Unannounced Care Inspection

Name of Establishment:	**The Somme Nursing Home**
RQIA Number:	**1300**
Date of Inspection:	**20 January 2015**
Inspector's Name:	**Lyn Buckley**
Inspection ID:	**IN017862**

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

1.0 General Information

Name of establishment:	The Somme Nursing Home
Address:	121 Circular Road Belfast BT4 2NA
Telephone number:	0289076 3044
Email Address:	admin@thesommenursinghome.co.uk
Registered organisation/ Registered provider/ Responsible individual:	The Somme Nursing Home Mr Jonathon Kitson – responsible individual
Registered manager:	Ms Gail Chambers
Person in charge of the home at the time of inspection:	Ms Gail Chambers
Categories of care:	NH – I, PH, PH(E) and TI
Number of registered places:	41
Number of patients accommodated on day of inspection:	41
Scale of charges (per week):	£581 - £681
Date and type of previous inspection:	4 February 2014 Secondary unannounced care inspection
Date and time of this inspection:	20 January 2015 10:15 – 16:00 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 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 responsible individual
- discussion with the registered manager
- discussion with staff on duty at the time of this inspection
- discussion with patients individually and with others in groups
- consultation with relatives visiting at the time of this inspection
- review of a sample of patient care records
- review of a sample of records required to be held in the home
- observation of care practices
- 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	**14 and with others in groups**
Staff	**3**
Relatives	**3**
Visiting Professionals	**0**

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

Issued To	Number Issued	Number Returned
Patients	**3**	**3**
Relatives/Representatives	**0**	**0**
Staff	**10**	**8**

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

The Somme Nursing Home is situated just off the Circular Road; Holywood Road, which is a mature residential area. The home is operated by the Board of Directors. The responsible individual is Mr CJ Kitson, executive director, and the registered manager is Ms Gail Chambers. Ms Chambers took up her post at the end of March 2014.

All bedrooms are situated on the ground floor and have en suite facilities. The home is split into four units. Each unit has its' own décor, living / dining area and communal sanitary facilities. The corridor that connects the unit is called' The Street' and there is a large communal area where patients can meet and where activities take place. Patients and their visitors also have access to tea and coffee making facilities and an enclosed central garden. Communal areas are bright and inviting, as are external garden areas.

Catering, laundry and cleaning services are provided 'in house'.

The home is registered to provide care for a maximum of 41 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 Executive Summary

The unannounced/announced inspection of The Somme Nursing Home was undertaken by Lyn Buckley on 20 January 2015 between 10:10 and 16:00 hours. The inspection was facilitated by Ms Gail Chambers, registered manager. The inspector also met and spoke with one member of the Board of Directors and Mr Jonathon Kitson, responsible individual and executive director of the Board. Verbal feedback at the conclusion of the inspection was provided to Ms Chambers and Mr Kitson.

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 4 February 2014.

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

As a result of the previous inspection two requirements were issued. These requirements were reviewed during this inspection and evidence was available to confirm that all but one element of one requirement had been addressed. Details of the inspector's review can be found in the section immediately following this summary.

Additional areas also examined included:

- care practices
- care records
- complaints
- patient finance questionnaire
- NMC declaration
- patients' and relatives comments
- staff comments
- staffing
- environment.

Details regarding these areas can been found in section 11.

Conclusion

The inspector can confirm that at the time of inspection the delivery of care to patients was evidenced to be of a good standard and that care was safe, effective and compassionate. The home was found to be calm and relaxed. Patients were observed to be treated with dignity and respect by staff. Patients and relatives spoken with were very clear in their praise of staff in relation to staff attitude and care delivery. Good relationships between patients and staff were evident.

The home was found to be warm, fresh smelling and spotlessly clean throughout.

In relation to the standard inspected; the inspector can confirm that the management of continence within the home was well maintained and the home is assessed as being compliant with this standard. Refer to section 10 for further details.

