Unannounced Care Inspection

Name of Establishment:	**Hamilton Care Home**
RQIA Number:	**1444**
Date of Inspection:	**26 February 2015**
Inspector's Name:	**Karen Scarlett**
Inspection ID:	**17065**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Hamilton Care Home
Address:	The Plantain 168 Ballycorr Road Ballyclare BT39 9DF
Telephone Number:	028 93341396
Email Address:	lucy_hamilton@btconnect.com
Registered Organisation/ Registered Provider:	Mrs Heather Hamilton
Registered Manager:	Ms Lucinda Dawn Hamilton
Person in Charge of the Home at the Time of Inspection:	Ms Lucinda Dawn Hamilton
Categories of Care:	NH-I ,RC-I ,RC-MP(E) ,RC-PH(E)
Number of Registered Places:	24
Number of Patients Accommodated on Day of Inspection:	21
Scale of Charges (per week):	Residential £526.00 Nursing £646.00
Date and Type of Previous Inspection:	15 July 2014, secondary unannounced inspection
Date and Time of Inspection:	26 February 2015 09.15 – 13.40
Name of Inspector:	Karen Scarlett

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- Discussion with the Registered Provider
- Discussion with the Registered Nurse Manager
- Discussion with staff
- Discussion with patients individually and with others in groups
- Consultation with relatives
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- A sample of staff induction records
- A sample of nursing staff competency and capability assessments
- Review of a sample of care records
- Review of patient activities record
- Observation during an inspection of the premises
- Evaluation and feedback

5.0 Consultation Process

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

Patients/Residents	7 and with others in groups
Staff	6
Relatives	2
Visiting Professionals	0

Questionnaires were provided by the inspector to staff to seek their views regarding the quality of the service.

Issued To	Number Issued	Number Returned
Patients/Residents	0	0
Relatives/Representatives	0	0
Staff	10	6

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

Hamilton Private Nursing Home is situated on an attractive rural site close to the town of Ballyclare. The registered manager is Ms Lucy Hamilton.

The facilities are provided on one level and are comprised of twenty single and two double bedrooms, two sitting rooms, dining room, toilet, bathing and shower facilities, a kitchen, laundry and office.

Car parking is available in the designated car park and an area for wheelchair users and emergency vehicles is available at the front of the home.

The approved building work to extend the premises to provide additional accommodation and en-suite bedrooms in line with the Nursing Homes Minimum Standards is nearing completion. This will also comprise a brand new purpose built kitchen, dining room and laundry room.

The maximum occupancy is 24 and the home is currently registered to provide care under the following categories:

Nursing Care

I	Old age not falling into any other category

Residential Care (Maximum of three residents)

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 was appropriately displayed and accurately reflected the categories of patients accommodated.

8.0 Executive Summary

The unannounced inspection of Hamilton Care Home was undertaken by Karen Scarlett on 26 February 2015 between 09.15 and 13.40. The inspection was facilitated by Ms Lucy Hamilton, registered manager, who was available for verbal feedback at the conclusion of the inspection, along with the registered provider, Mrs Heather Hamilton and the director, Mr Patrick Hamilton.

The focus of this inspection was to assess the level of compliance with Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection on 15 July 2014.

A number of documents are required to be submitted prior to the inspection and these were all received within the timeframe and offered the required assurances.

Patients were well presented in clothing suitable for the season. Patients and relatives comments were very positive about the care, the cleanliness of the home and the friendliness of the staff. There were no concerns raised by patients or relatives. Refer to section 11.5 for further information on patients and relatives.

The home's compliance with Standard 19: Continence care was assessed. In the three records examined there was no continence assessment completed to assess the continence needs of these patients. A recommendation has been made that a continence assessment is completed for all patients who require continence management and support. A care plan was in place to manage the continence needs of patients and these were reviewed on a monthly basis.

Discussion with the registered manager confirmed that staff were trained and assessed as competent in continence care. Sufficient numbers of registered nurses had been deemed competent in female catheterisation and stoma care. A number of staff had recently received training in male catheterisation and will continue to develop their competence in this regard.

Policies, procedures and guidelines in the promotion of continence and the management of incontinence were available in the home. A recommendation has been made for additional guidelines to be made available to staff and used as required.

A recommendation has also been made that regular audits of care records are undertaken to include the management of incontinence and the findings acted upon to enhance standards of care.

From a review of the available evidence, discussion with relevant staff and observation, the inspector can confirm that the level of compliance with the standard inspected was substantially compliant. A total of two recommendations have been made in regard to the standard and one recommendation has been made in regards to the auditing of care records (refer to sections 10.0 and 11.8).

