Unannounced Care Inspection

Name of Establishment:	**Hollygate**
RQIA Number:	**1308**
Date of Inspection:	**28 November 2014**
Inspector's Name:	**Loretto Fegan**
Inspection ID:	**IN017005**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Hollygate
Address:	126 Upper Knockbreda Road Belfast BT6 9QB
Telephone Number:	02890401272
Email Address:	irene@hollygate.net
Registered Organisation/ Registered Provider:	Hollygate Care Services Ltd
Registered Manager:	Ms Irene Margaret McBurney
Person in Charge of the Home at the Time of Inspection:	Registered manager, Ms Irene Margaret McBurney was present for most of the inspection and registered nurse, A Porter was the nurse in charge for the remainder of the inspection. Mr Mark Emerson, manager, was also present for the duration of the inspection.
Categories of Care:	NH-I, NH-PH, NH-PH(E), NH-TI
Number of Registered Places:	20
Number of Patients Accommodated on Day of Inspection:	20
Scale of Charges (per week):	£567-£690
Date and Type of Previous Inspection:	16 July 2013 Primary Unannounced Care Inspection
Date and Time of Inspection:	28 November 2014 12.05 – 16.50 hours
Name of Inspector:	Loretto Fegan

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- Discussion with the Registered Nurse Manager
- Discussion with Proprietor, Mr Ian Emerson
- Discussion with Manager, Mr Mark Emerson
- Discussion with staff
- Discussion with patients individually and with others in groups
- Consultation with relatives
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff induction records
- Review of a sample of staff duty rotas
- Review of a sample of care records
- Review of the complaints, accidents and incidents records
- Observation during a tour of the premises
- Evaluation and feedback

5.0 Consultation Process

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

Patients	**10**
Staff	**3 (in addition to the registered manager, Mr Mark Emerson, manager and Mr Ian Emerson, proprietor)**
Relatives	**1**
Visiting Professionals	**0**

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

Issued To	**Number Issued**	**Number Returned**
Patients	**2**	**2 (both completed by the inspector with the patients)**
Relatives/Representatives	**1**	**1(completed by the inspector with the relative)**
Staff	**10**	**9**

6.0 Inspection Focus

Prior to the inspection, the registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the 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

Hollygate Private Nursing Home is situated in a residential area of South East Belfast, adjacent to the Knock dual carriageway. The home is owned and operated by Hollygate Care Services Ltd. The current registered manager is Ms I McBurney.

The home provides accommodation and services on two floors, with access to the first floor via a passenger lift and stairs. The bedroom accommodation comprises sixteen single rooms and two double rooms. There are two sitting rooms and one dining room and a number of communal sanitary facilities available throughout the home.

There is a parking area within the grounds of the home. The home is convenient to main shopping areas and community services. Public transport facilities are available close to the home.

The home is registered to provide care for a maximum of twenty 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 Hollygate was undertaken by Loretto Fegan on 28 November 2014 between 12.05 – 16.50 hours. Most of the inspection was facilitated by the registered manager who received verbal feedback prior to going off duty. Mr Ian Emerson, proprietor and Mr Mark Emerson, manager were also present during the feedback at this time. Further feedback was provided to registered nurse A Porter. As agreed with the registered manager, Mr Mark Emerson received the overall feedback at the conclusion of the inspection which highlighted urgent actions to be addressed in relation to referring potential safeguarding issues to the adult safeguarding team in the Belfast Trust and submitting notification to RQIA in this regard. The inspector also requested that a care plan would be immediately put in place for one identified patient regarding a specific pain management issue. A follow-up telephone call was made by the inspector to the registered manager on 8 December 2014 regarding the overall feedback and the registered manager provided verbal confirmation that the urgent actions identified during the inspection were addressed.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous unannounced primary care inspection on 16 July 2013.

Prior to the inspection taking place, the inspector reviewed the completed self –assessment and other information submitted by the registered manager as part of the pre-inspection process (refer to section 11 and appendix 1). The responses in the returned quality improvement plan (QIP) pertaining to the care inspection undertaken on 16 July 2013 and notifiable events submitted by the home to RQIA were also reviewed. The inspector also reviewed incidents submitted to RQIA from the home and followed up specific cases / issues as part of the inspection process.