As a result of this inspection, two requirements and two recommendations are made.

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

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

9.0 Follow-Up on previous issues raised during the unannounced secondary care inspection conducted on 4 February 2014.

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	14(2) (c)	It is required that at the time of each patient's admission to the home, the following minimum information should be completed on the day of admission to the home. • a validated nursing assessment such as Roper, Logan and Tierney • validated bedrail assessment • a validated pressure risk assessment such as Braden • a validated nutritional risk assessment such as MUST • a validated falls risk assessment • a validated safe moving and handling assessment. The registered manager must ensure that named nurses are aware of their responsibilities in this regard.	**The inspector examined three randomly selected patient care records which evidenced that this requirement had been complied with.** **Discussion and review of records evidenced that the registered manager had implemented a system using interim 'paper records'. On the day of a patient's admission registered nurses recorded a comprehensive assessment of need, including any relevant nursing risk assessments, on the 'paper record' and then transferred the information to the computerised record adjusting and developing the care planning process as required.**	**Compliant**

2.	15 (2) (a) and (b)	It is required that one patient's care plan is further developed to evidence; • Whether or not this patient requires and/or has bed rails in use. • Consultation has taken place with the patient and/or their representative regarding the use of a conveen catheter.	**The inspector and registered manager were unable to accurately identify the patient referred to in this requirement.** **Therefore, the management of bedrails was reviewed separatley. Refer to section 11.2** **The inspector examined three randomly selected patient care records which evidenced that consultation with patients and or their representatives was recorded within the patients care record.**	**Substantially 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. Refer to section 11.3.

Since the previous inspection in February 2014, RQIA have been notified by the home of any incidents involving patients or staff in accordance with Regulation 30 of the Nursing Homes Regulations (NI) 2005 and any investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues.

During discussion, of a historical safeguarding case, the registered manager demonstrated that they had dealt with the issues 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 three patients' care records evidenced that bladder and bowel continence assessments were undertaken at the time of admission to the home. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. Assessments and care plans were reviewed on a monthly basis. The care plans reviewed addressed the patients' assessed needs in regard to continence management. Where registered nurses suspected that a patient had a urine infection, a urinalysis/test was undertaken and patients were referred to their General Practitioners (GPs) in an appropriate and timely manner. Review of 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.	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 guideline documents were in place: • RCN continence care guidelines • RCN guidelines for nurses on the management of lower bowel conditions/DRE • NICE guidelines on continence care in care homes • Incontinence product specific information – various appliances.	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 assessed on this occasion.	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 nursing and care had received training in continence care at the time of induction and thereafter, in relation to the use of products and appliances. Registered nurses in the home have received training in male and female catheterisation. The registered manager confirmed that if required patients could be referred to a continence specialist with the Trust.	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 inspector observed the moving and handling of two patients using the hoist. Techniques for moving and handling were in accordance with safe handling guidelines.

The inspector observed that registered nurses were administering medications at the commencement of the inspection process and that in some areas the morning medication administration was still underway as patients were preparing for their mid-day meal. It was concerning to then observe that the 'lunch time' medication administration commenced a short time after the completion of the morning administration.

This observation was discussed with one registered nurse and the registered manager. A recommendation is made that the registered manager reviews/audits the length of time taken for medication rounds and that any identified issues are addressed to ensure medicines are administered as prescribed and in accordance with prescribed therapeutic time lapses.

11.2 Care records

The inspector examined three randomly selected patient care records in relation to the management of bedrails.

It was evidenced that registered nurses undertook a bedrail risk assessment on the day of admission and reviewed this assessment regularly. However, the records reviewed did not indicate if bedrails were in use or not. In addition there was no evidence of the rationale for the use of bedrails particularly when the risk assessment tool directed the registered nurse to 'use with caution' or 'should consider alternatives'. This was discussed with the registered manager and a requirement is made.

11.3 Complaints

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

11.4 Patient Finance

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.

