Unannounced Care Inspection

Name of Establishment:	**Greenpark Private Nursing Home**
RQIA Number:	**1486**
Date of Inspection:	**10 February 2015**
Inspector's Name:	**Donna Rogan**
Inspection ID:	**IN017212**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Greenpark Private Nursing Home
Address:	5 Keady Road, Armagh, BT60 4AA
Telephone Number:	(028) 3752 7445
Email Address:	greenpark@utvinternet.com
Registered Organisation/ Registered Provider:	Mr Edward Maguire
Registered Manager:	Mrs Mary McKee
Person in Charge of the Home at the Time of Inspection:	Mrs Mary McKee
Categories of Care:	NH-I, NH-DE, NH-MP/MP(E), NH-PH/PH(E), NH-LD(E), RC-I, RC-LD(E), RC-MP(E)
Number of Registered Places:	62
Number of Patients Accommodated on Day of Inspection:	53 Total 13 Residential 40 Frail elderly nursing
Date and Type of Previous Inspection:	7 March 2014 Secondary Unannounced
Date and Time of Inspection:	10 February 2015 Secondary Unannounced 10.30 – 16.30 hours
Name of Inspector:	Donna Rogan

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- Discussion with the Registered Provider.
- Discussion with the Registered Nurse Manager.
- Discussion with staff.
- Discussion with patients individually and to others in groups.
- Consultation with relatives.
- Review of a sample of policies and procedures.
- Review of a sample of staff training records.
- Review of a sample of staff duty rotas.
- Review of a sample of care plans.
- Review of the complaints, accidents and incidents records.
- Observation during a tour of the premises.
- Evaluation and feedback.

5.0 Consultation Process

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

Patients/Residents	**28**
Staff	**12**
Relatives	**3**
Visiting Professionals	**1**

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**2**	**2**
Relatives/Representatives	**6**	**3**
Staff	**10**	**7**

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.

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

Greenpark Private Nursing Home is centrally located to Armagh and situated in private grounds. The home is a three storey building registered to accommodate a maximum of sixty-two persons requiring both nursing and residential care.

The bedroom accommodation comprises of a range of single bedrooms and double bedrooms.

There are a number of sitting rooms, a designated smoke room for patients and residents and two dining rooms, a kitchen, a laundry, toilet/washing facilities, staff accommodation and offices.

Suitable car parking facilities and a landscaped area are available at the front of the premises.

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

Nursing Care (I)	Old age not falling into any other category
Nursing Care (MP)	Mental disorder excluding learning disability or dementia
Nursing Care MP (E)	Mental disorder excluding learning disability or dementia - over 65 years
Nursing Care (PH)	Physical disability other than sensory impairment
Nursing Care PH (E)	Physical disability other than sensory impairment - over 65 years
Nursing (DE)	Dementia
Nursing LD (E)	Learning Disability - over 65 years
Residential Care (I)	Old age not falling into any other category
Residential Care LD (E)	Learning Disability - over 65 years
Residential Care MP (E)	Mental disorder excluding learning disability or dementia - over 65 years

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) was reviewed and was appropriately displayed in the foyer of the home.

8.0 Executive Summary

This summary provides an overview of the services examined during an unannounced secondary care inspection to Greenpark Private Nursing Home. The inspection was undertaken by Donna Rogan on 10 February 2015 from 10.30 to 16.30.

The inspector was welcomed into the home by Mary McKee, registered nurse manager. The registered provider Edward Maguire joined the inspection shortly after it had commenced. Mrs McKee was provided with verbal feedback at the conclusion of the inspection.

During the course of the inspection, the inspector met with patients and staff and 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.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. This self-assessment was received by RQIA on 28 April 2014. The inspector reviewed the responses provided, however, due to a change in inspection focus has been unable to validate all of the statements provided. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

As a result of the previous inspection conducted on 7 March 2014, three requirements were made. They were reviewed during this inspection. The inspector evidenced that all three requirements were fully complied with. One recommendation was made during the previous inspection. The inspector evidenced that the recommendation was fully complied with. Details of the actions taken regarding the previous requirements can be viewed in the section immediately following this summary.