The inspector observed care practices; this evidenced that the quality of interactions between staff and patients at the time of the inspection demonstrated courtesy, respect and engagement with the patients. Patients including those who were unable to verbally express their views were observed to be well groomed, appropriately dressed, relaxed and comfortable in their surroundings.

Patients spoken with and their questionnaire responses confirmed high levels of satisfaction with the standard of care, facilities and services provided in the home. A relative whom the inspector had the opportunity to speak with was also very positive regarding the standard of care provided. The registered manager agreed to follow up an issue raised by one patient through the adult safeguarding team in the Belfast HSC Trust; refer to section 11.7 for further details about patients and relatives.

Three patients' care records were examined in relation to continence management and support. The care records evidenced that the standard of record keeping in relation to this aspect of care reflected an assessment, care planning and evaluation process which included the promotion of continence / management of incontinence, fluid requirements and patient dignity. It is recommended that a supplementary bowel assessment such as the Bristol stool chart would inform the care plan and evaluation process.

Policies / procedures, induction and training were in place to support registered nurses and care staff in relation to continence management. However, it is recommended that stoma care and catheter care are also included in the home's policies and procedures. These policies / procedures should be further developed /reviewed to include evidence based references.

It was also recommended that evidence based guidelines in relation to bowel / bladder care should be sourced and made available to staff and that regular audits in relation to the management of incontinence should be undertaken to enhance already good standards of care.

A further recommendation was made that all registered nurses receive an update on male and female catheterisation, care of supra-pubic catheters and management of stoma care, until 100% compliance is achieved.

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

Discussion with the registered manager and review of the nursing and care staff duty roster for week commencing 24 November 2014 evidenced that the registered nursing and care staffing levels were in accordance with the RQIA's recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection.

During the inspection, the inspector spoke with a total of three staff; two registered nurses and one care staff, in addition to the registered manager and Mr Ian Emerson, proprietor and Mr Mark Emerson, manager. Nine staff completed questionnaires. Staff responses in discussion and in the returned questionnaires were very positive regarding the standard of care provided to patients. No issues or concerns were raised by staff.

Additional areas were also examined including:

- complaints, incident / accident records
- patients under Guardianship

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

Records examined were in the main found to be maintained in accordance with legislative requirements. However, the following issues were identified:

- two complaints were investigated by the home which should have been referred to the designated officer for safeguarding in the Belfast HSC Trust in accordance with regional Safeguarding of Vulnerable Adults (SOVA) guidance in the first instance. A requirement has been made in this regard.
- A care plan is required to be put in place for an identified patient with regard to a specific pain management issue.

Refer to section 10, 19.1 and Sections 11.2 & 11.3 for further detail.

The inspector undertook an observational tour of the internal environment of the home. All areas were maintained to an acceptable standard of hygiene and décor.

The inspector can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a satisfactory standard.

The inspector reviewed and validated the home's progress regarding the one requirement and six recommendations made at the previous care inspection on 16 July 2013 and confirmed compliance outcomes as follows: the requirement and four recommendations had been fully complied with; two recommendations were substantially compliant.

Verbal feedback of the inspection outcomes were given to Mrs McBurney, registered manager prior to her going off duty on the day of inspection and post inspection. As agreed with the

registered manager, feedback was also given to registered nurse A Porter on the day of inspection and Mr Mark Emerson (manager) received the overall feedback at the conclusion of the inspection which provided written confirmation of urgent actions to be addressed by the home.

As a result of this inspection, two requirements and five recommendations were made. This includes two recommendations restated for a second time.

