Unannounced Secondary Care Inspection

Name of Establishment:	**Glenkeen House**
RQIA Number:	**1414**
Date of Inspection:	**2 December 2014**
Inspector's Name:	**Norma Munn**
Inspection ID:	**IN017074**

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

1.0 General Information

Name of Establishment:	Glenkeen House
Address:	100 Glenkeen Church Road Randalstown BT41 3JX
Telephone Number:	(028) 9447 9794
Email Address:	jackie@hutchinsoncarehomes.com
Registered Organisation/ Registered Provider:	Hutchinson Homes Ltd
Registered Manager:	Jacqueline Elizabeth McShane
Person in Charge of the Home at the Time of Inspection:	Jacqueline Elizabeth McShane
Categories of Care:	NH-I, NH-PH, NH-LD RC-I, RC-MP(E), RC-PH(E)
Number of Registered Places:	40
Number of Patients Accommodated on Day of Inspection:	39
Scale of Charges (per week):	£491 - £691
Date and Type of Previous Inspection:	13 June 2013 and 17 June 2013 Primary Unannounced
Date and Time of Inspection:	2 December 2014 10:15 – 16:00
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 Jacqueline McShane, registered manager
- Discussion with staff
- Discussion with patients/residents individually and to others in groups
- Consultation with relatives
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- Review of a sample of care plans
- Review of the complaints, accidents and incidents records
- Observation during a tour of the premises
- Evaluation and feedback

5.0 Consultation Process

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

Patients/Residents	**12 individually and to others in groups**
Staff	**8**
Relatives	**2**
Visiting Professionals	**0**

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**1**	**0**
Relatives/Representatives	**1**	**1**
Staff	**5**	**4**

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

Glenkeen House is a purpose built two storey nursing home situated in a residential area on the outskirts of Randalstown. The nursing home is owned and operated by Hutchinson Homes Ltd. The current registered manager is Ms Jacqueline McShane

The home is entered via an entrance hall and reception area, which leads to lounge, dining facilities and office accommodation. The bedrooms are located on both floors and comprise of 40 single bedrooms. Toilet facilities, showers and bathrooms are located throughout the home. The first floor is accessed by either stairs or passenger lift. There are in-house laundry and catering facilities. Outside, the home is surrounded by well-maintained landscaped gardens and ample car parking is also provided within the grounds of the home.

The home is registered to accommodate 40 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
LD learning disability (1 identified patient)

Residential Care
I old not falling within any other category
MP (E) mental disorder excluding learning disability or dementia over 65 years
PH (E) physical disability other than sensory impairment over 65 years.

The home is also approved to provide day care for up to five persons. No day care was provided at the time of this inspection.

8.0 Executive Summary

The unannounced inspection of Glenkeen House was undertaken by Norma Munn on 2 December 2014 between 10:15 and 16:00 hours. The inspection was facilitated by Jacqueline McShane, registered manager and verbal feedback of the issues identified during the inspection was given to Jacqueline McShane 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 13 June 2013 and 17 June 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 confirmed that sufficient information had been provided.

During the course of the inspection, the inspector met with patients/residents 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
- meals and mealtimes
- patients'/residents' 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/residents was evidenced to be of a very satisfactory standard and patients and residents were observed to be treated by staff with dignity and respect.

The inspector undertook an inspection of the premises and viewed the majority of the patients'/residents' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a high standard of hygiene.

The inspector reviewed and validated the home's progress regarding the two requirements and three recommendations made at the last inspection on 13 June 2013 and 17 June 2013 and confirmed these as compliant.

As a result of this inspection two recommendations have been made in relation to meals and mealtimes.

