# Announced Primary Inspection

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| **Name of Establishment:** | **Glenview Private Nursing Home.** |
| **Establishment ID No:** | **1485** |
| **Date of Inspection:** | **19 May 2014** |
| **Inspector's Name:** | **Heather Moore** |
| **Inspection No:** | **16495** |

**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

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| **Name of Home:** | Glenview Private Nursing Home. |
| **Address:** | 9 Cabragh Road<br>Dungannon<br>BT70 3AH |
| **Telephone Number:** | 028 8776 7132 |
| **E mail Address:** | glenview.nursing@btconnect.com |
| **Registered Organisation/ Registered Provider:** | Mr Mervyn John & Mrs Jennifer Elizabeth Gregg |
| **Registered Manager:** | Mrs Eleanor Elizabeth Caroline Sands |
| **Person in Charge of the Home at the time of Inspection:** | Mrs Eleanor Elizabeth Caroline Sands |
| **Registered Categories of Care and number of places:** | NH-I, NH-PH, NH-PH(E), NH-DE, RC-I<br><br>45 |
| **Number of Patients/Residents Accommodated on Day of Inspection:** | 36 Patients<br>5 Residents<br><br>(1 patient in hospital on day of inspection) |
| **Date and time of this inspection:** | 19 May 2014:<br>08.40 hours -16.15 hours |
| **Date and type of previous inspection:** | 21 January 2014<br>Primary Announced |

## 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 provider.
- 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:

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| Patients/Residents | **10 individually and with others in groups** |
| Staff | **12** |
| Relatives | **4** |
| 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 /Residents | **6** | **6** |
| Relatives / Representatives | **3** | **3** |
| Staff | **10** | **8** |

## 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 | | |
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| **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

Glenview Private Nursing Home is registered to provide nursing care in the old and infirm, dementia, and physically disabled categories of care. The home is also registered to provide residential care in the old and infirm category of care.

A new extension was built to the home and was completed in June 2009. This extension is provided over two floors and comprises of 22 en-suite single bedrooms. Ten of these bedrooms are provided in a separate unit for dementia nursing patients.

The original building is single storey and comprises of 21 single bedrooms, six of which are en-suite, and one double bedroom, dining room, sitting areas, and a designated smoking area are provided. Bath, shower, and toilet facilities are provided throughout the home. There are also designated staff areas and offices provided.

The grounds around the home are landscaped and secure areas are provided to enable patients and residents to relax outdoors weather permitting.

There are adequate car parking facilities at the front, side and back of the home.

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 (announced) to Glenview Private Nursing Home. The inspection was undertaken by Heather Moore on 19 May 2014 from 08.40 hours to 16.15 hours.

The inspector was welcomed into the home by Mrs Carol Sands Registered Manager who was available throughout the inspection. Mr Mervyn Gregg Registered Provider was also available on the morning of the inspection. Verbal feedback of the issues identified during the inspection was given to the registered manager and the administrative 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 four 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 three relatives during the inspection.

The inspector spent a number of extended periods observing staff, patient and resident 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 on 21 January 2014, two requirements and six recommendations were issued. These requirements and recommendations were reviewed during this inspection.
The inspector evidenced that one requirement was fully addressed one requirement was substantially addressed and is therefore restated. Four recommendations were fully addressed, one recommendation was substantially addressed and is therefore restate and one recommendation was not addressed and is therefore restated for the second time. 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 Glenview.

There was evidence of comprehensive and detailed assessment of patient needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool.

Two requirements and two recommendations are made in regard to shortfalls in patients'/residents' care records.

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.

- **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 requirement is made in regard to the non-reporting of one incident under Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

- **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 were observed to be assisted with dignity and respect throughout the meal.

- **Management of Dehydration – Standard 12**

The inspector also examined the management of dehydration during the inspection. The home maintained fluid intake of those patients assessed at risk of dehydration. However examination of a sample of patients' fluid balance charts confirmed that two charts were not totalled over a 24 hour period and there were no entries from 19.00 hours in two patients' fluid balance charts.

Care plans also did not reflect the action to be taken if the patients/residents fluid targets were not achieved.

The patients' daily fluid intakes were also not recorded in the patients' daily evaluation of care and treatment records.

A requirement and a restated recommendation are made in regard to the management of dehydration.