Details can be found in the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, relatives, registered manager, Mr Ian Emerson, proprietor, Mr Mark Emerson, 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 from Unannounced Primary Care Inspection on 16 July 2013

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	18 (1)	The registered person shall provide facilities and services to patients in accordance with the statement of purpose required by regulation. Particular attention should be given to aspects of the environment including the replacement of lounge chairs and the use of third party bedrails and the serviceability of divan style beds in the home.	The registered manager confirmed that refurbishment has taken place, to include the replacement of some lounge chairs, and also tables and chairs in the dining room. The registered manager also confirmed that all divan style beds and third party bedrails have been replaced with profiling beds. The inspector undertook a tour of the premises which verified compliance with this requirement.	**Compliant**

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	25.13	It is recommended patients and representatives are made aware of the availability in the home of the annual quality report and the regulation 29 monthly monitoring report and they may read the reports if they so wish.	The inspector evidenced that information is prominently displayed informing patients and representatives of the availability of the home's annual quality report and the regulation 29 monthly monitoring reports.	**Compliant**
2	26.1	It is recommended the document 'Safeguarding Vulnerable Adults, A Shared Responsibility (1st Edition 2012) is available for staff reference in the home.	The document 'Safeguarding Vulnerable Adults, A Shared Responsibility (1st Edition 2012) was available for staff reference in the home. All three staff whom the inspector spoke with, were aware of the document.	**Compliant**
3	10.7	It is recommended: • "Let's talk about restraint" Rights, risks and responsibilities (RCN 2008) is available in the home for staff reference and; • where third party bedrails are in use they should be monitored in accordance with health and safety guidelines.	The document "Let's talk about restraint" Rights, risks and responsibilities (RCN 2008) was available in the home for staff reference. All three staff whom the inspector spoke with, were aware of the document. The registered manager confirmed that there were no third party bedrails in use. The twelve bedrooms viewed by the	**Compliant**

			inspector evidenced that these were replaced with integrated bedrails on profiling beds.	
4	5.3,11.6 and 11.3	It is recommended in relation to wound care management: • the dimensions of a wound should be recorded as per NICE guidelines on the wound observation chart each time the wound is dressed; • a care plan in relation to pain management should be developed where need has been assessed as present • the frequency of dressing of the wound should be clearly stated in documentation • regular photographic evidence of the wound should be present in the patient's care records; and • information leaflets regarding wound management and skin care should be available in the home and given to patients and/or representatives, where appropriate.	The inspector reviewed a care record in relation to wound care management. The record provided evidence that: • on 4 out of 8 occasions, the dimensions of the wound was recorded as per NICE guidelines on the wound observation chart each time the wound was dressed; • a care plan in relation to pain management was in place, • the frequency for dressing the wound was clearly stated, • regular photographic evidence of the wound was not present in the patient's care records, • information leaflets regarding wound management and skin care were available in the home for patient and/or representative use. **The aspects of the recommendation in relation to wound dimensions and photographic evidence of the**	**Substantially compliant**

			wound will be stated for the second time and followed up during the next care inspection.	
5	28.4	It is recommended all nursing staff complete training regarding wound management.	The registered manager informed the inspector that 50% of the registered nurses have completed training regarding wound management in October 2013. However, the training record in this regard was not available for inspection. **This recommendation will be stated for the second time and followed up during the next care inspection.**	**Substantially compliant**

6	30.4	It is recommended the competency and capability assessment for the nurse in charge of the home, in the absence of the registered manager reflects: • all sections of the assessment have been completed • both parties sign and date the completed assessment • there is a final statement of competency validated by the registered manager • wound management should be included in the competency and capability assessment	The inspector reviewed the competency and capability assessments undertaken during the past year in respect of two registered nurses who are in charge of the home, in the absence of the registered manager. This confirmed that all aspects of this recommendation were addressed.	**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.

The inspector reviewed the record of complaints since the previous care inspection on16 July 2013 and identified that two complaints were investigated by the home which should have been referred to the designated officer for adult safeguarding in the Belfast HSC Trust in accordance with regional Safeguarding of Vulnerable Adults (SOVA) guidance in the first instance. Refer to Section 11.2 for further detail.