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

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

The inspector would also like to thank the staff and relatives 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	20 (1) (a)	The registered person shall, having regard to the size of the nursing home, the statement of purpose and the number and needs of patients – Ensure that at all times suitably qualified, competent and experienced persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients.	Review of the staff duty rosters week commencing 23 November 2014 evidenced a deficit in the numbers of staff on duty between 17.30 and 19.45 hours. Discussion with the registered manager indicated that the deficit was due to unplanned compassionate leave. Review of duty rosters for weeks commencing 7 December 2014, 14 December 2014 and 21 December 2014 evidenced that planned staffing levels were in keeping with RQIA's recommended minimum staffing guidelines. The registered manager assured the inspector that staffing in the home will be kept under continuous review to ensure the patients' needs are met	**Compliant**
2	13 (1) (a)	The registered person shall ensure that the nursing home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients.	Discussion with staff, patients and residents and observation of care practices evidenced that patients'/residents' needs were being met in a timely manner.	**Compliant**

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	12.1	It is recommended that the registered manager and the cook meet with patients to determine their satisfaction with the choice, quality and timing of meals served. An action plan should be developed and action taken to address any issues identified.	Discussion with the cook and registered manager confirmed that meetings have taken place and actions have been taken to address any issues.	**Compliant**
2	28.4	It is recommended that further training on dignity and core values is provided for all staff.	Discussion with staff confirmed that further training had been provided. Observation of care practices and discussion with patients/residents evidenced that patients/residents were treated with dignity and respect and needs were being met in a timely manner.	**Compliant**
3	32.3	The registered person should ensure the home contains a purpose built/adapted smoking room or areas as part of the communal space commensurate with the needs of the service user group.	Discussion with the registered manager confirmed that the home currently do not have any patients/residents who smoke	**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

<table>
<tr><th colspan="2">STANDARD 19 - CONTINENCE MANAGEMENT
Patients receive individual continence management and support</th></tr>
<tr><td>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.</td><td>COMPLIANCE LEVEL</td></tr>
<tr><td>Inspection Findings:</td><td></td></tr>
<tr><td>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.</td><td>Compliant</td></tr>
</table>

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 registered manager confirmed that staff were trained and assessed as competent in continence care. Discussion with staff revealed that three identified registered nurses in the home were deemed competent in catheterisation and all registered nurses in the home were deemed competent in the management of stoma appliances. Staff informed the inspector that advice and support for continence management can be sourced from the continence nurse in the local Trust. Discussion with the registered manager confirmed that 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/residents with dignity and respect. Good relationships were evident between patients, residents and staff.

Patients/residents were well presented with their clothing suitable for the season. Staff were observed to respond to patients' and residents' requests promptly. The demeanour of patients indicated that they were relaxed in their surroundings.

11.2 Meals and Mealtimes

The inspector observed a selection of cold drinks being offered to the patients/residents mid-morning. Staff informed the inspector that food or snacks are not always offered at this time. This is not in keeping with best practice as outlined in 'Nutritional guidelines and menu checklist for residential and nursing homes' published by The Public Health Agency and a recommendation has been made.

The inspector also observed the serving of the lunch time meal. Observation confirmed that meals were served promptly and in a timely manner. Staff were observed providing assistance to patients/residents with respect and dignity. Tables were appropriately set with tablecloths, napkins, cutlery, crockery and condiments. The menu displayed on a notice board was difficult to read. This was discussed with the cook and a recommendation has been made

11.3 Patients'/Residents' Views

During the inspection the inspector spoke to 12 patients/residents individually and to others in groups. These patients/residents expressed high levels of satisfaction with the standard of care, facilities and services provided in the home. 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'/residents' comments were as follows:

"My room is always kept clean"
"I am looked after very well"
"The food is very good and I would like more meat"
"Staff are very helpful, very obliging and I am very happy here"

11.4 Relatives Views

Relatives spoken with expressed high levels of satisfaction with the standard of care, facilities and services provided in the home.

Examples of relatives' comments were as follows:

"Glenkeen House is the best, warm friendly home to date"
"Staff are exceptionally pleasant"
"It is very good care here"

11.5 Questionnaire Findings/Staff Comments

During the inspection the inspector spoke with eight staff which included the cook, registered nurses, care staff and ancillary staff. The inspector was able to speak to a number of these staff individually and in private. Four staff completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training 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;

"There is a good team here"
"I love this home, it is well run"
"We have an excellent matron who identifies all our training needs"
"A well run unit, well-staffed"
"Always good feedback from relatives"

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12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Jacqueline McShane, 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:

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

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.1 Prior to admisssion the nurse manager or nurse in charge will carry out an assessment using a validated assessment tool. This is to ensure that the home can meet the resident's needs, this assessment is based on the 12 Activities of Living which will identify any at risk needs and a care plan will immediately be put in place on admission to the home. This assessment will include medical history, allergies, next of kin, religion, a list of current medication list, also involve identifying if any specialist equipment is required e.g. profling bed, airflow mattress, specialist chair, bedrails etc. At this pre admission stage the Gain assessment tool is filled in identifying if the resident is at risk of	Compliant

infection or has had past history of so the home can put measures in place to prevent the spread of infection. The nurse manager or nurse in charge will base her assessment on the Roper Logan and Tierney Model of Nursing. Liason with resident's named worker takes place and a care plan is received and is used in conjunction with the pre assessment to develop a detailed and comprehensive care plan when the resident is admitted to the home, to ensure that the care plan reflects all of the resident's needs. After the pre assessment and receiving the care plan from the named workder and the home is confident it can meet all the needs an admission date is agreed. The resident's GP is also contacted prior to admission and a current medication list is received and the their medical history. 5.2 On admission to the home a named nurse will have been identified who will be responsible for ensuring a holistic assessment of the resident's needs are completed using the Roper Logan and Tierney Model of nursing. Assessments are carried out which include, Braden Scale, Moving and Handling, Falls Risk assesment, Continence assessemnt, Community Nutritional Risk assessment, Oral hygiene, Bedrail assessment, Wheelchair assessment and Resusitation Status. All of the above assessment will be completed immediately and finished within 11 days of admission. 8.1 On admission to the home Nutritional Screening is carried out based on the MUST Tool and reassessed monthly or more frequent if indicated by dietican or if needs present 11.1 Prior to admission to the home the pre assessment will include a skin status, the most Braden Score will be obtained if possible and liason with the named worked will also take place. On admission to the home a body map will be carried out which will identify any areas at risk. Liason with the multidisciplinary team will include information in relation to nutritional status, continence assessment and pain management. On admission the named nurse will carry out a Braden Scale, Nutritional assessement based on the MUST Tool which is based on the clinical judgement of the named nurse	

<table>
<tr><th colspan="2">Section B</th></tr>
<tr><td colspan="2">Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</td></tr>
<tr><td>Criterion 5.3
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</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>5.3 Prior to admission each resident will have been allocated a named nurse who has sole responsibility for planning and agreeing nursing interventions and drawing up a care plan to ensure all identified assessed needs at the pre admission stage and with the named worker's care plan are met. The care plan will be based on the 12 Activities of Living and will include maintaining a safe environment, oral hygiene, personal hygiene, elimination, pain, mouth care,</td><td>Compliant</td></tr>
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eating and drinking, communication, mobility, sleeping and any specified identified medical needs. This care plan will be individualised to reflect the needs of the resident, this is then implemented and assessed and evaluated on a monthly basis or more frequent if need be. Discussion with relatives will also take place to identify any needs the home needs to know about personal preferences eg dietary likes, dislikes, specific routines. Relatives are given the opportunity to see the care plan and signed documentation is placed in the resident's file. Approximately 2 weeks after admission a review will take place with the named nurse, named worker and relatives this will be to ensure that the placement is meeting the needs of the resident and all parties are happy with the placement and care plan that is in place, any areas of concern can be identified and measures put in place to overcome if applicable. Reviews will take place 6monthly or before if need be. 11.2 There are arrangements in place for staff to obtain advice and support from the tissue viability nurse when required. The staff can contact iniatilly for immediate advice and guidance which is then followed up with a written referral on the appropriate forms. 11.3 if a resident is assessed and identified "at risk" of developing pressure ulcers a documented prevention and treatment plan is devised and detailed with the care plan. Liason with other members of the multi disciplinary team will take place, GP, Tissue Viability Nurse, Named Worker and Dietican to ensure all measures are put in place to promote healing and prevention of reoccurence. An Open Wound Chart will be recorded each time a dressing is changed and progress will be recorded in the daily notes 11.8 Staff can make referral arrangements to the relevant health professionals, to tissue viablity nurse via phone iniatilly followed up with a written referral. Staff also have access to the Crest Guidelines, involvement of the GP and dietican for their expert advice, the care plan will be admended to reflect any new interventions put in place as a result 8.3 If the resident has been assessed as high risk following nutritional screening using the MUST tool a referral is made to the dietican immediately. This referral will be made verbally first followed by a written referral and any treatment advised will be implemented immediately. GP will also be contacted so a prescription can be available for any supplements that may have been prescribed. Involvement will other members of the multi disciplinary team will also take place if need be, speech and language therapist may need to be contacted if assessment of the resident's swallowing reflex needs to be carried out. The named nurse will update the care plan to reflect the needs, kitchen staff will be informed followed up with written confirmation when received. The 2014 Nutritional Guidelines and Menu Checklist of Residential and Nursing homes issued by the Public Health Agency will be displayed and the kitchen will have their own copy. Staff will also have access to Dysphasgia Diet Food Texture Descriptors March 2012 issued by National Patient Safety Agency and also Speech and Language Therapy guidelines on diet and fluid consistencies.	