**The inspector can confirm that based on the evidence reviewed, presented and observed; that the level of compliance with this standard was assessed as Substantially Compliant**

**Patients/residents/representatives and staff questionnaires**

Some comments received from patients/residents/ and their representatives;

- "I am very happy here."
- "The food is first class."
- "Thank you for caring for me so much, the family really appreciate it very much"
- "Everyone is kind."
- "It's a grand home."
- "Excellent care and provision here."
- "Great managers and staff."
- "Excellent staff and wonderful care."
- "The food is very good."
- "Mum is being looked after very well."
- "The home is first class."

Some comments received from staff;

- "The home is well run, the patients are all well looked after."
- "The food is very good."
- "Glenview is a busy place but it has a very good working atmosphere."
- "Residents are all very well looked after."
- "No I do not have training in pressure area care."
- "Yes I had an induction when I commenced work."
- "No, I have not had training in Nutrition or Dysphagia."

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

However areas for improvement are identified, six requirements, one restated requirement, three recommendations and two restated recommendations are made. These requirement s and recommendations are addressed throughout the report and in the Quality Improvement plan (QIP).

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

The inspector would also like to thank the patients, residents, the relatives and staff who completed questionnaires.

## 9.0 Follow-up on Previous Issues

| No | Regulation Ref. | Requirements | Action taken - as confirmed during this inspection | Inspector's Validation of Compliance |
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| 1 | 20 (1) (c ) (i) | It is required that staff as appropriate be trained in the following areas:<br><br>Staff supervision - senior staff<br>Pressure ulcer and management - senior staff<br>Pressure area care and prevention - care staff<br>Nutrition and hydration - registered nurses and care staff. | Inspection of staff training records confirmed that senior staff had received training on staff supervision on 12.3.2014.<br><br>Registered nurses had received training on pressure ulcer and wound management on 10.3.2014.<br><br>Care staff had not received training on pressure area care and prevention<br>Registered nurses and care staff had not received training on Nutrition and Hydration.<br><br>**Restated** | **Substantially compliant** |
| 2 | 20 ( 2) | The registered person shall ensure that persons working at the nursing home are appropriately supervised. | Inspection of staff training records confirmed that systems were in place for staff to receive staff supervision. | **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 additional details be provided in reports of unannounced visits undertaken under Regulation 29. | Inspection of a sample of Regulation 29 reports confirmed that additional details in reports were not provided.<br><br>**Restated** | **Substantially compliant** |
| 2 | 25.12 | It is recommended that details provided in reports of unannounced visits undertaken under Regulation 29 be discussed with staff during staff meetings /forums. | Inspection of minutes of staff meetings confirmed that information in regard to Regulation 29 was discussed with staff. | **Compliant** |
| 3 | 25.12 | It is recommended that audits are undertaken in the home on a regular basis. | Discussion with the registered manager and inspection of records confirmed that audits are undertaken in the home. | **Compliant** |
| 4 | 28.1 | It is recommended that the template used to undertake registered nurses induction programmes be reviewed to address the duties required to be undertaken by these staff including pressure ulcer prevention and management. | Since the previous inspection the template used to undertake registered nurses induction programmes had been reviewed to address the duties required to be undertaken by these staff including pressure ulcer prevention and management. | **Compliant** |
| 5 | 30.1 | It is recommended that a designated activity therapist be appointed to take the lead in the provision of activities to patients and residents. | Discussion with the registered manager confirmed that a designated activity has been appointed and shall be commencing her post on 02 June 2014. | **Compliant** |

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| 6 | 12.10 | It is recommended that patients' recommended daily fluid targets and the action to be taken if these targets are not being achieved be recorded in patients' care plans on eating and drinking. It is also recommended that patients' total fluid intake for each 24 hour period be recorded in the evaluations of care and treatment provided to patients. | Inspection of a sample of patients' daily fluid charts and three patients care records confirmed that patients recommended daily fluid targets and the action taken if these targets were not being achieved were not recorded.<br><br>The patients' total fluid intakes were not recorded daily in the evaluations of care and treatment provided to patients.<br><br>**Restated** | **Not Compliant** |

## 10.0 Inspection Findings

### Section A

**Standard : 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**

**Standard 5.2**

- **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission**

**Standard 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**

**Standard 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**

**Inspection Findings:**

Policies and procedures relating to pre-admission and admission for planned and emergency admissions were available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

There was evidence to demonstrate that patients'/residents' individual needs were established on the day they were admitted to the nursing home, and effective procedures were in place to manage any identified risks.

