Staff	4	0

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

Saintfield Lodge Nursing home is situated on the Old Saintfield Road Belfast adjacent to Knockbracken Healthcare Park. The nursing home is owned and operated by Four Seasons Healthcare Ltd and the current registered manager is Ms Melanie Reyes.

The home is a purpose built, two storey building. Accommodation for patients is provided on the ground and first floors of the home. Access to the first floor is via a passenger lift and stairs.

Bedroom accommodation is provided in single rooms situated on both floors of the home. There is a passenger lift between floors and each floor has a dining room and a variety of lounges. Bathroom, toilet and shower facilities are appropriately located throughout the home. The home is surrounded by landscaped gardens and car parking facilities are available.

Each floor has a dining area, designated smoking room, and nurses' station and treatment room. The kitchen, laundry, and hairdressing salon are located on the ground floor.

The home is registered to provide care for a maximum of 51 persons under the following categories of care:

Nursing care

MP mental disorder excluding learning disability or dementia under 65 years.

8.0 Executive Summary

The secondary unannounced inspection of Saintfield Lodge Nursing Home was undertaken by Heather Sleator on 8 January 2015 between 10:00am and 4:30pm. The inspection was facilitated by Melanie Reyes, 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 28 and 30 October 2013.

As a result of the previous inspection one requirement and four recommendations were issued. These were reviewed during this inspection and the inspector evidenced that the requirement and recommendations had been fully complied with. Details can be viewed in the section immediately following this summary.

The inspector reviewed assessments and care plans in regard to the management of continence in the home. Review of patient's care records evidenced that patients and/or their representatives were informed of changes to patient need and/or condition and the action taken. Areas for improvement were identified within the care records and two recommendations have been made.

Nursing staff spoken with on the day of the inspection were knowledgeable regarding the management of urinary catheters and the frequency with which the catheters within the home required to be changed. Discussion with staff and review of training records confirmed that there were staff trained and assessed as competent in urinary catheterisation.

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

Additional Areas Examined

Care Practices
Complaints
Patient Finance Questionnaire
NMC Declaration
Patients and Relatives Comments
Environment

Details regarding the inspection findings for these areas are available in the main body of the report. There were no areas for improvement identified with the additional areas examined.

Conclusion

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

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

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

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	12 (1) (a) (b) Standard 5.6	The registered person shall provide treatment, and any other services to patients in accordance with the statement of purpose, and shall ensure that the treatment and other services provided to each patient – (a) meet his individual needs; (b) reflect current best practice	The inspector verified that this requirement had been addressed. The inspector reviewed four patients' nursing care records. The review of the care plans evidenced care plans had been written in conjunction with assessed need and had been reviewed on a monthly basis.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	5.2 and 5.4	It is recommended an assessment in relation to pain is undertaken on admission and evaluated on a regular basis. Where a patient is receiving treatment of a wound a pain assessment should be undertaken at the time of each dressing and care plans amended if appropriate. The management of pain should be clearly evident in an individual's plan of care.	The inspector verified that this recommendation had been addressed. The inspector reviewed a care plan in relation to wound care management. The review evidenced that a pain assessment had been completed and was reviewed when the wound was redressed and on a regular basis thereafter. The wound management care plan included pain management and the effectiveness of analgesia.	Compliant
2	11.7	It is recommended the registered manager audits patients' care records in relation to wound management.	The inspector verified that this recommendation had been addressed. The registered manager completes a monthly audit in relation to wound care management. This is verified by the regional manager at the time of the monthly monitoring visit and detailed in the monthly report.	Compliant

3	11.3 and 11.4	It is recommended registered nurses ensure wound management includes; - photographic evidence is present of the status of the wound. This should be updated at regular intervals in accordance with NICE guidelines. - skin information leaflets are available and given to patients , where applicable - body mapping charts are updated where wound management is required.	The inspector verified that this recommendation had been addressed. The inspector reviewed wound management in nursing care records. Photographic evidence of the status of the wound was present, body mapping charts had been regularly updated and information leaflets regarding wound care management were available in the home.	Compliant

4	11.3 and 11.4	It is recommended wound assessment recording is completed, in full, each time a wound is dressed. Registered nurses should adhere to the frequency of dressing, as stated on wound assessment recording.	The inspector verified that this recommendation had been addressed. The review of nursing care records in respect of wound care evidenced registered nurses were adhering to clinical guidelines and wound management documentation was completed, in full, at the time of each dressing.	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 28 and 30 October 2013, RQIA have been notified by the registered manager of ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues.

Following discussion with the registered manager RQIA were satisfied that SOVA issues were dealt with in the appropriate manner and in accordance with regional guidelines and legislative requirements.