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 for all three patients. These assessments were recorded appropriately and reflected the identification of individual patient need in relation to continence / incontinence or if catheter or stoma care was required. However, as the assessments examined did not include detailed information in respect of the patients' usual bowel function using the Bristol stool chart, a recommendation is made in this regard. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. The care plans evidenced patient / relative involvement regarding the agreeing and planning of nursing interventions and addressed the patients' assessed needs in regard to continence management. However, as agreed with the registered nurse on duty, one identified patient required a care plan to be put in place immediately regarding a specific pain management issue. There was evidence of ongoing evaluation of nursing care taking place in relation to bowel and bladder care. The evaluation in relation to bowel function could be enhanced by using the Bristol stool chart. There was evidence of appropriate referral to General Practitioner / hospital services. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector can confirm that policies and procedures were in place in relation to continence management / incontinence management, however stoma care and catheter care should also be included in the home's policies and procedures. It is recommended that these policies / procedures are further developed /reviewed to include evidence based references. A recommendation has been made for the following guidelines to be readily available to staff and used on a daily basis: • British Geriatrics Society Continence Care in Residential and Nursing Homes • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence • RCN continence care guidelines The registered manager informed the inspector that bowel / bladder care forms part of the induction training for new staff, this was confirmed by examining two staff induction records and also by the care assistant whom the inspector had the opportunity to speak with. A registered nurse advised the inspector that the promotion of continence / management of incontinence is monitored by registered nurses working closely with care assistants in this regard. A recommendation is made that this process is formalised with regular audits to enhance already good standards of care. The document Essence of Care (2010) may be used as a guide to this process.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not applicable	
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:	
The registered manager confirmed that training for registered nurses in relation to male and female catheterisation took place in 2010. A recommendation has been made that all registered nurses receive an update on male and female catheterisation, care of supra-pubic catheters and management of stoma care. The registered manager advised that plans are in place for the representative from the company supplying continence products to provide staff with an update on the use of these products in December 2014.	Substantially compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

The inspector evidenced that the quality of interactions between staff and patients at the time of the inspection demonstrated courtesy, respect and engagement with patients.

Patients including those who were unable to verbally express their views were observed to be well groomed, appropriately dressed and their demeanour indicated that they were relaxed and comfortable in their surroundings.

11.2 Complaints

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

A complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The response returned by the registered manager indicated that complaints received during the year ending 2013 were addressed. The inspector reviewed the record of complaints since the previous care inspection on16 July 2013 and identified that two complaints were investigated by the home which should have been referred in the first instance to the designated officer for safeguarding in the Belfast HSC Trust in accordance with regional Safeguarding of Vulnerable Adults (SOVA) guidance. The inspector requested that these complaints would as a matter of urgency be referred retrospectively to the safeguarding team in the Belfast HSC Trust and that notification of this be submitted to RQIA. Following the inspection, RQIA received confirmation from the registered manager that a copy of these complaints were sent to the monitoring team at the Belfast HSC Trust. A requirement is made that all complaints are assessed in accordance with the regional SOVA guidance to ensure that any safeguarding issue contained therein are referred to the designated officer for safeguarding within the Trust in a timely manner. The home should not initiate any investigation regarding safeguarding issues until directed / agreed by the safeguarding team.

11.3 Records

In accordance with Regulation 19 (2) Schedule 4, a number of records are required to be kept in a nursing home. Prior to this inspection the registered person completed and returned a declaration to confirm that all documents listed were available in the home. The inspector sampled a number to confirm this as follows:

- duty roster record
- record of complaints
- record of accidents/ incidents
- record of visitors to the home
- care records

Records examined were in the main found to be maintained in accordance with legislative requirements. However, please refer to issues identified in section 10, criterion 19.1 and section 11.2 of this report.

The inspector followed up specific cases / issues pertaining to incidents/ accidents previously notified to RQIA. Further to verbal confirmation received on the day of inspection, the registered manager agreed to forward written confirmation to RQIA regarding the follow-up / outcome in relation to these identified events.

11.4 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 and clarification provided during the inspection 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 to RQIA indicated that all nurses, including the registered manager, were appropriately registered with the NMC.

11.6 Patients under Guardianship

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

The registered manager confirmed that there were no patients accommodated at the time of inspection in the home, who were subject to guardianship arrangements.