The inspector reviewed three patients' and residents' care records which evidenced that at the time of each patient's and resident's admission to the home, a registered nurse carried out initial risk assessments and developed agreed plans of care to meet the patient's and resident's immediate care needs.

Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, pain

and continence were also completed on admission.

Inspection of three patients' care records revealed that one patient's pain assessment was completed. A recommendation is made in this regard.

Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure ulcer/wound and if required, the specific care plans regarding the management of the pressure/ulcer wound.

In discussion with the registered manager she demonstrated a good awareness of the patients who required wound management intervention.

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

**Section B**

**Standard 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.**

**Standard 11.2**

- **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.**

**Standard 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.**

**Standard 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**

**Standard 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**

**Inspection Findings:**

The inspector observed that a named nurse system was operational in the home.

Review of three patients' care records and discussion with 10 patients' /residents'individually and four patient's representatives evidenced that patients, residents, and/or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. However inspection of three patients' care records confirmed that there was no written evidence in one patient's care record. A recommendation is made in this regard.

In relation to wound care, the inspector examined two patients' care records.

Body mapping charts were completed for patients and residents on admission. These charts were reviewed and updated when any changes occurred to the patients' skin conditions. However inspection of two care plans revealed that the pressure relieving equipment in place on the patients' beds and also when sitting out of bed was not recorded. A recommendation is made that this be addressed.

A daily repositioning and skin inspection chart was in place for patients with wounds and or at risk of pressure damage. A review of two repositioning charts revealed that patients' skin condition was inspected at each positional change and records of findings were maintained

Wound observation charts outlined the dimensions of wounds and were completed each time dressings were changed. Entries were also made in wound care records each time the dressings were changed.

Inspection of two patients' care records revealed that one pain assessment was in place however this assessment was not completed. A recommendation is made in this regard.

A requirement is also made that a specific care plan on pain management is maintained in the patient's care record.

Discussion with two registered nurses and review of four patients' care records confirmed that where a patient was assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention plan and treatment programme. Advice sought from the relevant healthcare professionals was recorded. Care records reflected advice provided by these professionals, and records reviewed demonstrated that the advice provided was adhered to.

The registered manager confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local healthcare trust. Staff spoken with was knowledgeable regarding the referral process. Discussion with two registered nurses evidenced that they were knowledgeable of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

Review of the records of incidents revealed that an incident in regard to wound care intervention was not reported to the RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. A requirement is made that this be addressed.

Patients' and residents' weights were recorded on admission and on at least a monthly basis or more often if required.

Patients' and residents' nutritional status was also reviewed on at least a monthly basis or more often if required.

Policies and procedures were in place for staff on making referrals to the dietician. These include indicators of the action to be taken and by

whom.

All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment.

Care records reviewed evidenced that patients and residents were referred for dietetic assessment in a timely manner.

Observation of practice and discussion with patients and staff evidenced that the nutritional care plans were being implemented.

Review of staff training records revealed that registered nurses had received training in wound management on 14 March 2014; care staff had not received training in pressure area care and prevention. A restated requirement is made that this is addressed.

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| **Provider's overall assessment of the nursing home's compliance level against the standard assessed** | **Substantially compliant** |
| **Inspector's overall assessment of the nursing home's compliance level against the standard assessed** | **Moving Towards Compliance** |

**Section C**

| **Standard 5.4**<br>• **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.**<br><br>**Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16** |
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| **Inspection Findings:** |
| Review of three patients' and residents' care records revealed that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs.<br><br>Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care including wound management for each patient.<br><br>Care plans were reviewed and updated on at least a monthly basis or more often if required. However one patient's bedrail risk assessment was not reviewed on a monthly basis or more often if deemed appropriate. A requirement is made in this regard.<br><br>Review of two patients' care records in relation to wound care and management of nutrition indicated that these were reviewed at least weekly.<br><br>Discussion with the registered manager and review of governance documents evidenced that the quality of care records was audited on a monthly basis however a number of care records were not audited. The registered manager undertook to address this issue. |

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

**Section D**

**Standard 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.**

**Standard 11.4**

- **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.**

**Standard 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)**

**Inspection Findings:**

The inspector examined four patients' care records which evidenced the completion of validated assessment tools such as;

- The Roper, Logan and Tierney assessment of activities of daily living
- Braden pressure risk assessment tool
- Nutritional risk assessment such as Malnutrition Universal Screening Tool (MUST).