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 four patients. However, areas for improvement were identified and recommendations have been made. The areas identified for improvement were; • the outcome of these assessments, including the type of continence products to be used, should be incorporated into the patients' care plans on continence care. • a consistent approach to the completion of risk assessment and care planning, detailing the type of incontinence product to be used should be in evidence. Only one care plan reviewed detailed the type of continence product to be used. • care plans should evidence what is current to the patient. If an intervention has changed it should be removed from the care plan. 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. 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. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place; • continence management / incontinence management • stoma care • catheter care The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines • British Geriatrics Society Continence Care in Residential and Nursing Homes • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	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 review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the registered manager revealed that four registered nurses in the home were deemed competent in female catheterisation, male catheterisation and suprapubic catheterisation. Care staff completed training in continence care at the time of induction. The registered manager informed the inspector that training opportunities, such as digital rectal examination, rectal administration of medicines stoma management and catheterisation are provided by the local health and social care trust. Two continence link nurses were working in the home and were involved in the review of continence management and education programmes for staff. This is good practice.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

During the inspection staff were noted to treat the patients with dignity and respect. Good relationships were evident between patients and staff.

Patients were well presented with their clothing suitable for the season. Staff were observed to respond to patients' requests promptly. 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 reviewed the complaint record. This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements.

11.3 Patient Finance Questionnaire

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

11.4 NMC Declaration

Prior to the inspection the 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 and Relatives Comments

During the inspection the inspector spoke to 10 patients individually and to others in groups. These patients expressed high levels of satisfaction with the standard of care, facilities and services provided in the home. Examples of patients' comments were as follows:

"I have no complaints."
"Food is ok."
"Staff are good, they're busy but still talk to you."
"I like it here."

The inspector spoke to one relative. The relative was satisfied with the care afforded by staff and stated “staff keep in touch and respond very quickly to anything I ask of them”.

11.6 Questionnaire Findings/Staff Comments

There were no questionnaires returned to the inspector at the time of the inspection.

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.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Melanie Reyes, 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:

Heather Sleator
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
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Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Upon admission to the unit an identified nurse carries out and records an initial needs assessment using validated assessment tool .In conjunction with the needs assessments we use a range of assessment tools to assess the patients care needs, such as the BRADEN Scale to predict the risk of pressure sores, the MUST malnutrition screening tool to identify nutritional needs, continence risk assessments, wound assessments, bed rail assessments and long term fall risk.	Compliant

Saintfield Lodge being a mental health unit would be utilizing assessment tools such as scale for dangerousness and scale for suicidal ideation for above risks. . All tools are ongoing and reviewed regularly. Information received from the Care Manager will also be included in this assessment. An identified nurse completes a comprehensive and holistic assessment of the resident's care needs using the validated assessment tools as cited in 5.1, within 11 days of admission. All the residents in the Home are assessed using the Malnutrition Universal Screening Tool A pre admission assessment is carried out on all residents prior to admission to the home where possible. A FSHC pre admission document is used for this purpose. This document consists of 16 sections which includes drug therapies and medication (including pain), mobility, nutrition, continence, personal hygiene and dress, skin integrity (which identifies Braden Scale and any required equipment) and infection control. As well as this pre admission assessment, information from Care Management is gathered. On admission to the home risk assessments as cited in 5.1 are completed with associated care plans devised. A plan of care is then developed to meet the resident's needs in relation to any identified risks . Discussion with the resident/representative in relation to their needs, wishes and expectations is carried out and can be evidenced in the care plan and on consent forms.	

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**
An identified named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs. The plan of care is discussed and agreed with the resident/representative - this can be evidenced by their signature on each individual care plan. Care plans are written in a person centered way and	Substantially compliant

demonstrate the promotion of of maximum independence and rehabilitation by stating what the resident can do for themselves. Advice and recommendations from other health professional such as TVN, podiatrist, dietician, speech and language therapist, physiotherapist and occupational therapist are taken into account and can be evidenced in the multidisciplinary team form, care plan and in the evaluation of care plan form. Registered nurses in the home are fully aware of the referral process. There are referral forms held in a designated file in the nurses office, which are used when a referral is necessary, this file also holds the name, address and contact number. This can be followed up with a phone call to the TVN where advice can be given prior to their visit. In the absence of the community TVN, staff can contact FSHC TVN for advice and if necessary a visit will be arranged. Where a resident is assessed as being 'at risk' of developing pressure ulcers, a care plan will be commenced. This care plan will be person centred, will identify all care to be provided to prevent a pressure ulcer from forming and will give due consideration to advice received from other multidisciplinary members. The treatment is agreed with Care Management and relevant members of the MDT. This is reported to the Regional Manager and monitored through the monthly dashboards as one of the key performance indicators. Should the need arise the GP is contacted and referral to the dietician made. Any patient having been seen by a dietician is reflected in their care plan	

