Announced Primary Inspection

Name of Establishment:	**Clareview House**
Establishment ID No:	**1443**
Date of Inspection:	**10 June 2014**
Inspector's Name:	**Bridget Dougan**
Inspection No:	**17160**

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544

1.0 General Information

Name of Home:	Clareview House
Address:	105 Doagh Road Ballyclare BT39 9ES
Telephone Number:	028 9334 9694
E mail Address:	Sharon@hutchinsoncarehomes.com
Registered Organisation/ Registered Provider:	Hutchinson Homes Ltd Mrs Naomi Carey
Registered Manager:	Mrs Sharon Bell
Person in Charge of the Home at the time of Inspection:	Mrs Edwina McAloney, Deputy Manager
Registered Categories of Care and number of places:	NH-I, NH-PH(E), RC-I, RC-PH(E) 35
Number of Patients Accommodated on Day of Inspection:	33 patients/residents
Date and time of this inspection:	10 June 2014: 12.00 – 17.00 hours
Date and type of previous inspection:	25 March 2014 Primary Unannounced

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 is required.

This is a report of a primary announced inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were 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.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

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

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the DHSSPS Nursing Homes Minimum Standards 2008.

The inspection process has three key parts; self-assessment (including completion of self -declaration), pre-inspection analysis and the inspection visit by the inspector.

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

- analysis of pre-inspection information
- discussion with the registered manager
- examination of records
- consultation with stakeholders

- tour of the premises
- evaluation and feedback.

Any other information received by RQIA about this registered provider has also been considered by the inspector in preparing for this inspection.

5.0 Consultation Process

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

Patients	**20**
Staff	**12**
Relatives	**5**
Visiting Professionals	**0**

Questionnaires were provided, during the inspection, to patients, their representatives and staff to seek their views regarding the service. Matters raised from the questionnaires were addressed by the inspector in the course of this inspection.

Issued To	**Number issued**	**Number returned**
Patients	**4**	**4**
Relatives / Representatives	**5**	**5**
Staff	**6**	**6**

6.0 Inspection Focus

The inspection sought to establish the level of compliance achieved regarding the selected DHSSPS Nursing Homes Minimum Standards.

The criteria from the following standards are included;

- Management of Nursing Care – Standard 5
- Management of Wounds and Pressure Ulcers –Standard 11
- Management of Nutritional Needs and Weight Loss – Standard 8 and 12
- Management of Dehydration – Standard 12

An assessment on the progress of the issues raised during and since the previous inspection was also undertaken.

The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.
The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Guidance - Compliance statements	**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

Clareview House is situated, just off the Doagh Road, in the outskirts of Ballyclare Town. It is on a main bus route to Ballymena, Antrim and Belfast. It was formerly a private dwelling and has been adapted and extended to provide nursing and residential care.

Clareview House nursing home provides accommodation over two floors. Accommodation comprises of communal lounges, dining facilities, a range of bath, shower and toilet facilities and accommodation in single bedrooms.

Stairs and a passenger lift access the first floor of the home. Car parking facilities are available to the front of the home.

The home is registered to provide care for persons under the following categories of care:

Nursing Care (NH)

I	Old age not falling into any other category
PH	Physical disability other than sensory impairment (one person)

Residential Care (RC)

I	Old age not falling into 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 certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) accurately reflected the categories of care and was appropriately displayed in a prominent position of the home.

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (unannounced) to Clareview House. The inspection was undertaken by Bridget Dougan on 10 June 2014 from 12.00 hours to 17.00 hours.

The inspector was welcomed into the home by Mrs Edwina McAloney, Deputy Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to the deputy manager at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector met with patients/residents, staff and five relatives. The inspector observed care practices, examined a selection of records and carried out a general inspection of the nursing home environment as part of the inspection process.

Questionnaires were issued to patients/residents, staff and relatives during the inspection.

The inspector spent a number of extended periods observing staff and patient interaction. Discussions and questionnaires are unlikely to capture the true experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience.

These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool is designed to help evaluate the type and quality of communication which takes place in the nursing home. A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix two.

As a result of the previous inspection conducted 25 March 2014, two requirements and four recommendations were issued. Two requirements were reviewed during this inspection and four recommendations have been carried forward for review at a future inspection. The inspector evidenced that the two requirements had been fully complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

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. (Selected criteria)

Standard 8: Nutritional needs of patients are met. (Selected criteria)
Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)

Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria)

Inspection Findings:

- **Management of Nursing Care – Standard 5**

The inspector can confirm that at the time of the inspection there was evidence to validate that patients receive safe and effective care in Clareview House.

