Unannounced Secondary Care Inspection

Name of establishment:	**Tennent Street (Sandringham Suite)**
RQIA number:	**1302**
Date of inspection:	**20 November 2014**
Inspector's name:	**Norma Munn**
Inspection number:	**IN017026**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Tennent Street Sandringham Suite
Address:	1 Tennent Street Belfast BT13 3GD
Telephone Number:	02890312318
Email Address:	tennent.street@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Health Care Mr James McCall
Registered Manager:	Ms Jacquelyn Grace Cairns
Person in Charge of the Home at the Time of Inspection:	Ms Narcisa Urbano
Categories of Care:	Nursing-I,PH, PH (E), TI
Number of Registered Places:	17
Number of Patients Accommodated on Day of Inspection:	17
Scale of Charges (per week):	£581
Date and Type of Previous Inspection:	Primary Unannounced Inspection 7 August 2013
Date and Time of Inspection:	20 November 2014 11:00 – 15:00
Name of Inspector:	Norma Munn

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 Jill Finlay, Acting Manager of Parkview Care Home in the absence of Jacquelyn Cairns, Registered Manager
- Discussion with Narcisa Urbano, Clinical Lead Nurse
- Discussion with Methyl Dagooc, Clinical Lead Nurse
- Discussion with patients individually and to others in groups
- Review of a sample of policies and procedures
- Review of a sample of staff duty rotas
- Review of a sample of care plans
- 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	**8 individually and to others in groups**
Staff	**6**
Relatives	**0**
Visiting Professionals	**0**

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

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

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

Tennent Street Care Centre is situated off the Crumlin Road in Belfast. There are shops, churches and amenities nearby.
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The nursing home is owned and operated by Four Seasons Health Care
The current registered manager is Ms Jacquelyn Grace Cairns.

The Care Centre has three suites, individually registered as separate homes.

This report refers to the Sandringham Suite.

The Sandringham Suite is a small, single storey unit of seventeen single rooms, all with ensuite facilities. Communal lounge and dining areas are provided. The kitchen, laundry and staff facilities are located centrally and accessed by all Suites

The Sandringham Suite is registered to provide care for a maximum of seventeen persons under the following categories of care:

Nursing care

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

8.0 Executive Summary

The unannounced inspection of Sandringham Suite, Tennent Street Care Centre was undertaken by Norma Munn on 20 November 2014 between 11:00 and 15:00 hours. The inspection was facilitated by Methyl Dagooc, clinical lead nurse.

Verbal feedback of the issues identified during the inspection was given to Methyl Dagooc clinical lead nurse , Narcisa Urbano, clinical lead nurse and Jill Finlay, acting manager of Parkview Care Home (who attended in the absence of Jacquelyn Cairns, registered manager) 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 7 August 2013.

Review of pre-inspection information submitted by the registered manager indicated that notifiable events were provided to RQIA in accordance with legislation. Analysis of other documentation including the returned QIP from the previous care inspection on 7 August 2013 confirmed that sufficient information had been provided.

During the course of the inspection, the inspector met with patients and staff, who commented positively on the care and services provided by the nursing home.

Standard 19: Continence Management

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

Additional areas were also examined including:

- care practices
- patients' views
- staffing and staff views
- environment

Details regarding these areas are contained in section 11 of the report.

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

A review of the staff duty rosters weeks commencing 3 November 2014 and 10 November 2014 evidenced that the planned number of staff on duty was in line with RQIA'S recommended minimum staffing guidelines.

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. Issues in relation to health and safety were identified and requirements have been made.

The inspector reviewed and validated the home's progress regarding the one requirement and one recommendation made at the last inspection on 7 August 2013 and confirmed compliance

outcomes as follows: The recommendation has been fully complied with and the requirement has been substantially complied with. One aspect of the requirement in relation to the cigarette debris at the entrance to the suite was discussed with staff and a recommendation has been made.