11.5 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.

The inspector examined the NMC registration checks and confirmed that a system was in place whereby registration checks were effectively managed.

11.6 Patients and relatives comments

During the inspection the inspector spoke with 14 patients individually and with others in smaller groups; and with three relatives visiting at the time of inspection.

Patients spoken with and the responses to the questionnaires (three) confirmed that patients were treated with dignity and respect, that staff were polite and respectful, that patients' needs were met in a timely manner and that they were happy and felt safe living in the home.

The inspector was impressed by the overwhelming positive response in relation to questions regarding staff attitude toward patients and the delivery of care. One patient stated:
'they [staff] *are excellent; all through the home'..*

Relatives also readily described their positive experience of the home, describing staff attitude and care delivery as excellent. This is commendable.

11.7 Staff Comments

During the inspection the inspector spoke with three staff and received eight completed staff 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. One staff member recorded the following comment; *'I feel the quality of care in The Somme is second to none'.*

Three out of eight staff questionnaire responses indicted that staff were 'dissatisfied' that they did not have enough time to listen and talk with the patients. However, the majority of staff responses, comments from patients and relatives, observation of care delivery and review of planned staffing levels indicated that patients were not rushed and that staff did take their time when delivery care.

11.8 Staffing levels

The inspector discussed the planned staffing levels for the home and reviewed the nursing and care staff duty rotas for the week commencing 19 January 2015. The registered manager confirmed that staffing levels were kept under review to ensure the assessed needs of patients were met. The registered manager informed the inspector that the home was staffed on the basis of a high dependency levels for all patients; irrespective of the dependency assessment outcome.

Staffing levels on the day were observed to meet the needs of the patients in a timely manner.

11.9 Environment

The registered manager accompanied the inspector on an inspection of the premises. The inspector viewed the majority of the patients' bedrooms, communal bathroom/shower and toilet facilities and all the lounge/dining areas. The home was found to be warm, fresh smelling and spotlessly clean throughout. Staff are to be commended for their efforts.

A few issues were identified as requiring improvement as follows:

- the inspector observed in one sluice that the door to the sluice was open and cleaning materials and other chemicals such as 'milton' and various spray bottles and tin were easily accessible. The registered manager determined that the lock on the cupboard within the sluice was broken. The registered persons during feedback agreed to check other sluices in the home, to remove the chemicals and cleaning product, as necessary, until a locking device could be fitted to the door of each sluice and to confirm they had done so by email to the inspector. A requirement is made.

  An email was received by the inspector on 21 January 2015 confirming that chemicals had been removed from sluices and that coded locking devices were to be fitted that day to the sluice room doors

- the use of microwaves by nursing and care staff should be reviewed to ensure that food hygiene practices are adhered to, particularly in respect of reheating requirements. A recommendation is made.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with the responsible individual and 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

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**
On admisssion to the home a nurse carries out a detailed activities of daily living assessement using the Roper, Logan and Tierney asssessment tool. This assessment will include any appropriate Risk Assessment using validated tools. This will form the bases of a care plan which is agreed with resident (where able) and the relaitves. The nurse will use any Care Management infromation to assist in this assessment. Within 11 days a full holistic care paln including all risk assesment will be completed. On admission and at least monthly or as resident needs dictate a MUST assessment will be carried out to establish a base line for each residents BMI and weight. During the pre-admission and admission process as well as MUST, a Pain and Continence Assessment will be carried out. Information will be gathered regarding any Pressure Ulcers or potential to develop and using clincial judgement any appropriate equipment will be supplied by the home.	Compliant