The inspector spoke with five staff and six completed questionnaires. Staff comments were overwhelmingly positive about the standard of care provided and the quality of team work in the home. No concerns were raised by staff. An examination of the duty rota evidenced that staffing was sufficient to meet the assessed needs of the patients. For further information on staffing please refer to section 11.6.

The home was maintained to a high standard of cleanliness and décor throughout. There were a number of issues identified which were not in accordance with best practice in infection prevention and control. These included shared creams in bathroom cabinets, inappropriate storage of items in bathrooms, inappropriate communal use of toileting slings and inappropriate decontamination and storage of commode pots in the sluice. A requirement has been made in this regard. Please refer to section 11.7 for further information.

The inspector can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a satisfactory standard and patients were mainly observed to be treated by staff with dignity and respect. There were two instances in which care practices were observed to have fallen below the standard expected. This was discussed with the staff nurse, registered manager and registered provider. It was also noted that there was no sufficient activities provision for patients and a recommendation has been made in this regard. Refer to section 11.1 for further information on care practices.

A selection of care records were reviewed and these were generally maintained to a good standard. A number of improvements are recommended in the recording of repositioning and fluid balance charts and requirements have been made in relation to each of these. The term “cot sides” was also noted to be used in care plans, which is has the potential to demean patients. A recommendation has been made that care plans are updated to use the term “bed rails” as an alternative. Please refer to section 11.8 for further information on care records.

The inspector reviewed and validated the home’s progress regarding the recommendation made at the last inspection on 15 July 2014 and confirmed this to be compliant.

As a result of this inspection, three requirements and five recommendations have been made.

Details can be found under Sections 10.0 and 11.0 in the report and in the quality improvement plan (QIP).

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

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

9.0 Follow-Up on Previous Issues

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	28.1	The registered manager should verify the staff members' competency and sign and date the completed induction training record.	Three staff nurse competency and capability assessments were viewed and had been signed and dated by the registered manager. Two induction records were viewed, one for a care assistant and one for a registered nurse. Both had been signed and dated by the registered manager and the inductee. This requirement has been addressed.	Compliant

9.1 Follow up on any issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

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

Since the previous inspection on 15 July 2014 RQIA have been notified by the home of no ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of three patients' care records evidenced that bladder and bowel continence assessments had not been completed. A recommendation has been made to ensure that assessments have been completed for all patients who require continence management and support. There was evidence in the three patients care records that continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. Review of three 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.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector can confirm that 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 catheter care guidelines Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines. A recommendation has been made for the following guidelines to be readily available to staff and used as required: • 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	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not applicable.	Not applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the manager revealed that sufficient numbers of registered nurses in the home were deemed competent in female catheterisation and the management of stoma appliances. A number of registered nurses had recently completed training in male catheterisation and will be continuing to develop their competence in this area. Furthermore, continence care and management was included in all staff inductions documents. A recommendation has been made that regular audits of care records, to include the management of incontinence, are undertaken and the findings acted upon to enhance already good standards of care (refer to section 11.8).	Substantially compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

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.

During the inspection staff were noted to treat the patients with dignity and respect. Good relationships were evident between patients and staff and interactions were relaxed and friendly. There were two instances involving three members of staff in total which were observed during an inspection of the premises. In one case a care assistant was quite abrupt with a patient and in the other two staff members were heard to be chatting to one another whilst delivering care to a very distressed patient in their bedroom. Neither staff member was heard to address or reassure the patient. This incident was discussed with the staff nurse concerned. The registered manager agreed to speak to these staff members and to consider if further training or supervision was required.

It was also noted that there was no formal activities provision for patients at present. The activities book detailed only four activities from 22 December until the last entry on 16 February 2015. This was discussed with the registered manager and registered provider and they stated that the activities therapist had left three months ago and they had tried to add activities provision to the duties of the care assistants. They realised this was not currently working well and are planning to recruit for a new activities therapist. A recommendation has been made in this regard.

11.2 Complaints

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

A complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The 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 these 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 and Relatives Comments

The inspector spoke with seven patients individually and with the majority of others in smaller 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:

"They look after me alright."
"The food is good."
"The home is always kept clean."
"Everything is OK."

The inspector spoke with two visiting relatives. They were very positive about the care, the food and the staff.