11.7 Patients/Residents and Relatives Comments

During the inspection, the inspector spoke with ten patients individually. Two of these patients provided responses to the questionnaire.

Patients spoken with and the questionnaire responses confirmed high levels of satisfaction with the standard of care, facilities and services provided in the home.

Patients' comments included:
"I am well looked after"
"staff are good to me"
"I like living in the home"
"staff are respectful"

During the inspection, one patient raised an issue which the inspector requested the registered manager to refer to the adult safeguarding team in the Belfast HSC Trust. Following the inspection, the RQIA have received confirmation from the registered manager that the matter has been referred to the adult safeguarding team.

The inspector spoke with one relative during the inspection, who also provided responses to the questionnaire. The relative spoke highly of the professionalism of the staff and stated that the

family were kept well informed of their relative's condition and the family were content with all aspects of care provided.

11.8 Staffing levels

Discussion with the registered manager and review of the nursing and care staff duty roster for week commencing 24 November 2014 evidenced that the registered nursing and care staffing levels were in accordance with RQIA's recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection.

11.9 Questionnaire Findings/Staff Comments

During the inspection, the inspector spoke with a total of three staff which included two registered nurses and one care staff. Nine staff completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory and additional training. Staff were very positive regarding the standard of care provided to patients and no issues or concerns were raised by staff.

Examples of staff comments were as follows;

"the standard of nursing care within Hollygate is excellent as residents are treated with dignity, respect and are encouraged to participate (as far as possible) with their plan of care. Irene McBurney is an excellent manager and ensures that standards are kept high"
""well supported with training and development"
"staff get on very well together and care is excellent"
"care excellent"

11.10 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 maintained to a high standard of hygiene.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs I McBurney, 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:

Loretto Fegan
The Regulation and Quality Improvement Authority
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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**
On admission the the Nursing Home the nurse on duty has the responsibility to complete Roper Logan and Teirney activities of living assessments as far as possible using information gained from pre-admission assessment and referral forms from multidisciplinary team. Any identified risks are highlighted and a validated risk assessment tool is completed ie Braden score. A plan of care for the resident's immediate risks are completed and enhanced by recording sheets such as repositioning charts. The home's policy states all assessment tools are completed within 7 days. On admission nutritional screening is carried out using MUST tool.	Compliant

Pre admission assessment form includes information on nutrition, pain , continence and skin condition.On admission the Braden score is completed and any immediate risk is high lighted.	

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**
On admission each resident has a named nurse who will discuss, plan and agree nursing interventions with resident/family to meet identified assessed needs.The care plan does promote independence as far as possible. Our calculated risk form states "to allow residents to maximise their potential in remaining independent a certain degree of	Compliant

risk is involved." The wound care policy states referrals to be made to tissue viability when ulcers are grade 2 or above. This service is accessed via call management.Where a resident is assessed as "at risk" a plan of care will be drawn up by the named nurse. The appropriate health professional will be contated when a risk assessment identifies a specfic need ie loss of appetite/ weight and reduced BMI score would result in a dietitian referral. For the residents comfort and as a preventative measure pressure relieving equipment will be requested for thoses patients at medium to high risk. All residents will be referred to podiatry on admission and when any lower limb and foot problems arise. This may be health service or private podiatry depending on residents condition and needs. The home's policy states that dietitian referrals should be sought when BMI is less than 18.5k,unintentional weight loss greater that 10%within previous 3-6 months, resident has eaten little or nothing for more than 5 days or are unlikely to eat little or nothing for 5 days. Dietitian will always visit every six months at least with residents who have a peg tube inserted. A care plan will be written for nutritional problems will include written advice from health care professional. A copy of their recommendations will be photocopied and given to kitchen staff. Audits will be carried out at meal times to ensure all residents receive appropriate diet.	