The inspector confirmed the following research and guidance documents were available in the home;

- The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.
- The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care
- The European Pressure Ulcer Advisory Panel (EPUAP).

Discussion with the registered manager and registered nurses confirmed that they had a good awareness of these guidelines. Review of three patients' care records evidenced that registered nurses implemented and applied this knowledge.

Discussion with the registered manager and review of governance documents evidenced that the quality of pressure ulcer/wound management was audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and residents and the principles of providing good nutritional care. Two registered nurses and two care staff consulted could identify patients and residents who required support with eating and drinking.

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

**Section E**

**Standard 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.**

**Standard 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.**

**Standard 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**

**Inspection Findings:**

A policy and procedure relating to record management was available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Home Minimum Standards (2008) and NMC professional guidance.

Registered nurses spoken with were aware of their accountability and responsibility regarding record keeping.

Review of three patients' and residents' care records confirmed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient and resident.

These statements reflected wound and nutritional management intervention for patients and residents if required.

Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patient's/resident' status or to indicate communication with others concerning the patients and residents.

Entries were noted to be dated, timed and signed with the signature accompanied by the designation of the signatory.

The inspector reviewed a record of the meals provided for patients and residents. Records were maintained in sufficient detail which enabled the inspector to judge that the diet for each patient was satisfactory. For example, the record evidenced a choice at each mealtime.

The inspector reviewed the care records of two identified patients of being at risk of inadequate food and fluid intake. This review confirmed that;

- The nurse in charge had discussed with the patient/representative regarding their dietary needs
- Where necessary a referral had been made to the dietician and or the speech and language therapist
- Care plans had been devised to manage needs and were reviewed regularly, monthly or more often if deemed appropriate
- Care plans were reflective of recommendations made by specialist healthcare professionals.

Review of a sample of fluid balance charts for one patient revealed that the fluid intake records for this patient failed to evidence:

- The total fluid intake for two days
- An effective reconciliation of the total fluid intake against the fluid target established
- Action to be taken if targets were not being achieved
- A record of reconciliation of fluid intake in the patient's daily progress notes.

A requirement and a restated recommendation are made in regard to the maintenance of patients' fluid balance charts.

Staff spoken with on the day of inspection were knowledgeable regarding patients' and residents' nutritional needs.

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| **Provider's overall assessment of the nursing home's compliance level against the standard assessed** | **Substantially Compliant** |
| **Inspector's overall assessment of the nursing home's compliance level against the standard assessed** | **Moving Towards Compliance** |

**Section F**

| **Standard 5.7**<br>• **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.**<br><br>**Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16** |
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| **Inspection Findings:** |
| Please refer to criterion examined in section E. In addition the review of patients' care records evidenced that consultation with the patients and/or their representatives had taken place in relation to the planning of their care. This is in keeping with the DHSSPS minimum standards and the Human Rights Act 1998. |

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

**Section G**

**Standard 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**

**Standard 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)**

**Inspection Findings:**

Prior to the inspection a patients' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that all patients in the home had a care review undertaken through care management arrangements between 01 April 2013 and 31 March 2014.

The registered manager informed the inspector that care management reviews were held post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff attends each review. A copy of the minutes of the most recent review was held in the patient's care record file.

The inspector viewed the minutes of four care management reviews which evidenced that, where appropriate patients and their representatives had been invited to attend. Minutes of the review included the names of those who had attended an assessment of the patients' needs and a record of issues discussed. Care plans were updated to reflect recommendations made at care management reviews where applicable.

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

**Section H**

**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 Homes Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**

**Inspection Findings:**

A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance.

There was a four weekly menu planner in place. The registered manager informed the inspector that the menu planner had been reviewed and updated in consultation with patients, residents / their representatives and staff in the home. The current menu planner was implemented on 01 April 2014.