As a result of this inspection, two requirements and one recommendation have been made.

Details can be found under Sections nine and eleven in the report and in the quality improvement plan (QIP).

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

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

9.0 Follow-Up on Previous Issues

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
1	27 (2) (b)	The registered person shall, having regard to the number and needs of the patients, ensure that the premises to be used as the nursing home are of sound construction and kept in a good state of repair externally and internally. Attention should be given to the areas discussed in the summary and include: • the mechanical ventilation in the bathroom/shower/toilet facilities should be assessed as a number of these facilities were malodourous at the time of inspection • the registered manager should ensure remedial action is taken regarding the base of any bed which does not have a protective/washable	Review of the environment and discussion with staff identified that the majority of issues had been addressed. However, the inspector observed cigarette debris at the entrance to the suite and on the grass verge. This was discussed with staff and a recommendation has been made.	Substantially compliant

		covering • a number of bedrooms require to be repainted and walls made good. The bedrooms were identified to the registered manager • cigarette debris was observed at the entrance of the suite and on the grass verge • the raised beds outside the suite which are patients see should be planted and/or made more attractive for patients enjoyment • the outlook of the lounge and some bedrooms is of the entrance to the main kitchen and laundry. Consideration should be given to enhancing the outlook from these areas for patients • the menu board in the dining room was difficult to read, a new menu board should be provided.		

No	Minimum Standard Ref.	Recommendations	Action taken – as confirmed during this inspection	Inspector's validation of compliance
1	11.6	It is recommended information on skin care and prevention of skin damage is available in an accessible format for patients, and their representative.	Discussion with staff confirmed that information has been made available on skin care and prevention of skin damage for patients, and their representatives	Compliant

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. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. There was evidence in three 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 three patients' 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. The care plans reviewed addressed the patients' assessed needs in regard to continence management. 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 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 • 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	
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 clinical lead nurse confirmed that staff were trained and assessed as competent in continence care and stoma care. The inspector was informed that two male patients in the home required catheter care and one registered nurse had recently attended training in male catheterisation. Regular audits of the management of incontinence are undertaken and the findings acted upon to enhance already good standards of care.	Compliant

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

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.

Discussion with the clinical lead nurse confirmed 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' Views

During the inspection the inspector spoke to eight 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. One patient informed the inspector that a bathroom sponge could not be located in her bathroom. The inspector discussed this concern with the clinical lead nurse to address. A number of patients were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients' comments were as follows:

"The salads are beautiful"
"Food is quite good."
"Care great"
"Everyone is well looked after"

11.6 Questionnaire Findings/Staff Comments

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

Examples of staff comments were as follows;

“It is a really happy and caring environment “
“The staff are very caring and very pleasant”
“We have time to listen and talk to our residents”
“Good communication”

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. Patients’ bedrooms were observed to be homely and personalised. The inspector observed several radiator covers to be damaged and needed repaired or replaced. Discussion with the maintenance person confirmed that replacement radiator covers had been ordered

Discussion with staff indicated that room temperatures on the day of the inspection were higher than normal. This was discussed with the clinical lead nurse and the maintenance person and it was agreed that a review of the room temperatures would be carried out and if necessary room temperatures adjusted accordingly.

It was observed that the fire doors in the kitchenette, dining room and front entrance were being wedged/propped open. The practice of wedging/propping open fire doors must cease and a requirement has been made.