The inspector inspected four patients/residents care records and while there was evidence of comprehensive and detailed assessment of patient/residents needs from date of admission until January 2014, there were some omissions in risk assessments following this date. A MUST assessment had not been completed for one patient/resident since January 2014 and Braden assessments had not been reviewed monthly or more frequently depending on the needs of patients/residents. The inspector was informed that the home had moved from paper records to a computerised care record system in January 2014 and while all staff had received training, it was taking some time for staff to become familiar with the new system. A requirement has been made to ensure comprehensive reviews of patients/residents assessments of need and the risk assessments are maintained on a regular basis.

There was written evidence maintained in all the care records reviewed to indicate that discussions had taken place with patients/residents and their representatives in regard to planning and agreeing nursing interventions.

There was also evidence that the referring HSC Trust maintained appropriate reviews of the patient's satisfaction with the placement in the home and the quality of care delivered.

Compliance Level: Moving towards compliance

- **Management of Wounds and Pressure Ulcers –Standard 11**

The inspector evidenced that wound management in the home was well maintained. There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment. Care plans for the management of risks of pressure ulcers and wound care were maintained to a professional standard. A recommendation has been made for care assistants to complete update training in the prevention of pressure ulcers.

Compliance level: Compliant

- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**

The inspector reviewed the management of nutrition and weight loss within the home.

Robust systems were evidenced with risk assessments and appropriate referrals to GP's, speech and language therapists and or dieticians being made as required.

The inspector also observed the serving of the lunch meal and can confirm that the patients were offered a choice of meal and that the meal service was well delivered. Patients/residents were observed to be assisted with dignity and respect throughout the meal.

Compliance level: Compliant

- **Management of Dehydration – Standard 12**

The inspector also examined the management of dehydration during the inspection. The home maintained fluid balance records for those patients/residents assessed at risk of dehydration. Patients/residents were observed to be able to access fluids with ease throughout the inspection.

Compliance level: Compliant

Patients / residents / their representatives and staff questionnaires

Some comments received from patients/residents and their representatives:

- "We're well fed and well looked after."
- "I'm very happy here."
- "I'm very happy with the care."
- "Some of the windows in my wife's bedroom do not open and the room can be very warm at times."

Some comments received from staff:

- "I feel Clareview is a happy place for management, staff and patients."
- "I feel I do not get enough time to sit and talk to patients."

A number of additional areas were also examined

- Records required to be held in the nursing home
- Guardianship
- Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)
- Patient and staff quality of interactions (QUIS)
- Complaints
- Patient finance pre-inspection questionnaire
- NMC declaration
- Staffing and staff comments
- Comments from representatives/relatives and visiting professionals
- Environment.

Full details of the findings of inspection are contained in section 11 of the report.

Conclusion

The inspector can confirm that at the time of inspection the delivery of care to patients/residents was evidenced to be of a good standard. There were processes in place to ensure the effective management of the themes inspected.

The home's general environment was well maintained.

Patients/residents were observed to be treated with dignity and respect.

A total of one requirement and one recommendation were made as a result of this inspection. A further four recommendations made at the previous inspection have been carried forward for review at a future inspection.

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

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	27(4)	It is required that all fire exits and escape routes are kept clear. Registered persons must ensure that these areas are checked by a senior member of staff before contractors leave to confirm materials/debris/equipment has been stored appropriately and that the fire exits and escape routes are clear. Records of this check must be maintained. **Ref: Section 9 (requirement 1) and Section 11(11.6)**	The inspector undertook an inspection of the home and viewed a number of patients/residents' bedrooms, communal facilities and toilet and bathroom areas. The inspector can confirm that at time of the inspection all fire exits and escape routes were kept clear and records were maintained of all checks carried out by senior staff.	**Compliant**
2	20(1)(a)	It is required that the registered manager informs RQIA of the decision made regarding the staffing for night time by return of this QIP. **Ref: Section 11 (11.7)**	The inspector can confirm that written correspondence was received informing RQIA that an additional twilight shift had been rostered from 20.00 – 23.00 hours each night to facilitate assisting patients/residents to bed in a timely manner. The inspector reviewed four weeks duty rotas and was able to validate this information.	**Compliant**