The inspector discussed with the registered manager and a number of staff the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients.

Staff spoken with were knowledgeable regarding the individual dietary needs of patients to include their likes and dislikes. Discussion with staff and review of the record of the patient's meals confirmed that patients were offered choice prior to their meals.

Staff spoken with were knowledgeable regarding the indicators for onward referrals to the relevant professionals e.g. speech and language therapist or dieticians.

Inspection of staff training records confirmed that staff require training in Nutrition and Hydration. A restated requirement is made in this regard.

As previously stated under Section D relevant guidance documents were in place.

Review of the menu planner and records of patients' and residents' choices and discussion with a number of patients, residents 'registered nurses and care staff it was revealed that choices were available at each meal time. The registered manager confirmed choices were also available to patients and residents who were on therapeutic diets.

| | |
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| **Provider's overall assessment of the nursing home's compliance level against the standard assessed** | **Substantially Compliant** |
| **Inspector's overall assessment of the nursing home's compliance level against the standard assessed** | **Substantially 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**<br>• **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.**<br>**Criterion 12.5**<br>• **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.**<br>**Criterion 12.10**<br>• **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:**<br>o **risks when patients are eating and drinking are managed**<br>o **required assistance is provided**<br>o **necessary aids and equipment are available for use.**<br>**Criterion 11.7**<br>• **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.**<br><br>**Nursing Homes Regulations (Northern Ireland)2005:Regulation/s13 (1) and 20** |
| **Inspection Findings:** |
| The inspector discussed the needs of the patients and residents with the registered manager. It was determined that a number of patients had swallowing difficulties.<br><br>Review of training records revealed that staff had not attended training in dysphagia in past 12 months. A requirement is made in regarding to this training.<br><br>Review of patients' care records who had been assessed by a speech and language therapist confirmed that their care plans had been |

reviewed to include the speech and language therapist's recommendations.

Discussion with registered manager confirmed that meals were served at appropriate intervals throughout the day and in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.

The registered manager confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning, afternoon and at supper times.

The inspector observed that a choice of fluids to include fresh drinking water were available and refreshed regularly. Staff were observed offering patients and residents fluids at regular intervals throughout the day.

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and residents and the principles of providing good nutritional care. Two registered nurses and two care staff consulted could identify patients who required support with eating and drinking.

On the day of the inspection, the inspector observed the lunch meal. Observation confirmed that meals were served promptly and assistance required by patients and residents was delivered in a timely manner.

Staff were observed preparing and seating the patients and residents for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients and residents with their meal and patients and residents were offered a choice of fluids. The tables were well presented with condiments appropriate for the meal served.

Discussion with the registered manager, registered nurses, care staff and review of the staff training records revealed that registered nurses were trained in wound management however care staff were not trained in pressure care and prevention. A restated requirement is made in this regard.

A tissue viability link nurses was employed in the home.

Discussion with the registered nurses clearly evidenced their knowledge in the assessment, management and treatment of wounds. Review of the template used to undertake competency and capability assessments for the registered nurses revealed that pressure ulcer/wound care was addressed.

| | |
|---|---|
| **Provider's overall assessment of the nursing home's compliance level against the standard assessed** | **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 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
- Sample of the minutes of patients/relatives and staff meetings. Heather no need to include as Linda stated in template

### 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' and residents' lunch meal which was served in the dining room. The inspector also observed care practices in the day room following the meal. The observation tool used to record this observation was the Quality of Interaction Schedule (QUIS). This tool uses a simple coding system to record interactions between staff, residents, patients and relatives. The inspector evidenced that the quality of interactions between staff patients and residents were positive.

| | |
|---|---|
| Positive interactions | All positive |
| Basic care interactions | |
| Neutral interactions | |
| Negative interactions | |

### 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. The evidence provided in the returned questionnaire indicated that there were no complaints recorded since the previous inspection.

### 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 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 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 10 staff members during the inspection process and eight staff completed questionnaires.

Examples of staff comments were for as follows:

- "The home is well run, the patients are all well looked after."
- "The food is very good."
- "Glenview is a busy place but it has a very good working atmosphere."
- "Residents are all very well looked after."
- "No I do not have training in pressure area care."
- "Yes I had an induction when I commenced work."
- "No, I have not had training in Nutrition or Dysphagia."