The following environmental issues were also identified and require to be addressed:

- Incontinence products were stored in the electric room
- The electric room was unlocked despite signage displayed on the door “ keep locked “

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Methyl Dagooc clinical lead nurse , Narcisa Urbano, clinical lead nurse and Jill Finlay, acting manager of Parkview Care Home 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:

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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**
Prior to admission to the Home, the Home Manager or designated representative from the Home carries out a Pre-Admission assessment. Information is gleaned from the resident/representative (where possible), the care records and information from the Care Management Team informs this assessment. Risk Assessments such as the Braden Tool are carried out, if possible, at this stage. Following a review of all information, a decision is made in regard to the Home's ability to meet the needs of the resident. On admission to the Home an identified nurse completes the initial assessments using a Person Centred approach. All documentation is on Epicare system , there are no paper assessments it is all completed electronically .The nurse	Substantially compliant

communicates with the resident and/or representative, refers to the Pre-Admission assessment and to the information received from the Care Management team to assist him/her in this process. There are two assessments completed within twelve hours of admission:- an Admission Assessment which includes photography consent, record of personal effects and record of 'My Preferences' and a Needs Assessment which includes 16 areas of need- the additional comments section within each of the 16 sections includes additional necessary information that its required to formulate a Person Centred plan of care for the Resident. In addition to these two documents, the nurse completes Risk Assessments immediately on admission. These include a skin assessment using the Braden Tool, a body map, an initial wound assessment (if required), a moving and handling assessment, a falls risk assessment, bed rail assessment, a pain assessment and nutritional assessments- including the MUST Tool, FSHC nutritional and oral assessment. Other risk assessments that are completed within seven days of admission are a continence assessment and a bowel assessment. Following discussions with the resident/representative, and using the nurse's clinical judgement, a plan of care is then developed to meet the resident's needs in relation to any identified risk, wishes and expectations. This can be evidenced in the Care Plan and consent forms. The Home and Regional Managers will complete audits on a regular basis to quality assure this process.	

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**
A named nurse completes a comprehensive and holistic assessment of the resident's care needs using the assessment tools cited in Section A, within 7 days of admission. The named nurse devises care plans to meet	Substantially compliant

identified needs and in consulation with the resident/representative. The care plans demonstrate the promotion of maximum independence and focuses on what the resident can do for themselves, as well as what assistance is required. Any recommendations made by other members of the multidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable. Registered nurses in the Home are fully aware of the process of referral to a TVN when necessary. In the Belfast Trust the TVN can be contacted directly via the Quality Assurance department , the Specialist Nurse team is an added point of contact for the nursing staff in the home and they provide a lot of support . . Referrals are also made via this process in relation to residents who have lower limb or foot ulceration to either the TVN or a podiatrist. If ncessary, a further referral is made to a vascular surgeon by the G.P, TVN or podiatrist. Where a resident is assessed as being 'at risk' of developing pressure ulcers, a Pressure Ulcer Management and Treatment plan is commenced. A care plan will be devised to include skin care, frequenct of repositioning, mattress type and setting. The care plan will give due consideration to advise received from other multidisciplinary members. The treatment plan is agreed with the resident/representative, Care Management and relevant member of the MDT. The Regional Manager is informed via a monthly report and during the Reg 29 visit. The Registered Nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Staff request a referral to the Dietician via the residents GP l. The dietician is also available over the telephone for advise until they are able to visit the resident. All advice, treatment or recommendations are recorded on the Epicare under therapy section , with a subsequent care plan being complied or current care plan being updated to reflect the advice and recommendations. The Care Plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in the home and other members of the MDT are being kept informed of any changes.	

