Unannounced Care Inspection

Name of Establishment:	**Lakeview Private Nursing Home**
RQIA Number:	**1421**
Date of Inspection:	**26 March 2015**
Inspector's Name:	**Donna Rogan**
Inspection ID:	**IN017241**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Lakeview Private Nursing Home
Address:	1c Orchard Road Crumlin BT29 4SD
Telephone Number:	02894422733
Email Address:	Dorothy.stafford@adad.co.uk
Registered Organisation/ Registered Provider:	Spa Nursing Homes Ltd Mr Chris Arnold
Registered Manager:	Mrs Dorothy Stafford
Person in Charge of the Home at the Time of Inspection:	Mrs Dorothy Stafford
Categories of Care:	NH - I NH - PH NH - PH(E) NH - TI RC-PH, RC-PH(E) RC-TI
Number of Registered Places:	42 (39 Nursing, 3 Residential)
Number of Patients Accommodated on Day of Inspection:	29 Nursing 3 Residential
Date and Type of Previous Inspection:	10 December 2013 Primary Unannounced Inspection
Date and Time of Inspection:	26 March 2015 10.30 to 16.30 hours
Name of Inspector:	Donna Rogan

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 Residential 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 staff.
- Discussion with patients individually and to others in groups.
- Consultation with three 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	**20**
Staff	**10**
Relatives	**3**
Visiting Professionals	**0**

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**2**	**0**
Relatives/Representatives	**3**	**0**
Staff	**9**	**9**

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

Lakeview Private Nursing Home is a two storey purpose built home situated in a quiet residential area, close to the village town centre of Crumlin.

Accommodation is provided on both floors, in thirty single and six double bedrooms. Access to the first floor is via a passenger lift and stairs. Day areas, kitchen, laundry, toilets and bathrooms facilities are located throughout the home.

Mrs Dorothy Stafford is the registered manager for the facility.

The home is registered to provide nursing care for 39 patients within the category of NH-I, old age not falling within any other category, NH-PH, NH-PH (E) physical disability over and under pension age and NH-TI terminally ill, and residential care for a maximum of three residents within the categories of RC- PH, RC-PH (E) physical disability over and under pension age and RC-TI terminally ill.

The Inspector reviewed the 'Certificate of Registration' issued by The Regulation and Quality Improvement Authority (RQIA). This was appropriately displayed in the front foyer of the home.

8.0 Executive Summary

The unannounced inspection of Lakeview Nursing Home was undertaken by Donna Rogan on 26 March 2015 between 10:30 and 16:30. The inspection was facilitated by Dorothy Stafford, registered manager who was also available for verbal feedback at the conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection of 10 December 2013.

As a result of the previous inspection five requirements were and three recommendations were issued. These were reviewed during this inspection and the inspector evidenced that all five requirements and all three recommendations have been fully complied with. Details of the findings regarding the previous requirements and recommendations can be viewed in the section immediately following this summary.

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

The inspector reviewed assessments and care plans in regard to management of continence in the home. Review of patient's care records evidenced that patients and/or their representatives were informed of changes to patient need and/or condition and the action taken. Nursing staff spoken with on the day of the inspection were knowledgeable regarding the management of urinary catheters and the frequency with which the catheters within the home required to be changed. Discussion with staff and review of training records confirmed that staff were trained and assessed as competent in urinary catheterisation. There were no areas for improvement identified within this theme.

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

Additional Areas Examined

Care Practices
Complaints
Patient Finance Questionnaire
NMC Declaration
Patients/relatives questionnaires and comments
Staff questionnaires and comments
Environment
Care records

Details regarding the inspection findings for these areas are available in the main body of the report. There were issues raised regarding the environment. The issues raised are listed in section 11.7 and a requirement is made in this regard. The inspector commended the quality of the care records on this occasion. They were found to be person centred and up to date and were reflective of patients' needs. One recommendation was made in relation to the care records.

Conclusion

As a result of this inspection one requirement and one recommendation was made in relation to the environment. Details of the requirements can be found in the quality improvement plan (QIP) of this report.