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	25.12	It is recommended that following each visit an action plan is developed to address any areas for improvement and the subsequent visit report evidences that the responsible individual has 'followed up' on the action plan issued previously. **Ref: Section 10, Theme 1 (section B)**	This recommendation was not reviewed at this inspection. It will therefore be carried forward for review at a future inspection.	**Not inspected**
2	25.12	It is recommended that management consider displaying information as to the report availability ensuring relatives know they can ask for a copy. For example, a poster on the relatives' notice board. **Ref: Section 10, Theme 1 (section C)**	This recommendation was not reviewed at this inspection. It will therefore be carried forward for review at a future inspection.	**Not inspected**
3	28.6	It is recommended that training records are maintained in accordance with minimum standards which includes retaining a copy of the content of any training provided to staff. **Ref: Section 10, Theme 2 (16.3)**	This recommendation was not reviewed at this inspection. It will therefore be carried forward for review at a future inspection.	**Not inspected**
4	25.2	It is recommended that staff are provided with awareness/training on the interim guidance on deprivation of liberty safeguards (DOLs) and how they relate to patient/residents. **Ref: Section 10, Theme 2 (10.7)**	This recommendation was not reviewed at this inspection. It will therefore be carried forward for review at a future inspection.	**Not inspected**

11.0 Additional Areas Examined

11.1 Documents required to be held in the Nursing Home

Prior to the inspection a checklist of documents required to be held in the home under regulation 19(2) schedule 4 of The Nursing Homes Regulations (Northern Ireland) was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required documents were maintained in the home and were available for inspection. The inspector reviewed the following records:

- The home's statement of purpose
- The patient's guide
- Sample of reports of unannounced visits to the home under regulation 29
- Sample of staff duty rosters
- Record of complaints
- Sample of incident/accidents
- Record of food provided for patients/residents
- Statement of the procedure to be followed in the event of a fire

11.2 Patients under guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection. During the inspection there were no patients in the home who were subject to a guardianship order.

11.3 Human Rights Act 1998 and European Convention on Human Rights (ECHR) DNSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspector discussed the Human Rights Act and the Human Rights Legislation with the registered manager. The inspector can confirm that copies of these documents were available in the home.

11.4 Quality of interaction schedule (QUIS)

The inspector undertook a number of periods of observation in the home which lasted approximately 30 minutes each.

The inspector observed the patients/residents lunch meal which was served in the dining room. The inspector also observed a small number of patients/residents having their lunch meal in their own bedrooms.

The observation tool used to record these observations uses a simple coding system to record interactions between staff, patients/residents and visitors.

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix 2.

The staff was observed seating the patients/residents in preparation for their lunch in an unhurried manner.

The staff explained to the patients/residents their menu choice and provided adequate support and supervision.

Observation of care practices revealed that staff were respectful in their interactions with the patients/residents.

Overall the periods of observations were positive.

11.5 Complaints

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. Complaints recorded since the previous inspections were investigated appropriately.

11.6 Patient Finance Questionnaire

Prior to the inspection a patient 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.

11.7 NMC declaration

Prior to the inspection the registered manager was asked to complete a pro forma 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 pro forma indicated that all nurses, including the registered manager were registered with the NMC.

11.8 Staffing /Staff Comments

On the day of inspection the inspector examined staff duty rosters for four weeks. Inspection confirmed that registered nurses and care staff staffing levels for day and night duty were in accordance with the RQIA's recommended minimum staffing guidelines.

The inspector spoke to 12 staff members during the inspection process and reviewed six staff completed questionnaires.

Examples of staff comments were as follows:

- "I feel Clareview is a happy place for management, staff and patients."
- "I feel I do not get enough time to sit and talk to patients."

11.9 Patients/residents Comments

The inspector spoke to 20 patients/residents individually and with others in groups. Four patients/residents completed questionnaires.

Examples of their comments were as follows:

- “We’re well fed and well looked after.”
- “I’m very happy here.”

11. 10 Relatives’ Comments

The inspector spoke to five relatives and these relatives completed questionnaires.

An example of the relatives’ comments is:

- “I’m very happy with the care.”
- “Some of the windows in my wife’s bedroom do not open and the room can be very warm at times.”

The issue was discussed with the deputy manager who agreed to get it resolved.