11.6 Questionnaire Findings/Staff Comments

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

Examples of staff comments were as follows;

"I feel that we provide the best care possible."
"Very homely with excellent care."
"Good team work."
"Residents are afforded their dignity at all times and are given the best care we can provide."
"The equipment and the building are nothing but the best and this helps us to provide the best care possible."

11.7 Environment

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

There were a number of issues identified which were not in accordance with best practice in infection prevention and control including the following:

- unlabelled creams in bathroom cabinets which could be potentially shared and increase the risk of cross contamination
- Items such as wipes, pads, waste bags and equipment noted on bathroom shelves, radiators, toilet cisterns and floors
- Commode pots in the sluice rack not properly decontaminated or inverted to dry
- Two toileting slings hanging on a hoist with the potential for inappropriate communal use and cross contamination

A requirement has been made in this regard.

In addition the sluice room and laundry room are currently adjoining with no separating door which is not in accordance with best practice in infection prevention and control. This was discussed with the registered manager and the registered provider who explained that a new and spacious laundry room was included in the new building which is nearing completion. In the meantime every effort should be made to limit the potential spread of infection in the laundry room.

11.8 Care Records

A selection of care records were reviewed both in paper and electronic formats. The records were generally maintained to a high standard with evidence of relevant risk assessments being completed on admission and reviewed at least monthly. Care plans were in place to address the needs of the patients and these were reviewed at least monthly. Detailed progress notes were kept electronically for each patient and identified the staff member who made the entry.

A number of improvements were required in relation to record keeping. Repositioning charts were found to be inconsistently completed with some entries clearly omitted. Individual time frames for repositioning were not included on the repositioning chart in accordance with best practice guidelines. A requirement has been made.

Fluid balance charts were being completed for several patients but these were not appropriately totalled to assess if the patient had sufficient fluid intake or output. A requirement has been made.

It was also noted in two of the care plans reviewed that the term “cot sides” was used to refer to bed rails. This is a potentially demeaning term and should not be used in the care records. A recommendation has been made that the term “cot sides” be removed from all care records and the term “bed rails” used instead.

It was further noted that no care record audits were currently being undertaken to identify any issues with documentation and to facilitate improvement. A recommendation has been made that care records are regularly audited and the results communicated to staff to enhance the quality of care (refer to section 10.0).

A total of two requirements and two recommendations have been made in regards to care records.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Lucy Hamilton, Mrs Heather Hamilton and Mr Patrick Hamilton, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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

Enquiries relating to this report should be addressed to:

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Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
Criterion 5.1 There is a comprehensive policy in use and we always try and either visit new patients in their own home or in hospital. The assessment tool used is Roper, Logan and Tierney. Braden and CNRST scores are completed at this time or a recent score is taken from the hospital or nursing home from which the resident is transferring. Any information received from the care management team is used in this pre-admission assessment. Criterion 5.2 On admission, the nurse on duty carries out a full assessment using Roper Logan and Tierney - The twelve activities of living - to thoroughly assess nursing needs. The risk assessment tools used are: Braden - pressure sore prevention tool; Community Nutritional Risk Screening tool; Bed rails safety risk assessment; and our own moving and handling assessment. Care plans are drawn up within a few days from the date of admission. Criterion 8.1 At the Hamilton we use the Community Nutritional Risk Screening Tool (CNRST) - this would often be completed at the pre-admission and would then be reassessed on the first day of admission with an up to date weight and BMI calculation. Criterion 11.1 At Hamilton Private Nursing Home we use the Braden score - which includes the resident's nutritional status, continence status, ability to feel pain, ability to mobilise and reposition themselves.. This is completed on the pre-admission combined with the nurse's clinicial judgement to ensure any necessary pressure relieving equipment is in situ for the resident's admission to HPNH. Braden is repeated on the first day of admission to ensure there has been no change in the resident's at risk status - again combined with the nurse's clinical judgement.	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
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. We always strive to promote maximum independence and rehabilitation. We always take into account advice and recommendations from relevant health professionals. The care plans are clear and easy to read with each patient's individual identified problems addressed. Staff are always encouraged to promote independence at all times. Criterion 11.2 All staff nurses at HPNH are aware of how to obtain advice from the tissue viability nurse and are aware of how to make the relevant referrals to tissue viability and other disciplines related ie dietician, OT and physio. Criterion 11.3 Where a resident is assesed as 'at risk' of developing pressure ulcers a pressure ulcer prevention care plan would be drawn up by that resident's named nurse. This would be agreed with the resident and his/her representatives and all relevant professionals. Criterion 11.8 There are referral arrangements in place at Hamilton to refer to podiatry or tissue viability anybody who would be at risk of or who has developed lower limb or foot ulceration. Criterion 8.3 As we use the Community Nutritional Risk Scoring Tool the nurses at the HPNH can refer a resident directly to the community dieticians at Whiteabbey Hospital using the referral form provided by the screening tool. This is faxed to the dieticians directly if a patient is medium risk with no improvement after 1 month or scores 2 or more for weight loss or appetite. An immediate referral is made if a resident is assessed as high risk. The details of these referrals are recorded in the residents' "significant factors" section of Residata. Any recommendations made by the dietician or GP are adhered to.	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 on-going process that is carried out daily. This is documented in the daily statement and any changes in circumstances result in new care plans being drawn up. Care plans and all risk assessments are routinely reviewed monthly and the date and time clearly documented on Residata. All our care plans are recorded on the Residata system. On the Residata system records are dated and time stamped on entry and cannot be altered historically therefore maintaining a true chronological record of events. Full care plan history is recorded on Residata with each edit allowing a historic log of changes from admission.	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
Criterion 5.5 We adhere fully to standard 5.5. All nursing interventions are carried out under the instruction of the patients' GP. All our nurses are aware of their responsibility to keep their nursing knowledge up to date and evidence based. Staff nurses are encouraged to keep abreast of all new research by subscribing to a nursing journal and by use of the internet at HPNH. Our policies and procedures are reviewed regularly and are all evidence based. We are open to advice from other professional bodies. Criterion 11.4 At HPNH we use the European Pressure Ulcer Advisory Panel (EPUAP) Grading tool to assess skin damage and then an appropriate plan of care is implemented. Criterion 8.4 Clear and up to date nutritional guidelines are provided in the Community Nutritional Risk Scoring Tool and information pack and are used on a daily basis by staff. The menus at the nursing home are nutritious and are based around this advice provided in the pack by the dieticians. We try to cater for the individual nutritional needs of all our residents and our cook regularly talks to all residents to determine all likes and dislikes which she records in a notebook. Specific guidelines are provided to the cook for our diabetic residents' nutritional needs.	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
Criterion 5.6 All records are kept according to NMC guidelines. Each nurse has his/her own password for Residata and the system is in accordance with NMC guidelines on record keeping. On the Residata system records are dated and time stamped on entry and cannot be altered historically therefore maintaining a true chronological record of events. Criterion 12.11 All menus are retained for inspection. A daily food and fluid chart is kept for any residents who require help with feeding or who score highly on the Community Nutritional Risk Scoring Tool. Criterion 12.12 A daily food and fluid chart is kept for any resident who requires assistance or encouragement with eating and drinking. The food and fluid chart records food and fluid offered even it is refused and any alternative supplements offered eg Fortisip. The same would apply to any resident who is prone to weight gain and was eating excessively. Where necessary we would make a referral to the dietician and keep a record of such referrals and advice given.	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The delivery of care is monitored and recorded on a day to day basis in the daily statement. All care plans are reviewed monthly and this is clearly documented. We do a quality questionnaire annually to ascertain the views of patients, relatives and staff about the care delivered. The report of this is made available to all relatives and staff and the action plan implemented.	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**
Criterion 5.8 Patients and relatives are always advised in good time of multi-disciplinary review meetings and are encouraged to attend and contribute. These meetings are always very thorough and a qualified nurse always takes part in these meetings. The outcomes of the review meetings are studied and recorded in the patient's notes and a copy is sent to the relative by the Permanent Care Review Team. Care plans are then amended accordingly. Criterion 5.9 We do not record the minutes of review meetings. However we record anything of note in the patient's significant factors section of the daily statement. Patients and their representatives are informed verbally of progress toward the agreed goals. A copy of the review report is kept in the patient's file. Any further referrals are made straight away and this is recorded in the significant factors section of the daily statement.	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**
Criterion 12.1 All residents are provided daily with a nutritious and varied diet. Our menus are rotating so they do not become repetitive. Menus are changed regularly to take account of changing tastes among the residents. On a daily basis residents can make special requests and our cook is happy to oblige. These menus were drawn up with reference to the Community Nutritional Risk Scoring Tool and Information Pack and after consultation with residents. Any recommendations made by dieticians or other professionals and disciplines are fully adhered to. Criterion 12.3 Our menus offer residents a choice at each mealtime and individual requests are catered for if nothing on the menu appeals. A choice is also offered to those on therapeutic and specific diets.	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
Criterion 8.6 All our qualified nurses are competent in caring for residents with swallowing difficulties. All our nurses are aware of the risk signs of possible aspiration and when to refer to Speech and Language for urgent assessment. All instructions drawn up by the Speech and Language Therapist are incorporated into individual residents' care plans and are adhered to fully. Community Speech and Language Therapist are available by telephone for advice if staff are at all concerned about a resident. Criterion 12.5 All our meals are provided at conventional times. Hot and cold drinks and snacks are always available as is fresh drinking water. Criterion 12.10 Staff consult the care plans daily and so are aware of any relevant matters regarding eating and drinking. Adequate numbers of staff are always available at meal times to avoid risks and to provide assistance. All necessary aids and equipment are available. Criterion 11.7 Nurses at the Hamilton Private Nursing Home keep themselves up to date in the skills and expertise in wound management. The full time staff nurses attended an excellent tissue viability course in May 2013 which boosted their confidence in this area and Lucy Hamilton and Stephanie Hamilton attended the RCN seminar on tissue viability May 2014. All staff nurses at HPNH would be competent in carrying out a wound assessement and appying wound care products and dressings and accurately documenting what they had done and a plan of care for that wound so that there is complete continuity of care. They have full access to the Northern Ireland Wound Care formulary and know how to use it to help in their assessment of the wound and picking a suitable dressing and plan of care.	Compliant