Conclusion

The inspector can confirm that at the time of this inspection the delivery of care to patients was evidenced to be of a good standard. There were processes in place to ensure the management of continence care. One recommendation was made in regard to this theme.

In addition to the theme inspected the inspectors also reviewed the following;

- Care practices
- Complaints
- Patient finance questionnaire
- NMC declaration
- Patients/Residents and Relatives Comments and returned Questionnaires
- Questionnaire Findings/Staff Comments
- Fire safety
- Environment

Requirements are made in relation to care practices, fire safety and the environment. A total of three requirements and one recommendation are made following this inspection. These requirements are detailed throughout the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, 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, 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
1	27 (2)	The registered person shall conduct a risk assessment for all 'third party bed rails' in use in the home and ensure they are maintained in accordance with the Medical Device/Equipment Alert MDEA (NI) 2007/09.	There are currently no third party bed rails being used in the home. The registered manager was knowledgeable regarding the requirement regarding the appropriate management of bedrails for both integral and third party.	Compliant
2	27 (2)	Provide RQIA in writing confirmation of the agreed plan to replace beds identified as having 'third party bed rails' in place which do not meet the standard as advised in Medical Device/Equipment Alert MDEA (NI) 2007/09. Continue to monitor all bed rails in accordance with best practice. Records should be maintained.	The inspector can confirm that the agreed plan was forwarded to RQIA and was carried out as planned. The registered manager confirms that all bed rails in the home are currently being managed in accordance with best practice.	Compliant

3	20 (3)	Ensure that all staff managing wounds/pressure ulcer care should have a competency and capability assessment completed. Records should be maintained of the supervision and competency and capability assessments carried out.	The inspector reviewed three staff competency and capability assessments of three registered nurses. All three contained competency levels regarding managing wounds/pressure ulcer care.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	25	Ensure information is placed on the patient/relatives' notice board informing patients and their representatives that copies of the Regulation 29 unannounced visit and the annual quality report are available on request.	The inspector observed information placed on the patient/relatives notice board informing patients and their representatives that copies of the Regulation 29 unannounced visit and the annual quality report were available upon request.	Compliant

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

RQIA is satisfied that the registered manager has dealt with all notification of incidents/ issues in the appropriate manner and in accordance with regional guidelines and legislative requirements.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**Compliance Level**
Inspection Findings:	
Review of five patients' care records evidenced that bladder and bowel continence assessments were undertaken for patients. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. There was evidence in five patients care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. Review of five patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. The care plans reviewed addressed the patients' assessed needs in regard to continence management. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**Compliance Level**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place; • stoma care • catheter care They were up to date and reflective of best practice guidelines. The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines for improving continence care were available • NICE guidelines for urinary faecal incontinence • British Geriatrics Society Continence Care in Nursing and Residential Care It is recommended that a policy is developed regarding the management of urinary continence and faecal continence/incontinence and constipation care. Discussion with staff revealed that they had an awareness of the above policies and guidelines. There is a continence link nurse aligned to the home from the local Healthcare Trust, staff confirmed that they would often contact the continence link nurse for advice and guidance.	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 validated
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**Compliance Level**
Inspection Findings:	
Discussion with the nurse manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the nurse manager revealed that all two registered nurses in the home had received recent training and were deemed competent in female and male catheterisation and the management of stoma appliances. Both registered nurses were identified in the home as the continence link nurses working in the home and were involved in the review of continence management and education programmes for staff. All care staff have recently received training in Effective Fluid Management, the content of the training included dysphasia management and the practice of thickening fluids. This is good practice and is commended. A review of two members of staff induction programme evidenced that continence care was included in the programme for all grades of care staff.	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

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

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

The afternoon routine was observed to be well organised. Patients spoken with stated that they could choose where to have their lunch. Patients also informed the inspector that their continence needs were tended to in a timely way, they stated that when they sounded the nurse call system that their request was usually answered promptly.