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**
5.4 Reassessment of the resident's needs is on going carried out by day and night staff and recorded in the daily nursing notes. Idntified reassessment dates are documented in the care plan evaluation which is every month or earlier as required.	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**
5.5 Within the home we have research based documentation readily available for staff. Up to date information is displayed in the home. Registered staff are on the live NMC Register and work within the code, care staff are registered on the NISCC register and adher to their standards. Staff have access to the internet and regular nursing magazines are readily available with up to date articles 11.4 The NPUAP (National Pressure Ulcer Advisory Panel 1989) tool is used as advocated by the Crest Guidelines and detailed within the Crest Guidelines for the prevention and management of pressure sores. An appropriate care plan will be devised and treatment plan implemented. 8.4 The national guidelines and menu checklist booklet is readily available for use within the home, a copy is displayed in the kitchen noticeboard	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**
5.6 Nursing records are kept in accordance with the NMC guidelines and contain outcomes for each identified problem following the assessment carried out using the Roper, Logan and Tierney model of nursing. All our records are computerised and we have a policy in place called the do's and don'ts or record keeping which was devised using the NMC record keeping guidence for nurses and midwives. The care plans are audited on a regular basis against this policy to ensure they are followed 12.11 Immediately a resident is admitted to the home the kitchen staff are informed of their dietary needs, a choice of 2 menus is given daily and the kitchen staff keep a record of all meals provided to all residents. Any dietary change received from Speech and Language Therapy a copy is given to the kitchen and the orginal is filed in the resident's file	Compliant

12.2 If it is identified that there is a concern regarding a resident's eating pattern whether it be excessive eating or not eating enough or concerns over fluid intake, the care plan will be updated to reflect this concern, a food and fluid record chart will be kept daily, the fluid requirement for 24hours will be calculated and the total taken will be totalled at the end of the day and staff will be aware of any deficit in the recommended amount. Any concern regarding the resident dietary needs will be referred to the relevant professionals, a copy of the referral will be documented and any immediated actions, recommendations will be implemented and all relevant parties will be kept up to date	

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 care delivered is monitored and recorded in the daily progress notes for all residents on a daily basis over the 24 hour period. The interventions are evaluated monthly or more frequent if there is an identified need. Residents and their representatives are kept up to date of any changes in care by staff as need arises. Formal reviews are carried out after 2 weeks and then 6 monthly thereafter, this is in conjunction with the named worker and family, care plan needs identified and measured against home's care plan to ensure needs are being met. A sheet has been devised and is signed by named nurse, resident and representative after agreeing with the home's care plan and satisfied that all needs have been identified and being met	Compliant

<table>
<tr><th colspan="2">Section G</th></tr>
<tr><td colspan="2">Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</td></tr>
<tr><td>Criterion 5.8
• Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.
Criterion 5.9
• The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>5.8 The care plan is devised on information received from the preadmission assessment, care worker,family representatives and resident if appropriate and are encouraged to attend formal multidisciplinery reviews. A review date is arranged to suit the home and family representatives, on the day of the review residents are invited to attend if suitable, during the review the resident is offered the chance to comment on all aspects of the care that is being delivered to them, a copy of the review is sent to the home and is kept in the resident's file and a copy is sent to their representative