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

The inspector would also like to thank staff 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	29 (3)	The responsible person shall ensure that unannounced visits to the home shall take place at least once a month and shall be unannounced. The responsible person should prepare a written report which should be available in the home upon request.	The inspector reviewed the unannounced regulation 29 inspection reports. They were conducted at least once a month. A written report was prepared and was available.	Compliant
2	20 (1) (c)	The registered manager shall ensure that all staff receives appraisal, mandatory training and other training appropriate to the work they are to preform; Ensure all staff receive an annual update on safeguarding vulnerable adults	The inspector reviewed the appraisal reports for the past year. Appraisals had been conducted for all staff. The registered manager had commenced a programme of appraisals for the incoming year. A review of training records evidenced that staff had received an annual update on safeguarding vulnerable adults.	Compliant

3	15 (2)	The registered manager shall ensure that the assessment of patients' needs is kept under review. Ensure pain assessments are carried out on admission to the home. The primary nurse should ensure that the specifics within the Trust care plan are incorporated into one patient's care plan as discussed. This should be completed using the home's policies and procedures. Ensure wound observation charts are completed every time the wound is redressed. Ensure all entries are signed in the care records by the person making the entry.	The inspector reviewed five care records. All contained assessments of patients' needs and were kept under review. Pain assessments were observed to be carried out on admission to the home. The specifics within the Trust care plans were incorporated into the patients care records. Wound observation charts were completed every time the wound was redressed. The care records reviewed evidenced the signature of the person making the entry in the care records.	Compliant

4	13 (7)	The registered person shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff. The registered person shall address the following issues; • review the mixture of items stored under the stairs in the entrance to the home • the registered manager's office is required to be tidied and re-decorated • dining room furniture is required to be cleaned and replaced • medicines storage area is required to be cleaned and the signage is required to be reviewed • both clinical rooms	The inspector reviewed the infection control audits. They were completed monthly and included an action plan which was addressed. The area under the identified stairs was observed to be cleared. The manager's office is currently being tidied and has been redecorated. Dining room furniture has been replaced. The medicines storage area has been refurbished with new furniture and the signage has been renewed. Both clinical rooms have been totally refurbished	Compliant

		are required to be totally refurbished and redecorated • ensure all emergency equipment is effectively cleaned and accessible • ensure when food is being transported that it is appropriately covered • dust and debris was found in patients bedrooms • review the storage of patients' food in bedrooms • a dessert bowl was observed on top of a clinical waste bin • thoroughly clean the room used for hairdressing • remove the stocking from the identified call bell • remove the extension lead and plug was observed beside the sink	and redecorated. Emergency equipment has been effectively cleaned and was observed to be accessible. Food was observed to be appropriately covered when being transported. Patients' bedrooms were observed to be clean. Food in patients' bedrooms was appropriately stored. There were no items observed to be stored on top of clinical waste bins. The hairdressing room was observed to be clean. All call bells were observed to be appropriately maintained. The extension lead and plug has been removed.	

		• remove the broken socket • review the domestic arrangements in the home to ensure that the home is maintained clean at all times. **Ref 11.4**	The broken socket has been removed. Domestic arrangements have been reviewed and there is sufficient staff on duty to ensure the home is maintained clean at all times.	
5	27	The registered person shall ensure that the fitness of the premises shall meet the needs of the patients, that the premises to be used as the nursing home are of sound construction and kept in a good state of repair externally and internally. The registered person shall ensure that all parts of the nursing home are kept clean and reasonably decorated. The registered person shall take adequate precautions against the risk of fire. The registered person shall ensure the following issues	From the previous inspection a new responsible person has been nominated and registered. A refurbishment and redecoration programme has been identified and agreed with RQIA. The inspector can confirm that the agreed action plan has been adhered to and the home is maintained in sound construction and kept in a good state of repair both externally and internally. The home was observed to be kept clean and reasonably decorated. There were no issues raised regarding fire safety during this inspection.	Compliant

		are addressed; • Replace the dining room furniture and replace/varnish the flooring an action plan of how this will be implemented should be forwarded to the RQIA. • Both treatment/clinical rooms should be effectively cleaned. All emergency equipment should be easily accessible and cleaned. • Domestic staff should be aware of health and safety risks such as the display of 'wet floor' signs. Domestic trollies should never be left unattended. Domestic stores should be kept locked when unattended. • Ensure nurse call system is easily	Dining room furniture has been replaced. The dining room floor has been varnished. Both treatment/clinical rooms were cleaned. All emergency equipment was observed to be clean and easily accessible. Discussion with domestic staff demonstrated that they were aware of health and safety risks such as the appropriate display of 'wet floor' signs. During the inspection domestic trollies were appropriately attended and domestic stores were locked where appropriate. The nurse call system was observed to be easily accessible.	