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 daily evaluation record will state all changes in residents condition. The plan of care will identfy the agreed nursing intervention and on going assessment. The resident/representative will be kept informed of all changes and progress. The plan of care will also be signed by resident/representative as will the monthly evaluations.	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 nursing home has NICE guidelines for the prevention and treatment of pressure ulcers, SIGN guidelines for chronic leg ulcers, RCN guidelines for management of venous leg ulcers, Northern Ireland wound formulary for assessment and mangement of leg ulcers, Gain guidelines for oral health care, for palliative care and for Diabetes in care homes. Public health guidelines for Incidents and outbreaks in nursing homes. These guidelines have been used for creating the home's policies. Residents who are "at risk" of skin damage will be have their skin checked and recorded on CREST repositioning chart which clearly grades their skin. Assessment chart for wound management is recorded when a wound is present. This clearly highlights the factors which could delay healing, type and location of wound, dates referred to multidisciplinary team, a recording chart for each dressing change and wound treatment plan and evaluation. This chart has diagrams for body and feet so as the location of the wound can be clearly marked. 2014 nutritional guidelines and menu checklist now in use in the nursing home, the menus will be up dated using these guidelines also for reference on a daily basis.	Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The home has a policy on NMC guidelines regarding all recordings. Records are kept of all pre-admission assessments, risk assessments, nursing interventions and all reviews and outcomes of care and procedures. All records will be dated, timed and signed by appropriate persons. All visits from multidisciplinary team will be recorded in residents notes and all written instructions will enhance the care plan. All accidents,incidents and complaints are recorded. A detailed record is kept of each resident's choice of menu for lunch and tea time. These records can be cross referenced to the menus. Additional records are kept for those residents who are "at nutritional risk" these indicate the quantity of different foods taken at breakfast, dinner and tea these records also include snacks. Residents at "nutritional risk" will have an identified plan of care, if the resident is unable or chooses not to eat a meal and alternative is offered, if this is refused the resident may be encouraged to eat at a later time or a supplement will be offered if prescribed. I f this is a recurring problem staff will monitor resident's weight on a weekly basis,same will be	Compliant

recorded using MUST tool. Management of the problem will be taken as per the risk, this may need a referral to the dietitian. All residents will have their fluid intake monitored and this will be recorded using fluid balance charts. Each chart will clearly state the amount of fluid the resident requires over 24 hour period this amount is attained depending on residents weight. A resident who is eating excessively will have their weight assessed and GP will be contacted regarding the problem and a referral made to dietitian as per nursing home policy.	

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 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 residents and their representatives.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Residents are encouraged and facilitated to participate in all aspects of reviewing outcomes of care where possible. When residents are unable to participate then families would be made aware of outcomes of care. Residents who are able are encouraged to attend multdiscipary review meetings. Care managers will speak with resident who are unable to attend care manager review meetings. The results of review meetings are recorded in the careplan, copies of the minutes of meetings are kept in the resident's file. The home has not had any issues or concerns from residents/families at review meetings in the past year however it there were required changes these would be recorded in the residents careplan in agreement with resident/family and they would be kept informed of all progress as stated in home's care plan policy.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Menus are rotated over a 3 week cycle and revised every six months using up to date nutritional guidelines ensuring variety . All relevant guidance from speech and language and dieticians are photocopied and a copy given to kitchen staff and one for care plan. A list of residents likes and dislikes are recorded and filed in the kitchen for reference. The menu offers residents two choices at lunchtime only one choice at tea time however if residents do not like the choices an alternative will be offered and the same recorded. Choices are also offered to those on specifice diets this is evidenced by records.	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**
Some staff , nurses, care assistants and cook have already attended swallowing awareness training on 14/3/2013. When speech and language therapists visit the home a nurse will always be present to receive information and techniques for the resident being assessed and will pass on this information at hand over reports and to all staff members. Written information is placed in the residents file beside the associated problem in care plan and a copy of all speech and language recommendations are given to the kitchen staff who file in the ppropriate file for reference on a daily basis. Breakfast is served from approximately 8-10.30am. Lunch is served from 12.45pm and tea from 5pm.	Substantially compliant