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

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The named nurse will continue to discuss,plan and agree nursing interventions with resident / relatives to ensure that each resident is encouraged to maintian as much of their own independence where possible. Where recommendations have been supplied by other relevant Health Care professioanls these are discussed with the resident / relative to ensure that the resident is fully aware of the advice that has been given in relation to activities of daily living, this will include such thing as their mobility, the use of pressure relieving equipment. Where a resident has a compromise in that they could / have developed a pressure ulcer then an RN will send an immediate referral thorugh to Tissue Viability nurse in mean time she will use her clinical judement if a dressing is required and best practice to maintain the conditon of the pressure ulcer. An agreed plan will be discussed with the residnent and relative this could include the use of an ulternating pressure relieving mattress and cushion, a repositioning chart and increase in protein content of diet. Where there is a pressure ulcer in the lower extemities then a referral with be put through to Poditary, again clinicla judgement and pressure reliving aids will be used to ensure that zero pressure is maintained to the lower extermities. If while monitoring nutritional intake either through recording or observation that the resident is nutririonally compromised, then G.P. will be contacted asked to make a referral to Dietician.The resident will be encouraged with a forified diet ; i.e. cream , butter and milky puddings / drinks will be provided. The resident will be commenced on an Food & Fluid chart to closely monitor their intake. MUST risk assessment will be re-evlauated and weekly weights will be recorded while awaiting guidence from Dietician. Once seen by Dietician then their recommendations andplan will be impletemented and resident encouraged with same.	Compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Each resident will have their care needs monitored and recorded on a day to day basis they will be further evaluated at least monthly or when there is any change in residents condition, with the resident and relatives involvement where able to ensure that goals are realistic and care remains relevant to that individual.	Compliant

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<tr><th colspan="2">Section D</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 5.5
• 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)</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>All nurses use evidence based rearch and professional guidence in the delivery of safe and effective care to residents. The use of the Braden risk assessment is used to screen residents before admission on admission and at least monthly or when as changes occurs in any residents condition; to monitor their risk of pressure ulcer damage or potential damage. This is used to ascertain care needs and implement a care plan with appropriate treatment for that individual. This could include the use of pressure relieving equipment, commencement of a "Repositioning Chartt" to ensure that resident position is regularly altered, skin intergitity is checked and prevent any or further damamge. The nurse and chefs, use current nutritional guidelines on a daily bases to ensure that residents receive well balance nutrirional diet incoropating foods from all main food groups. This is especially important in relation to residents who have special diets or nutrition - related disorders.</td><td>Substantially compliant</td></tr>
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<tr><th colspan="2">Section E</th></tr>
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<tr><td>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</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 maintain contemporaneous records in accordance with NMC guidelines which include all nursing interventions, activities and procedures that have been carried out. Nurses will aslo keep records in same fashion of nursing interventions that any resident does not wish to have carried out with reason for same. A record is kept of the meals provided so that they can be inspected to ensure that they provide a nutritionly adequate diet for all residents. All residents are offered the choice of two different meals at each sitting and where a resident is unable to choose for themselves then the staff will be aware of likes and dislikes and any special requirements and will record that they have chosen for that resident. Staff record all food and fluids that are consumed on a daily bases for all residents. Where a resident is either under or over eating then this is discussed a the resident will be commenced on a Food and Fluid chart to to monitor accordingly. Where necessary referral is made to Dieticians through own G.P. for advice and plan of nutritional care. all such referrals and will be discussed with the resident / relatives and a record kept in the residents care plan progress notes.</td><td>Substantially compliant</td></tr>
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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**
All Nurses will monitor the care that is delivered and record on a day to day basis the outcome to ensure that it meets residents need and remains appropriate. Each residents individual care paln will be further review on a monthly bases , all care needs and risk assessment will be fully evlauated to ensure that no changes have occurred (and if so this will be discussed with the resident / relative) and new goals will be established and implemented.	Compliant