		accessible. • Ensure a fire risk assessment is completed on the gas and electric fires used in both lounges, prior to them being used. • Confirm in writing that the gas and electric fires have been incorporated in the fire risk assessment and that any recommendations made are actioned. • Ensure that adequate controls are in place to manage risk and any unnecessary risk to the health and safety of patients should be eliminated. • Review the quality of the environment with regards to the management and control of infection. Ensure all areas of the home are	A fire risk assessment was completed regarding the use of the gas and electric fires. They are not currently in use and remain for decorative purposes only and policy and procedure is in place. RQIA has received confirmation that the gas and electric fires have been incorporated into the fire risk assessment. Recommendations have been actioned. Adequate controls are in place to manage any unnecessary risks to the health and safety of patients have been eliminated. The registered manager has implemented infection control audits in relation to the environment and the control of infection. During the inspection all areas of the home were observed to be clean.	

		maintained clean. • Ensure there are no items stored under the stairwells and ensure fire exits are maintained clear at all times. • Provide the RQIA in writing an action plan which includes timescales as to how and when the home will be refurbished and a good standard of decoration maintained. • Remove the free standing electrical radiator from the identified lounge. Monitor the heat in the lounge to ensure it is adequate. • Ensure infection control training is provided to all staff and the information supplied is embedded into practice. • The wedging open of fire doors must	There was no inappropriate storage of equipment stored under the stairwells. Fire exits were observed to be maintained clear. An action plan has been received by RQIA which included timescales as to how and when the home will be refurbished and a good standard of redecoration being maintained. There were no free standing electrical radiators in use in the identified lounge. The heat in the home was comfortable and warm during the inspection. A review of infection control training evidenced training had been arranged and attended on 6 and 8 May 2014 by 30 staff. Discussion with staff demonstrated that the training had been embedded into practice. There were no doors observed to be wedged open during the inspection.	

		cease with immediate effect.		

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	25.12	It is recommended that the regulation 29 visit reports should include the following; • the record of events, for example incidents and accident records; • the record of complaints; and • recorded their opinion as to the standard of nursing provided in the home at the time of their visit. • an action plan identifying any aspects for improvement as an outcome of the visit A recommendation has also been made that any requirements and/or recommendations made by any person/agency authorised to inspect the home should be reviewed at this time. The action taken and progress made in relation to any requirements and recommendations should be	The Regulation 29 visit reports were reviewed and observed to include the following; Information on incidents, accidents and events, A record of complaints. A record was maintained of their opinion as to the standard of nursing provided during their visit. An action plan which identified any aspects for improvement as an outcome of the visit. The report also included the progress made in relation to any person/agency authorised to inspect the home.	Compliant

		monitored by the registered provider/responsible individual.		
2	25.13	It is recommended that the annual quality report includes the following details; • the outcomes of satisfaction surveys • actions taken to address any deficits • evidence of consultation with patients, representatives and staff • training undertaken by staff in the home over the previous 12 months • review of patient/relative meetings and any action taken in response to suggestions/comments made • environmental/estates issues • examples of recreational opportunities for patients • objectives/goals for the incoming year	A review of the annual quality report included the details of all the details as listed in this recommendation.	Compliant

3	11	Ensure the care records include the regular photography of wounds as supporting evidence in keeping with best practice guidelines (NICE). Information leaflets on skin care and prevention should be available in the home for patients and their representative to evidence that any information or education, verbal or written which had been given to patients and their representatives. Evidence should be maintained of whom the information had been supplied and by whom.	A review of the care records evidenced that regular photography of wounds is provided in keeping with best practice. Information leaflets on skin care and preventions are available in the home.	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.

There are currently no ongoing safeguarding issues in the home.