11.11 Environment

The inspector undertook an inspection of the home and viewed a number of patients/residents’ bedrooms, communal facilities and toilet and bathroom areas.

The home was clean, warm and comfortable. Major renovation and refurbishment work had been completed since the previous inspection and this is commended. Further refurbishment work was underway at the time of the inspection.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed Mrs Edwina McAloney, Deputy 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:

Bridget Dougan
The Regulation and Quality Improvement Authority
Hilltop
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Omagh
BT79 0NS

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**
A pre admission assessment is carried out prior to admission to assess if the home is able to provide the correct plan of assessed care as drawn up initally by the care management team. This assessment is completed by the Manager/ Nursing sister or a qualified staff nurse in their abscence. This proceess can be negated if required to facilitate an emergency admission with the information being given verbally to a trained staff member via telephone with them following the pre admission assessment criteria used by the	Compliant

home. A comprehensive holistic assessment of the patients care needs using the validated assessment tool of Roper Logan and Tierney model of care and risk assessments are completed within 72 hours of admission including nutritional risk assessment, Braden pressure risk assessment, Abbey pain scale, Falls risk assessment and Continence assessment spanning over day duty and night duty to achieve a comprehensive assessment of their needs. These assessments are combined with clinical judgement of the staff who are assisting the patient on a daily basis	
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**
Prior to arranged admission there is a named nurse allocated to the patient to complete inital documentation and to continue with the assessments on admission with discussion and in agreeance with the patient and/or the family. All care plans take into account the ability of each individual to promote as much indepence as possible in a realistic and safe way taking into account all advice and recommendations from relevant health professionals. There is automatic referral of all patients to the Podiatrist and Opthalmic services. If required following received information and clinical assessments carried out in the home there is also a Dietetic referral made and Tissue viability referral if approriate. The tissue viability and podiatrist work in conjunction with each other aas required so as to ensure that the staff follow the correct plan of care If the patient is referred to the dietican the nutritional plan drawn up by the dietican is provided to the kitchen and all staff are made aware of the needs both verbally and in the patients care plan and multidisciplinary notes Also there is access to The Nutritional guidelines and menu list for residential and nursing homes 2014.	Compliant

Section C

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**

Re assessment is an ongoing process that is carried out on a daily basis according to the fluctuating needs of the patient. Risk assessments and care plans are updated on a monthly basis, and as required to ensure that the best care is being delivered at all times. The patients needs and requirements are also discussed with the patients family and named worker from the trust and adjustments made to the plan of care as seen fit in the best interest of the patient The Trust carries out yearly reviews of the patient which the family or a suitable representative attend in conjunction with the home and the patient themselves	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 are supported by Roper Tierney and Logan and guidance in practice from the NMC ,RCN , RQIA, NISCC, NHSCT and NICE guidelines and protocols. Braden is used as a validated tool to screen patients and individual treatment plan is implemented accordingly in conjunction with other multidisciplinary professionals as required such as the tissue viability nurse and podiatrist.	Substantially compliant

The 2014 Nutritional guidelines and menu checklist for residential and nursing homes produced by HSC public health agency are available in the home for nursing staff and a copy is available in the kitchen.	

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**
Contemporaneous nursing records in accordance with NMC guidelines are kept at present in written format and computerised format as the home is currently transferring to the EPIC care record system. A seperate written record at present, is maintained by the activity therapist detailing the activities provided on a group and individual basis documented for each patinet in the home.	Compliant

A record is kept of the meals provided in the kitchen on a daily menu sheet and intakes are also documented for patients whose care plan indicates the need to do so of all the food and fluid they consume over a twenty four hour basis. All patients on admission to the home are commenced on a fluid balance chart for one month regardless of their assessed needs as this gives the home a base line from which to work if the patients condition deteriorates. All patients on any form of food supplement or thickener have a daily fluid chart completed. All patients who choose not to eat or who eat excessively are also monitoresd using a food chart and the advice and input from speech and language department and dietician and GP is used as approriate. Patients who require Peri enteral gastric feeding are also commenced on on a fluid balance chart. Any concerns are raised with the nurse in charge and referred to the appropriate multidisciplinary team and a record of all intervetion and advice is kept.	
Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care carried out on a daily basis according to the fluctuating needs of the patient is reassessed as required in a contemporaneous way. Risk assessments and care plans are updated on a monthly basis, and as required to ensure that the best care is being delivered at all times. The patients needs and requirements are also discussed with the patients family and named worker from the trust and adjustments made to the plan of care as seen fit in the best interest of the patient The Trust carries out yearly reviews of the patient which the family or a suitable representative attend in conjunction	Compliant