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The plan of care will indicate the frequency of review and re assessment. The resident will be assessed on an ongoing daily basis and any changes noted in the progress notes and care plan evaluation form. Any change will be reported on the 24 hour shift report for the Home Manager's attention. Dressing regimes will be documented in the care plan with frequency of dressing change indicated. All dressing changes will be documented on the ongoing wound assessment form and on the care plan evaluation form. Due date for dressing change will be diarised and carried forward after each intervention.	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 guidelines such as - EPUAP - European Pressure Ulcer Advisory Panel (2009), NICE Guidelines: The prevention and treatment of pressure ulcers (2005), NICE Guidelines: The use of pressure relieving devices (beds, mattresses and overlays) for the prevention of pressure ulcers in primary and secondary care (2003), NICE Guidelines: Information for the public- Pressure ulcers - prevention and treatment (2005), and CREST Guidelines: Guidelines on the general Principles of caring for ptients with wounds (1998). A resource file is situated in the nurse's office in which nurses can refer to as necessary. The named nurse who is responsible for assessing and screening a resident who has skin damage uses the EPUAP grading system. Following this grading an appropriate plan of care is devised. There are up to date guidelines on both units of the home which staff can refer to.	Substantially compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are contemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome of plan. Food intake charts are maintained on all patients at all times and Fluid balance charts are maintained for those patients at risk Care plans are in place for patients identified to not be eating or drinking well. Referrals are made via GP when required	Substantially compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care delivered is monitored and recorded on a daily basis on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan of care or more frequent if there is a change in the resident's condition. Residents and/or their representatives are involved in the evaluation process.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Outcomes of the care are discussed at care management reviews with the patients and the relatives. Participation is encouraged in this review and issues are addressed in relation to the care needs as soon as possible. The staff at Saintfield Lodge are encouraged to be visible and approachable, discussing all aspects of care with relatives and patients on an ongoing basis both formally and informally. The manager is also on hand to provide support and assistance to all parties. Review meetings are recorded by the care manager at time of review. These forms are sent to either the patient or their representatives for a written account of what has been discussed and agreed upon at the meeting. The nursing care plan is amended to reflect any changes. The care plan agreement can then be signed when the patient/representative agrees with the changes and a time scale for goals agreed. The patient/representative is updated on all changes in condition on an ongoing basis and this is reflected in the care plan. A care review meeting can be called at anytime, but it doesn't always have to be called if a patient/representative wishes to discuss the care informally.	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**
Patients are offered a choice of meals at mealtimes. All modified diets as directed by SALT are adhered to and care planned. At each mealtime there is a choice of food on the menu. The choice for patients who cannot express their needs is made by staff who choose according to the patients likes and dislikes. Menus are displayed outsied the dining room on a notice board. Menus are written daily on a whiteboard inside the dining room.	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**
Staff have experience of patients with feeding difficulties through working in the Home. Meals are at set times throughout the day. In between mealtimes snacks are available throughout the day. Fluids are are distributed throughout the home.	Substantially compliant

Staff are present to supervise patients in the dining room. Staff are aware of any patient who is at risk of choking, or who require assistance or supervision. Each nurse has completed an education module on pressure area care. The home will have a link nurse who will receive enhanced training, to provide support and education to other nurses within the home on an ad hoc basis. Central training on wound care related topics will be arranged on at least on a monthly basis, for nurses requiring further educational support. All nurses within the home will have a competency assessment completed. Competency assessments will have a quality assurance element built into the process.	

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Care Inspection

Saintfield Lodge

8 January 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with Melanie Reyes, registered manager, at the conclusion of the inspection visit.

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

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

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

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

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	19.1	It is recommended continence care plans detail the type of continence product to be used and the details of the patient's toileting programme. **Ref: criterion 19.1**	One	Addressed .Supervision arranged with trained staff to reinforce person centred care planning that is specific to resident's continence needs	One month
2	5.3	It is recommended care plans accurately reflect patients' needs. Care interventions detailed in care plans should be current and not historical, for example if a care intervention within a care plan is no longer applicable the care plan should be amended at the time of the monthly evaluation, or before. **Ref: criterion 19.1**	One	Addressed. Regular Care Profile audits carried out. Findings cascaded to staff and Primary Nurse to ensure care plans are accurate and reflecting resident's needs.	One month

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	MELANIE REYES
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Carol Collins CAROL COLLINS DIRECTOR of OPERATIONS

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable			
Further information requested from provider			

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	
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	X	Heather Sleator	06/03/15
Further information requested from provider			