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 five 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. The continence assessment in use was regularly revised. The assessment viewed by the inspector evidenced the decision making processes used to identify the continence needs of the individual. There was evidence in five 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 general practitioner's as appropriate. Review of five patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. The care plans reviewed addressed the patients' assessed needs in regard to continence management. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**Compliance Level**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place; • Continence management/incontinence management. • Stoma care. • Catheter care. The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines. • British Geriatrics Society Continence Care in Residential and Nursing Homes. • NICE guidelines on the management of urinary incontinence. • NICE guidelines on the management of faecal incontinence. Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**Compliance Level**
Inspection Findings:	
Not applicable	Not validated
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**Compliance Level**
Inspection Findings:	
Discussion with the registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the registered manager revealed that registered nurses in the home were deemed competent in female catheterisation, male catheterisation, suprapubic catheterisation and the management of stoma appliances. Care staff completed training in continence care as part of their induction. The promotion of continence and the management of incontinence are completed by all staff at the time of induction. The review of one staff induction training record evidenced this training had been completed and had been validated by the registered manager. Regular audits of the management of continence products are undertaken by the registered manager. The registered manager informed the inspector that the deputy nurse manager is the incontinence link nurse in the home.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

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

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

11.2 Complaints

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

The inspector discussed the management of complaints with the registered manager and reviewed the complaint record. This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements.

11.3 Patient Finance Questionnaire

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

11.4 NMC Declaration

Prior to the inspection the registered manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC.

11.5 Patients/Residents and Relatives Comments

During the inspection the inspector spoke with twenty patients individually and to others in groups. These patients expressed high levels of satisfaction with the standard of care, facilities and services provided in the home. A number of patients were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients' comments were as follows:

"I couldn't be happier"
"Staff are really kind and attentive"
"The food is good and there is always a choice"
"I feel safe and content"
"We want for nothing"

Two patient questionnaires were issued. However, none were returned. There were no issues raised by patients to the inspector during the inspection.

Three questionnaires were issued to relatives during the inspection for completion. None were returned. However the following comments were made by three relatives visiting on the day of inspection;

“it is excellent here”
“everyone is so well cared for”
“we are kept well informed”
“staff are excellent”
“This is a great home”

There were no issues raised by relatives or their representatives during the inspection to the inspector.

11.6 Questionnaire Findings/Staff Comments

During the inspection the inspector spoke with ten staff. The inspector was able to speak to a number of these staff both individually and in private. Nine staff questionnaires were issued during the inspection, all nine staff returned the questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

The following comments were made to the inspector and returned in the staff questionnaires;

“quality of care is of a high standard”
“we are a good team, I enjoy my job thoroughly”
“patients are treated with dignity and respect”
“staff attend training courses regularly to enable them to deliver a good standard of care”
“we all work as one big happy team”

There were no issues raised by staff to the inspector during the inspection.

11.7 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients’ bedrooms, bathrooms, shower and toilet facilities and communal areas. There have been significant improvements made regarding the environment since the previous inspection. The inspector acknowledges the commitments of the management to ensure the requirements and recommendations from the previous inspection report have been implemented. During this inspection the home was observed to be comfortably heated and all areas were maintained to a high standard of hygiene.

The following areas are required to be addressed all identified areas room numbers etc. were provided to the registered manager during the inspection;

- Continue to implement the redecoration programme to ensure all identified bedrooms are repainted.

- Eradicate the malodour in the identified bedroom.
- Review the locking mechanism on the identified clinical room door.
- Ensure RQIA receives a minor variation application in regards to the change of usage of a bedroom into a storeroom as discussed with the registered manager.

11.8 Care records

The inspector reviewed five care records. The inspector commends the improvements in the overall management of care records on this occasion. The inspector observed them to be relevant, descriptive, individualised and person centred to meet the patients' needs. There was evidence of patient involvement where relevant in the care records. Following discussion with patients, relatives and staff the inspector evidenced that the care records were up dated when patients' needs changed in a timely way and in keeping with best practice. One issue was raised regarding the monthly evaluation of care records. It is recommended that monthly evaluations of care are more meaningful and reflective of the care delivered during the stated period of time. Care plans no longer relevant to the care records should be clearly discontinued and filed.

12.0 Quality Improvement Plan

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

Donna Rogan
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9th Floor
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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**
At the time of each residents admission the manager carries out and records an initial assessment using Roper Logan and Tierney. A comprehensive, holistic assessment is completed within five days, including care planning and risk assessment. Nutritional screening is carried out using the malnutrition screening tool. The Braden scale is also completed by the named nurse.	Compliant

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

recording/updates are in place. Care plans are updated 4 weekly and as necessary to meet individual needs. These documents/and records are checked by the care manager.	