5.9 The results of all reviews are immediately recorded in the residents care records, the care plans are updated to reflect any changes or recommendations. These results will have been agreed with all parties present at the review before being typed up and becoming official. The home will receive a documented copy of the minutes of the review and a copy will be sent to their representative. Residents and their representative are kept informed of progress being made and any change to the nursing care plan by the qualified staff on a daily basis</td><td>Compliant</td></tr>
</table>

<table>
<tr><th colspan="2">Section H</th></tr>
<tr><td colspan="2">Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</td></tr>
<tr><td>Criterion 12.1
• Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.
Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.
Criterion 12.3
• The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.
A choice is also offered to those on therapeutic or specific diets.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>12.1 Residents are provided with a nutitious and varied diet which is tailored to meet individual resident's dairy needs and preferences. The 2014 Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes is readily available in the home and is used as part of the planning menu process. The menu is rotated over a 3 week basis. On admission to the home the cook will find out what the residents likes and dislikes are, if there are any special needs e.g. diabetic, gluten free diet etc. All the meals are home cooked, this includes traybakes/cakes etc provided for afternoon teas. All patients are offered a choice of meals on a daily basis, guidelines are available for all staff on individual residents needs as provided by the dieticans and a copy is given to the kitchen staff

12.3 There is an alternative menu available if the residentf does not like the option available at that specific meal time. There is also a choice available for residents on specific diets e.g. diabetic or soft diets</td><td>Compliant</td></tr>
</table>

<table>
<tr><th colspan="2">Section I</th></tr>
<tr><td colspan="2">Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</td></tr>
<tr><td>Criterion 8.6
• Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.
Criterion 12.5
• Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.
Criterion 12.10
• Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:
o risks when patients are eating and drinking are managed
o required assistance is provided
o necessary aids and equipment are available for use.
Criterion 11.7
• Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>8.6 Training is presently being carried out on nutritional needs of residents including malnutrition importance of fluid consumption, dysphasia, reasons for swallowing difficulties. Any recommendations received from speech and language therapist, a copy is given to the kitchen staff, orginal copy is put into resident's file and the communication book is updated so all staff are aware of changes. Care plans will be amended immediately and evaluated regulary to ensure changes are being implemented. Staff received an update of this training on a yearly basis, and reflects any new documentation received.</td><td>Compliant</td></tr>
</table>

12.5 Breakfast is served between 9.30am and 10.30am, drinks are provided at 11am, lunch is served from 12.30midday to 1.30pm. Tea biscuits, bread and pudding is provided at 3pm, diner is served from 5pm, evening tea with snacks is provided at 7pm. Jugs of water, juice is provided throughout the day to suit the individual preferences of the residents. Throughout the day residents can have tea coffee or snack if they wish outside of the allocated times of meals 12.10 Each resident's care plan will identify their specific dietary needs, all care staff will be kept up to date on any changes affecting the well being of the residents, a written account will be recorded in the communication book. A list has been compiled detailing resident's dietary needs, consistencies and fluid type, Dysphagia diet food texture descriptors and Speech and language therapy department consistencies is displayed on the notice board in the kitchen. Staff also have access to the nutritional guidelines and menu checklist Adequate staffing is available at mealtimes to give assistance to the residents who require it. A table with guidelines on the use of fluid thickener is placed in dining room for all staff to refer to. Specific aids and utensils are available for individual residents if required 11.7 There are regular opportunities available for nurses to attend training sessions in relation to wound assessment and care to develop their expertise and skills in wound management to include carrying out a wound assessment and apply wound care products and dressings.	

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

Quality Improvement Plan

Unannounced Secondary Care Inspection

Glenkeen House

2 December 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 Ms Jacqueline McShane, 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.

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	12.4	The registered person must ensure that the daily menu is displayed in a suitable format so that patients/residents know what is available at each mealtime **Ref: Section 11.2**	One	The writing on the menu board displayed in the dining room is wrote with a black pen instead of a red one making it more visible for the resients to read. The menu board is filled in daily	By 30 December 2014
2	12.5	The registered person must ensure that a variety of hot and cold drinks and snacks are offered to the patients/residents midmorning **Ref: Section 11.2**	One	At the 11 o clock snack trolley, tea and coffee are now offered along with cold juices,a selection of yohurts and biscuits are still provided for the residents	By 30 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	Jacqueline Mc Shane
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Janet Montgomery

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Norma Munn	26 January 2015
Further information requested from provider			