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<tr><th colspan="2">Section G</th></tr>
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<tr><td>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)</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>Resients and their relatives are kept up to date with any changes that occur in their care needs and are offered to contribute to the outcome of the care delivered on a monthly bases when evaluations are being conducted or as an when a residents condition dicticates.Residents and their relatives are encouraged to be present at all Care Management reviews so that they can contributes to the delivery of the care that is provided by the home to ensure that it meets their needs. Any agreed action plan at these meetings will be documented and a nursing care plan with appropriate changes and realistic goals developed, so that all parties can progress towards these goals. A hard copy is kept of Care Management reviews for reference.</td><td>Compliant</td></tr>
</table>

<table>
<tr><th colspan="2">Section H</th></tr>
<tr><th 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.</th></tr>
<tr><td>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)</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>The Nursing Homes provides a well balanced and varied nutritious menu that meets individual needs and preferences of all residents. The Nurse Manager works with the Catering staff to ensure that the menu is constructed using Nutritional guidelines and taking into account the time of year for seasonal foods and special occassions. the menu offers two choices for main meals and where a residents doesn’t wish any of these then the Chef will endevour to provide the choice for that resident. A record is kept if the choice that was to be provided is unable to be served and reaosn for same, this will be informed to the residents and the alternative choice that is being offered. Menus are dispalyed in the dinning room for each day so that resient / relatives are aware of the meals to be provided.</td><td>Compliant</td></tr>
</table>

<table>
<tr><td colspan="2">Section I</td></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 and Care Staff have training and skills to ensure that they are able to assist residents who require various feeding techiniques due to swallowing difficulties. These will be recorded in the residents care plan plus any instructions that that have been provided by Speech and Lanaguge therapists, this could include the use of special utensils or cups. These instructions are evaluated and all staff keep fully informed of any resident who is experiencing difficulty. Where a resident is having a degree of diffiuculty with food and fluids and while awaiting Speech and Language input then a safe consitency for that resident will be commenced and SALT informed of same. Meals are provided at conventional times but where a resident prefers to eat at a later time then this can be accomadated. Hot</td><td>Compliant</td></tr>
</table>

and cold drinks and snacks are available at all times. All staff are available at all meals times to enusre that adequate asssitance is provided to all residents. If a resident has a wound then all Nursing staff have attended training and are up to date on wound assessment and dressing choice, relevant guidelines are also available in theHome so that staff can refer to these fro furhter guidence. Nurse will discuss with each other to ensure that safe and effective care is delivered to all residents at all times.	

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

Quality Improvement Plan

Secondary Unannounced Care Inspection

The Somme Nursing Home

20 January 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with Ms G Chamber, registered manager and Mr CJ Kitson, responsible individual, 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	12 (1)	Patient care records must contain evidence of the decision making process for the use, or not, of bedrails following an assessment of need. **Ref: Section 11 (11.2)**	One	Clear instructions have been given to all RN's in regard to Bedrail Risk Assessment, Care Plans been in place in relation to same and documentation of the decision made.	By end of February 2015.
2	14 (2) (a) (b) and (c)	Any chemical used within the home must be stored securely and in accordance with COSHH regulations. **Ref: Section 11(11.7)**	One	On day of inspection all chemicals where removed from cupboards in sluice rooms. Next day key entery locks where applied to sluice room doors.	Urgent action required.

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	37	A review/audit of the length of time taken for medication rounds should be undertaken to ensure medicines are administered as prescribed and in accordance with prescribed therapeutic time lapses. **Ref: Section 11(11.1).**	One	A full review / audit of medication rounds will be undertaken and kept under review to ensure that medicines administered are in accordance with prescribed theraputic time lapes.	By end of February 2015.
2	35	A review of the use of microwaves by nursing and care staff should be undertaken to ensure that food hygiene practices are adhered to; particularly in respect of reheating requirements. **Ref: Section 11(11.8)**	One	All nursing / care staff will receive Basic Food Safety and a detailed record will be maintained of any food that is required to be re-heated by nursing / care staff.	By end of February 2015.

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

NAME OF REGISTERED MANAGER COMPLETING QIP	Gail Chambers
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jonathan Kitson

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Lyn Buckley	23/02/15
Further information requested from provider			