## 11.9 Regulation 29 Visits

Inspection of a sample of reports of unannounced visits undertaken under Regulation 29 confirmed that a recommendation made in the previous inspection report in regard to providing additional details in the report was not addressed. For example the outcome of audits, observation of care practices on the day of the visit, staff appraisals, staff supervision, staffing levels including the number and grades of staff. Management and nursing initiatives currently being undertaken in the home should also be included. A restated recommendation is made that this be addressed

## 11.10 Patients' Residents' Comments

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

Examples of their comments were as follows:

- "I am very happy here."
- "The food is first class."
- "Everyone is kind."
- "It's a grand home."
- Thank you for caring for me so well, the family appreciate it so much."
- "The home is first class."

## 11.11 Relatives' Comments

The inspector spoke to three relatives and two relatives completed a questionnaire. Examples of their comments were as follows:

"Great managers and staff"
"Excellent staff, all the staff are wonderful."
"Mum is being looked after very well."
"The home is first class"
"Excellent care and provision"

## 11.12 Environment

The inspector undertook a tour of the home and viewed a number of patients' and residents' bedrooms, communal facilities and toilet and bathroom areas. The premises presented as warm, clean and comfortable with a friendly and relaxed ambience. However during a tour of the premises it was revealed that an external medicine was inappropriately stored in a patient's bedroom in the Dementia Unit of the home. A requirement is made in this regard.

## 12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Carol Sands, Registered Manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

**Heather Moore**
**The Regulation and Quality Improvement Authority**
**Hilltop**
**Tyrone & Fermanagh Hospital**
**Omagh**
**BT79 0NS**