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

Quality Improvement Plan

Unannounced Care Inspection

Hamilton Care Home

26 February 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 Ms Lucy Hamilton, registered manager, Mrs Heather Hamilton, registered provider and Mr Patrick Hamilton, director, 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.	13 (7)	The registered person must ensure that suitable arrangements are made to minimise the risk of infection. This is particularly in relation to the following: • the presence of creams and toiletries in patients' bathrooms which could be potentially shared and increase the risk of cross contamination • Items such as wipes, pads, waste bags and equipment noted to be stored inappropriately in bathrooms • Commode pots in the sluice rack not properly decontaminated or inverted to dry • toileting slings hanging on a hoist with the potential for inappropriate communal use and cross contamination **Ref: section 11.7**	One	All residents' creams have been removed from bathroom cupboards and are stored correctly in residents own bedroom locked cupboards. The importance of this has been reiterated to all staff. All spare items such as wipes, bags etc are to be stored and put away after every use in the cupboards provided. Staff have all been retrained in the use of the bed pan washers and how to store pots on the sluice rack. Toileting slings are stored in residents own bedrooms and the importance of this has been reiterated to all care staff.	From date of inspection

2.	12 (1) (a) & (b)	The registered person shall provide treatment to patients which meets their individual needs and reflects current best practice. This is particularly in relation to: • ensuring that the repositioning schedule is adhered to and records of same are up to date • individualised time frames for repositioning are recorded on the chart and care plan **Ref: section 11.8**	One	All staff nurses have been made aware of these failings in record keeping and this will be monitored by myself as registered manager.	26 April 2015
3.	15 (2)	The registered person must ensure that the assessment of patient's needs is kept under review, particularly in relation to: • ensuring that fluid balance charts are recorded and totalled accurately and appropriate actions taken as required **Ref: section 11.8**	One	All staff nurses have been made aware of these failings in record keeping and this will be monitored by myself as registered manager.	26 April 2015

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.	19.1	Continence assessments should be completed for all patients who require continence management and support. **Ref: section 10.0**	One	This has been fully addressed.	26 April 2015
2.	19.2	The following best practice guidance should be made available to staff and used as required: • 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 **Ref: section 10.0**	One	These documents are all available at the nurses' station.	26 March 2015
3.	25.11	Care records should be regularly audited to ensure they are consistent with the home's policies and procedures and appropriate actions taken to enhance the quality of care. **Ref: section 10.0 and 11.8**	One	This has been commenced, each named nurse will edit another named nurse's care plans 3 monthly.	26 April 2015

4.	1.1	The term “cot sides”, which has the potential to demean patients, should be removed from nursing documentation and the term “bed rails” used instead. **Ref: section 11.8**	One	This has been replaced with the term 'bed rails' in the 3 care plans in question. All staff nurses have been made aware of same.	26 April 2015
5.	13.5	It is recommended that the registered provider offer a structured programme of varied activities and events and enable patients to participate by providing equipment, aids and staff support. **Ref: section 11.1**	One	Our new Activities Co-ordinator started work on 20/03/15.	26 May 2015

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Lucy Hamilton
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Heather Hamilton

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Karen Scarlett	23/4/15
Further information requested from provider			