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 Needs Assessment, Risk Assessments and Care Plans are reviewed and evaluated a minimum of once a month or more often if there is a change in the resident's condition. The plan of care dictates the frequency of review and a re-assessment, with the agreed time interval recorded on the plan of care. The resident is assessed on an ongoing daily basis with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported in the senior cover folder for the Managers attention .. The Home and Regional Managers will complete audits and compile action plans if any deficit is noted.	Substantially 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**
The Home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to. The validated pressure ulcer grading tool used by the Home to screen residents who have skin damage is the EPUAP grading system. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission, then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime, or if the condition of the pressure ulcer changes. There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', 'RCN- Nutrition Now', 'PHA- Nutritional Guidelines and Menu Checklist for Residential and Care Homes' and 'NICE Guidelines- Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in relation to nutrutional care, diabetic care, care of subcuteanous fluids.	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 plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines- Record keeping: Guidance for nurses and midwives. Records of the meals provided for each resident at each mealtime are recorded on a daily menu choice form. The Catering Manager also keeps records of the food served and includes any specialist dietary needs. Residents who are assessed as being 'at risk' of malnutrition, dehydration or eating excessively have all their food and fluids recorded in detail on a daily basis on the touch screen food and fluid section . The fluid intake is totalled at the end of the 24hr period, and the nurse utilises this information. If any deficits are found appropriate action is taken and this is recorded in the residents notes .If a referral is required to a memebr fo the MDT the nurse informs the resident and their representative and thisis recorded in the residents notes .	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 on the plan of care or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their representatives are involved in the evaluation process.	Substantially 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**
Care Management Reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the residents file. Any recommendations made are actioned by the Home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals.	Substantially 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**
The Home follows FSHC policies and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and receommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if required. The Home has a 3 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives- residents meetings, one to one meetings and food questionaires. The PHA document- 'Nutritional and Menu Checklist for Residential and Nursing Homes' is used to ensure that the menu is nutritious and varied. Copies of instructions and recommendation from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs. Residents are offered a choice of two meals and desserts at each meal time, if a resident does not want anything from the daily menu, an alternative meal of their choice is provided. The menu offers the same choice, as far as possible, to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room.	Substantially 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**
Registered nurses and care staff have received training on dysphagia this year .. The Speech and Language therapost and dietician also give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines- 'Nutrition Support in Adults' and NPSA document- 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for feeding, equipment to use and assistance required. The kitchen	Substantially compliant

receive a copy of the SALTs recommendations and this is kept on file for reference by the kitchen. Special diets are displayed in the kitchen and on meal record charts. Meals are served at the following times; Breakfast- 08.30 Morning Tea- 11.00 Lunch-12.30 Afternoon Tea- 15.00 Dinner- 17.00 Supper- 19.30 There are variations to the above if a resident requests to have their meals outside of these times. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. There are foods available outside of these times for those residents who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedroom, these are replenished on a regular basis. Any matters concerning a residents eating and drinking are detailed on each individual care plan- including for e.g. likes and dislikes, type of diet, consistency of fluid, any special equipment required and if assistance is required. A diet notification form is completed for each resident with a copy given to the kitchen and one held in the care file. Meals are not served unless a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Appropriate aids such as plate guards and specialised cutlery are available as necessary and as indicated in the plan of care. Each nurse has completed an education e-learning module on pressure care. The Home has a link nurse who has received enhanced training, to provide support and education to other nurses within the Home and on an ad hoc basis. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the Home have a competency assessment completed. Competency assessments 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**
	Substantially compliant

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Secondary Unannounced Care Inspection

Tennent Street (Sandringham Suite)

20 November 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Methyl Dagooc clinical lead nurse , Narcisa Urbano, clinical lead nurse and Jill Finlay, acting manager of Parkview Care Home 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	27 (4)	The registered person must ensure that the practice of wedging/propping open fire doors must cease. **Ref: Section 11.8**	One	This has been addressed.All wedging and propping open of doors has ceased.	By 20 December 2014
2	14 (2)	The registered person must ensure that • the electric room remains locked when not in use • the storage of products in the electric room must cease **Ref: Section 11.8**	One	This has been addressed.The electric room remains locked when not in use,and the storage of products in the electric room has ceased.	By 20 December 2014

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	32.5	The registered manager must review the disposal of cigarette debris to improve the appearance of the front entrance to the suite. **Ref: Section 9.0**	One	This has been addressed,all cigarette debris has been removed and the area is monitored on a regular basis to ensure it remains free of debris.	By 20 December 2014

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Jackie Cairns
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall Carol Cousins 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	Yes	Norma Munn	30 January 2015
Further information requested from provider			