with the home and the patient themselves. For a new admission there is an inital two week review involving the patient and their representatives the home and the trust and this is then followed by a 6 monthly review and if there are no issues then the review is carried out on a yearly basis. if it is required more frequently then it is arranged as needed in conjunction awith all parties	
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**
Patients are encouraged and facilitated to attend all reviews arranged by the trust facilitated by the home and have input if they so wish to the review as they initally have had input into their assessed need of care.The results and minutes of all review meetings are recorded by the named worker from the trust and sent out to the families and the nursing home by the trust according to their protocols, timelines and bench marks	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**
Patients are offered and provided with a nutritious and varied diet in accordance with the Nutritional guidelines and menu checklist for residential and nursing homes 2014 from the hsc Public Health agency and in conjunction with any specific dietican reports and speech and language therapy and all this encompasses the patients individual likes dislikes and choices in regards to what they eat alternatives are always available to the menu provided.	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**
All nurses and care staff have up to date knowledge and skills in regards to feeding techniques for patients who have swallowing issues and adhere to the instructions provided by speech and language therapist a record of which is kept in the patients notes and a copy is given to the catering staff . Meals are provided at convetional times with snacks etc provided as required. Fresh cool water and cordials is available at all times for patients and if needed their visitors. Staff are aware of all matters pertaining to indiviual patients eating and drinking ensuring that all directions from the multidiscplinary team are adhered tyo and fluid balance charts are completed. Necessary aids and equipment are available for patients on an indiviually assessed basis. When a patient requires wound care the nurses are appropriately skilled in dealing with wounds but also have an excellent rapport with the tissue viability nurse which allows them to utilise the expertise of the tissue viability nurse in regards to the best practice for the particular wound dressing to promote optimum healing and minimise the distress and pain caused to the patient	Compliant

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

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

Unannounced Primary Inspection

Clareview House

10 June 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 Mrs Edwina McAloney, Deputy Manager, either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirement	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	15 (2) (b)	The registered person shall ensure that a comprehensive assessment of the patients' needs is maintained and kept under review.	One	All activities and patients needs reviewed regularly as Epicare system provides reminders. As manager I follow up any issues in letter for offering staff any further help if needed.	From the date of this inspection

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	25.12	**Carried forward for review at the next inspection:** It is recommended that following each visit an action plan is developed to address any areas for improvement and the subsequent visit report evidences that the responsible individual has 'followed up' on the action plan issued previously. **Ref: Follow up on previous issues**	One	Action plan in place and details of any follow up required to action plan is recorded on next regulation 29.	Following receipt of this QIP
2	25.12	**Carried forward for review at the next inspection:** It is recommended that management consider displaying information as to the report availability ensuring relatives know they can ask for a copy. For example, a poster on the relatives' notice board. **Ref: Follow up on previous issues**	One	Notice is displayed on relatives/residents notice board and it is in the newsletter and re iterated at relatives meetings	Following receipt of this QIP
3	28.6	**Carried forward for review at the next inspection:** It is recommended that training records are maintained in accordance with minimum	One	Training records are maintained according to minimum standards and a copy of content is being retained. All trainers aware of this.	Following receipt of this QIP

		standards which includes retaining a copy of the content of any training provided to staff. **Ref: Follow up on previous issues**			
4	25.2	**Carried forward for review at the next inspection:** It is recommended that staff are provided with awareness/training on the interim guidance on deprivation of liberty safeguards (DOLs) and how they relate to patient/residents. **Ref: Follow up on previous issues**	One	Training has been organised for Tuesday 9th Sept 2014 Thursday 11th Sept 2014 Depending on attendance will dictate further training sessions for staff.	Following receipt of this QIP
5	11.1	The registered manager should ensure that all care staff receive update training in the prevention of pressure ulcers **Reference: Section 8**	One	Training has been organised for 2nd September 2014 and 16th Sept 2014	Within six weeks from receipt of this QIP

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	Sharon Bell
Name of Responsible Person / Identified Responsible Person Approving Qip	Naomi Carey

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	B. Dougan	10/11/14
Further information requested from provider			