_____ _____

**Heather Moore** **Date**
**Inspector/ Quality Reviewer**

| 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**<br>• **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.**<br>**Criterion 5.2**<br>• **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.**<br>**Criterion 8.1**<br>• **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.**<br>**Criterion 11.1**<br>• **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.**<br><br>**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** |
| Prior to and within 11 days of admission both the Nurse Manager and the home's Staff Nurses undertake detailed assessments of each patient using validated tools these include the twelve activities of daily living the MUST tool, Falls Risk Assessment, Pressure Ulcer etc. Information with regards to the prospective patient is sought both from the family as well as the placing Health and Social Care Trust to enable a comprehensive and accurate plan of care to be developed to best meet the needs of the patient. | Substantially 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**<br>• **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.**<br>**Criterion 11.2**<br>• **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.**<br>**Criterion 11.3**<br>• **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.**<br>**Criterion 11.8**<br>• **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.**<br>**Criterion 8.3**<br>• **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.**<br><br>**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** |
| Each patient has allocated within the home a Named Nurse who has full responsibility for their patient and the discussing, planning and agreeing care interventions to enable the needs of the patient to be met, this also includes attendance at Care Review meetings etc.<br>The home has in place robust systems and procedures which enable referrals to be made where necessary to seek advice and support of the relevant healthcare professionals with regards to nutrition and tissue viability. | Substantially 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**<br>• **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.**<br><br>**Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16** | |
| **Provider's assessment of the nursing home's compliance level against the criteria assessed within this section** | **Section compliance level** |
| The home provides 24 hour nursing care this means that each patient is monitored on such a basis and that re-assessment is carried out on an ongoing 24 hour basis and where changes or issues are identified then these are detailed and documented along with timescales and acted upon. | Substantially 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**<br>• **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.**<br>**Criterion 11.4**<br>• **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.**<br>**Criterion 8.4**<br>• **There are up to date nutritional guidelines that are in use by staff on a daily basis.**<br><br>**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** |
| Nursing interventions, activities and procedures carried out by the Nurses are based upon the Guidelines Standards and research evidence which has been developed is in place from professional bodies and standard setting agencies such as the NMC, NICE, RQIA Department of Health etc.<br>The home has in place a validated pressure ulcer grading tool which is used to screen patients who have skin damage to identify condition and progress monitored so that the effectiveness of the treatment plans implemented can be monitored and amended as required.<br>The home's staff on a daily basis use up to date nutritional guidelines. | Substantially 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**<br>• **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.**<br>**Criterion 12.11**<br>• **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.**<br>**Criterion 12.12**<br>• **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.**<br>**Where a patient is eating excessively, a similar record is kept.**<br>**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.**<br><br>**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** |
| Registered Nurses employed within the home record contemporaneous nursing notes in accordance with the NMC guidelines of all interventions, activities and procedures that are carried out in relation to each patient including observations made.<br>Records are kept of the meals provided by the home in sufficient detail to enable judgement to be made as to the diet of the patient being satisfactory.<br>Where it is deemed necessary a record is maintained on a 24hr basis of fluids and food offered, taken and the quantity, these are then reviewed by the nursing staff and discussed where possible with the patient, based upon the professional judgement of the nursing staff, advice or a referral would be made to the relevant healthcare professionals. Records of all advice and referrals are maintained. | Substantially 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**<br>• **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.**<br><br>**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** |
| There is continous ongoing monitoring and recording of the care delivered which is assessed against outcomes, this is subject to documented review with all relevant parties including the patient, family members and healthcare professionals with mutually agreed outcomes and timescales by those involved. | Substantially 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**<br>• **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.**<br>**Criterion 5.9**<br>• **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.**<br><br>**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** |
| Where possible based upon the individual wish and ability of the patient within the home they are encouraged to attend and to participate and contribute in relation to all aspects of the patient review meetings.<br>The minutes of the review meetings are circulated to all those in attendance, with next of kin and representatives kept updated with regards to progress. | Substantially 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**<br>• **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.**<br>**Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.**<br>**Criterion 12.3**<br>• **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.**<br>**A choice is also offered to those on therapeutic or specific diets.**<br><br>**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** |
| The home provides each patient with a wide range of nutritious foods to suit the individual likes and dislikes.<br>Dietary preference of each patient is recorded,<br>Diets provided are based upon the guidance provided by dieticians and the appropriate guidance documentation.<br>The menu provided by the homes experienced kitchen staff offers each patient individual choice, there is always more than one choice for main meals, the kitchen also provides for patients who are on special therapeutic diets or who have specific dietary needs. | Substantially 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**<br>• **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.**<br>**Criterion 12.5**<br>• **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.**<br>**Criterion 12.10**<br>• **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:**<br>o **risks when patients are eating and drinking are managed**<br>o **required assistance is provided**<br>o **necessary aids and equipment are available for use.**<br>**Criterion 11.7**<br>• **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.**<br><br>**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** |
| The homes Nurses and Care Assistant staff have undergone training with respect to the management of feeding techniques in relation to patients who have swallowing difficulties, based upon the instructions of the speech and language therapist as well as other healthcare professionals.<br>The kitchen provides nutritional meals at times which includes hot and cold drinks and snacks including fresk drinks are available on a 24Hr basis. | Substantially compliant |

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

The Regulation and Quality Improvement Authority



# Quality Improvement Plan

## Announced Primary Inspection

### Glenview Private Nursing Home

### 19 May 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Carol Sands, Registered Manager during the inspection feedback.

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

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

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

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

**Statutory Requirements**

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

| No. | Regulation Reference | Requirements | Number of Times Stated | Details Of Action Taken By Registered Person(S) | Timescale |
|---|---|---|---|---|---|
| 1 | 16 (1) | The registered person shall ensure that a specific care plan on pain management is maintained in care plans for patients who require wound care intervention.<br><br>**Ref: Section B** | One | CARE PLAN IS NOW IN PLACE ON PATIENT WITH WOUNDS AND WILL CONTINUE ON PATIENTS WHO HAVE A WOUND. | From the date of this inspection |
| 2 | 16 (2) | The registered person shall ensure that patients' bedrail risk assessments are reviewed monthly or more often if deemed appropriate.<br><br>**Ref: Section B** | One | STAFF NURSES HAVE BEEN INFORMED. | From the date of this inspection |
| 3 | 30 (1) (d) | The registered person shall give notice to the RQIA without delay of the occurrence of any event in the nursing home which adversely affects the well -being or safety of any patient.<br><br>**Ref: Section B** | One | REGISTERED PERSON UNDERSTANDS AND WILL GIVE NOTICE OF SAME SHOULD IT ARISE. | From the date of this inspection |
| 4 | 14 (2) (c) | The registered person shall make arrangements for any unnecessary risks to the health or safety of patients are identified and so far as possible eliminated.<br><br>**Ref: Section11 point 11.11** | One | THIS HAS BEEN ADDRESSED. | From the date of this inspection |