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**
Resident's care plans are holistic/ individualised to meet care needs. Assessment/and planning and re-evaluation is ongoing process. Care plans are updated every 4 weeks, and as necessary records of professional visits, doctors visits and investigation for example blood tests are included in the care plan.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All nursing interventions/and procedures are supported by for example NMC Guidelines, RCN and Department of Health Guidelines such as NICE, Public Health Agency. Braden scale is utilised for predicting pressure sore risk. A care plan reflects appropriate planned interventions for appropriate care. Nutritional guidelines and menu checklists are adhered to. Menu's have choices and are updated to include Winter, Spring, Summer and Autumn rotations	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**
Care plans and records are inaccordance with the NMC Guidelines. These care plans commnence prior to admission and continue to be planned and implemented with the resident/family/care manager/other professional bodies. Meals provided/and residents satisfaction are met for the individual records are kept of food diaries, intake and output charts, and weights. Nutritional concerns are reported to the nurse in charge/manager. Appropriate referrals are made to other professionals. Records are kept of these actions and outcomes. Holistic assessment is individualised/ and ongoing and reflect relevant professional advice.	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Residents receive safe and effective nursing care. The outcome of care delivered is monitored and recorded on a daily basis. Benchmarks are inplace for example weights, medications, pain management. Residents and families, care management are involved in delivery of care	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**
Relatives/residents are encouraged to participate in planned multi disciplinary reviews arranged by the Trust. Following reviews any updates/changes required to care plan are recorded and all persons are kept informed of progress towards agreed goals.	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**
Residents are provided with a nutritous and varied diet. The menu offers residents choices, which includes those on a specific diet requirement. Any additional requirement at meal times can be individualised to meet the requests of the residents. Snacks etc are available outside of mealtimes. Full account is taken of guidance documents and guidance for dietician, speech and language and any other disciplines.	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Staff Nurses have uptodate knowledge and skills in managing feeding techniques for residents who have swallowing difficulties; these include folowing instructions for thickening fluids. Instructions by speech and language are kept in residents care plans. A staff nurse is present at meal times to give guidance to the team. Meals are provideed at convenient times, hot and cold drinks and snacks are given at customary intervals. Staff have access to the kitchen to provide further snacks/ drinks as requested by the resident/relatives. Fresh drinking water is available at all times. Staff nurses have the skills and experience in wound management which includes assessment and application of wound care products. University of Chester provide an education and training manual, with sections for self	Compliant

assessments. Tissue viability assessment/and guidance is also requested and documented in the individuals care plan. Residents/relatives are updated re: care management.	

Provider's Overall Assessment of The Nursing Home's Compliance Level Against Standard 5	Compliance Level
	Provider to complete

Appendix 2

Explanation of coding categories as referenced in the Quality of Interaction Schedule (QUIS)

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic care: (BC) – basic physical care e.g. bathing or use if toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.**
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc. (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are□ tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away • Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others	Examples include: Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (NS) – communication which is disregarding of the residents' dignity and respect.**
Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions • Not showing interest in what the patient or visitor is saying	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness') • Seeking choice but then ignoring or over ruling it • Being angry with or scolding older patients • Being rude and unfriendly • Bedside hand over not including the patient

References

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.

Quality Improvement Plan

Secondary Unannounced Care Inspection

Lakeview Private Nursing Home

26 March 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with Dorothy Stafford, registered manager, during the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	27	The registered manager should ensure the following issues are addressed; • Continue to implement the redecoration programme to ensure all identified bedrooms are repainted. • Eradicate the malodour in the identified bedroom. • Review the locking mechanism on the identified clinical room door. • Ensure RQIA receives a minor variation in regards to the change of usage of a bedroom to a storeroom as discussed with the registered manager. **Ref 11.7**	One	Eradicated the malodour in the identified bedroom Reviewed the locking mechanism on the clinical rooms minor variation request to the RQIA being processed Continuing to implement the re d ecoration programme	3 Months

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	The registered manager should ensure that the monthly evaluation of care is more meaningful and reflective of the care delivered during the stated period of time. Care plans no longer relevant to the care records should be clearly discontinued and filed. **Ref 11.8**	One	Monthly evaluation is more meaningful and reflective of the standard of care delivered Care plans no longer relevant to current practices are clearly discontinued and filed	One month

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Dorothy Stafford
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Chris Arnold

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Donna Rogan	22/05/15
Further information requested from provider			