Residents who have very delayed swallow and require assistance with feeding are fed approximately 20minutes earlier to ensure adequate time for residents swallowing requirements and to prevent residents being rushed at their meal. Hot drinks, snacks, fresh drinking water and juice are available throughout the day, jugs of fresh drinking water and juice are placed in both lounges each morning and renewed at lunch time. Fresh drinks are also available for residents who prefer to stay in their rooms. Nutritional risk assessments are carried out on admission, reviewed monthly or more often as required. If a risk is identified then a plan of care is put into action. Residents will be referred to the appropriate health professional as per the nursing home nutrition policy based on NICE guidelines. At handover reports all staff are made aware of changes in residents eating and drinking activity and nursing interventions. All caring staff are made available at meal times to ensure adequate supervision and assistance with feeding residents. Advice from the occupational therapist will be sought if necessary aids and equipment are required. Nurses have attended pressure ulcer training prevention and treatment 2013. Compression bandaging and hoisery training took place in the nursing home on 17/4/2014 . All nurses hope to attend update on wound assessment and wound care products in July 2014.	

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

Quality Improvement Plan

Secondary Unannounced Care Inspection

Hollygate

28 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 the registered manager either during or after the inspection visit.

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

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

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

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

Statutory Requirements

This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Nursing Homes Regulations (NI) 2005

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	16 (2) (b)	The registered person must ensure that a care plan is put in place for an identified patient with regard to a specific pain management issue **Ref – Section 10.0, criterion 19.1**	One	Pain plan of care and pain tool in place.	From date of inspection
2	14 (4)	The registered person must ensure that arrangements are in place to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse by: • ensuring that all complaints are assessed in accordance with the regional Safeguarding of Vulnerable Adults (SOVA) guidance and any safeguarding issue contained therein are referred to the designated officer for adult safeguarding within the Trust in a timely manner. • The home should not initiate any investigation regarding safeguarding issues until directed to do so by the safeguarding team **Ref – Section 9.1 & 11.2**	One	We now report all complaints of any type of alledged abuse regardless how minor or major th ecomplaint may be. In line with our policy, no investigation is initiated until instructed to do so by the safeguarding team.	From date of inspection

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	5.3	It is recommended in relation to wound care management: • the dimensions of a wound should be recorded as per NICE guidelines on the wound observation chart each time the wound is dressed; • regular photographic evidence of the wound should be present in the patient's care records **Ref – Follow up on previous issue (Section 9.0)**	Two	Staff reminded to record wound charts each time a wound is dressed as per homes policy. Photograohs will now be taken of all wounds - policy has been updated to state same.	From date of previous inspection
2	28.4	It is recommended all nursing staff complete training regarding wound management. **Ref – Follow up on previous issue (Section 9.0)**	Two	All nurses who need wound training will be attending training on 24th March 2015.	31 March 2015
3	19.1	It is recommended that a supplementary bowel assessment such as Bristol stool chart informs the care plan and evaluation process **Ref – Section 10.0, criterion 19.1**	One	Bristol Stool CHart has been used in the home for a few years now, however baseline has now been implemented into the assessments of living on admission.	31 December 2014

4	19.2	It is recommended that: evidence based guidelines in relation to bowel / bladder care are sourced a and made available to staff that policies / procedures in relation to continence / incontinence management include stoma and catheter care and are further developed /reviewed to include evidence based references regular formal audits of the management of incontinence are undertaken **Ref – Section 10.0, (criterion 19.2)**	One	We have the following documents available: RCN Improving Continence Care for Patients NICE Urinary Continence Care in Residential/Nursing Homes Essence of Care 2010 - Bowel/Continence Care. NICE Managing Fecal Incontinence Policies and procedures updated and developed. Programme for formal audits of the management of incontinence are being developed.	31 January 2015
5	19.4	It is recommended that all registered nurses receive an update on male and female catheterisation, care of supra-pubic catheters and management of stoma care until 100% compliance is achieved **Ref – Section 10.0, (criterion 19.4)**	One	Spoken to the nursing home support team who state that nurses do not need to retrain in these areas, however received information from the Royal Marsden Documents on elimination so that all staff can read and update. Awaiting date from Coloplast for management of stoma training.	31 March 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	Irene McBurney
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Craig Emerson

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	x	Loretto Fegan	28/01/15
Further information requested from provider			