| | | | | | |
|---|---|---|---|---|---|
| 5 | 20 (1) (c) (i) | The registered person shall ensure that staff be trained in the following areas:<br><br>• Pressure area care and prevention (care staff)<br>• Nutrition and Hydration (registered nurses and care staff)<br><br>**Ref: Section B & Section H** | Two | TRAINING IS CURRENTLY BEING SOURCED FOR PRESSURE CARE AND PREVENTION FOR CARE STAFF. NUTRITION + HYDRATION TRAINING – I DISCUSSED SAME WITH DIETATION & GLENVIEW IS ON THE LIST FOR TRAINING. | Two Months |
| 6 | 20(1)(c)(i) | The registered person shall ensure that staff as appropriate be trained in Dysphagia<br><br>**Ref : Section I** | One | I AM SOURCING THIS – PART OF THIS HAS BEEN COVERED IN FIRST AID TRAINING. * | Two Months |
| 7 | 13(1)(a) | The registered person shall ensure that the nursing home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients.<br><br>This requirement is made in regard to the maintenance of patients' fluid balance charts.<br><br>**Ref: Section E** | One | THIS HAS BEEN ADDRESSED.<br><br>COMPLETED OVER A 24 HOUR PERIOD. | From the date of this inspection |

* STAFF ARE AWARE WHEN 'SALT' VISIT THE INFORMATION * IS PUT IN A FOLDER FOR THEM TO ADHERE TO. DYSPHAGIA TRAINING IS NOW ARRANGED FOR 2nd SEPT. 2014.

**Recommendations**

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

| No. | Minimum Standard Reference | Recommendations | Number Of Times Stated | Details Of Action Taken By Registered Person(S) | Timescale |
|---|---|---|---|---|---|
| 1 | 5.3 | It is recommended that the patients' pressure relieving equipment in use on patients' beds and when sitting out of bed be addressed in patients' care plans on pressure area care and prevention.<br><br>**Ref: Section B** | One | STAFF NURSES HAS BEEN INFORMED | One Week |
| 2 | 5. 2 | It is recommended that a pain assessment be maintained in patients' care records (if applicable).<br><br>**Ref: Section B** | One | SAME HAS BEEN ADDRESSED | One week |
| 3 | 5.3 | It is recommended that written evidence is maintained in patients' and residents' care records to indicate that discussions had taken place with patients, residents, and their representatives in regard to planning and agreeing nursing interventions.<br><br>**Ref: Section B** | One | HAS BEEN DISCUSSED WITH PATIENT AND IS NOW IN PLACE. | One week |
| 4 | 12.10 | It is recommended that patients' recommended daily fluid targets and the action to be taken if these targets are not being achieved be recorded in patients' care plans on eating and drinking. | Two | A 24 HOUR FLUID BALANCE CHART IS BEING RECORDED & MAINTAINED. | From the date of this inspection |

| | | | | | |
|---|---|---|---|---|---|
| | | It is also recommended that patient's total fluid intake for each 24 hour period be recorded in the evaluations of care and treatment provided to patients.<br><br>**Ref: Section E** | | THIS IS NOW BEING ADDRESSED. | |
| 5 | 25.12 | It is recommended that additional details be provided in reports of unannounced visits undertaken under Regulation 29.<br><br>**Ref Section11 point 11.9** | One | THIS HAS BEEN RELAYED TO PERSON UNDERTAKING REG. 29 | One Month |

**The registered provider / manager is required to detail the action taken, or to be taken, in response to the issue(s) raised in the Quality Improvement Plan. The Quality Improvement Plan is then to be signed below by the registered provider and registered manager and returned to:**

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

**Signed:** _____ **Signed:** Carol Sands

**Name:** MERVYN GREGG **Name:** CAROL SANDS
**Registered Provider** **Registered Manager**

**Date** 9th July 2014 **Date** 9th July 2014

| QIP Position Based on Comments from Registered Persons | Yes | Inspector | Date |
|---|---|---|---|
| Response assessed by inspector as acceptable | ☐ | ☐ | 23.7.14 |
| Further information requested from provider | | | |