There was a good atmosphere in the home. There is an organised activity programme ongoing. Patients spoken with stated they enjoyed the activities organised. One patient commented in the returned questionnaire that they "would love an activities room".

A review of the staffing rosters evidenced that there are only three registered nurses on duty in the home from the hours of 08.00 to 14.00, for a total of 53 patients/residents. The registered manager informed the inspector that 13 are residential residents. However, registered nursing staff are managing their care on a daily basis, for example administrating their medication and completing their care records. Therefore this should be reflective in the staffing skill mix and numbers and a total of four registered nurses should be on duty between the hours of 08.00 and 14.00. The registered manager agreed to address this issue as a priority.

11.2 Complaints

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

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

11.3 Patient Finance Questionnaire

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

11.4 NMC Declaration

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

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

11.5 Patients/Residents and Relatives Comments and returned Questionnaires

During the inspection the inspector spoke with all patients in the home either individually or in groups. All 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:

"The care we get is great"
"I couldn't be happier"
"Staff are so kind and considerate, I'm not afraid to ask for anything"
"I like the food, I can't complain"
"I always get plenty to eat"
"I'm very happy with care in Greenpark, I love the food and always get enough to eat"
"It's a happy friendly home"
"All my needs and wants are met"
"Good atmosphere in the home"
"The quality of care I receive is brilliant"

The inspector also spoke with three relatives visiting at the time of the inspection. All were very positive regarding the care their relatives were receiving in the home. They were confident that they could approach management if they had any issues in the home. All stated that they felt they were kept well informed of changes in their relatives needs and felt they were involved in their care. There were no issues raised by patients/residents or relatives to the inspector during the inspection.

Three questionnaires were returned with the following comments;

"I am confident that my relative is receiving good care and treatment in the home"
"Staff speak to my relative in an appropriate manner"
"The care provided by Greenpark is excellent. My mum is very well looked after and I am grateful to all the staff. Mary does an excellent job in running the home".

The inspector also spoke with one visiting professional during the inspection the professional stated that they felt that the overall management in the home had improved with a stable manager in place.

11.6 Questionnaire Findings/Staff Comments

During the inspection the inspector spoke with 12 staff. The inspector was able to speak to a number of these staff individually and in private. Staff responses during discussion indicated that staff received an induction, completed mandatory training, completed additional training in relation to continence care 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. There were no issues raised by staff to the inspector during the inspection nor were any made in the retuned in the staff questionnaires.

Examples of staff comments were as follows;

“We are all happy in work”
“The care is second to none”
“I can approach the manager if I have any need for anything”
“We are well trained and equipped for our jobs”
“Satisfied that I have time to talk and listen with patients”
“Satisfied patients are afforded privacy”
“We get an update on training every year”
“I think the quality of care is very good and the food provided is excellent”
“It’s a pleasure to work here”

11.7 Fire safety

On the day of the inspection there had been an incident where the fire alarm sounded following a cigarette not being properly extinguished by a patient. The incident was a small fire which caused quite a bit of smoke in the smoking room. The incident was immediately dealt with by staff in the home. The fire was immediately extinguished. The inspector consulted with the estates inspector for the home from RQIA and a visit was arranged on the 12 February 2015. Following the inspection by the estates inspector and it was assessed that staff had acted quickly and appropriately following the alarm sounding. The registered manager agreed to review the management of smoking in the home by all patients to ensure their assessment is up to date and that their car plan is up to date and suited to their current needs. A requirement is made in this regard.

11.8 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 good standard of hygiene.

Since the previous inspection the following work had been completed;

- The front reception and B side reception both have been re-decorated and re-carpeted and new furniture purchased.
- The main reception has had the desk removed, it has be redecorated and the wooden flooring has been restored and new furniture has been purchased.
- Two dining rooms have been repainted and new accessories have been purchased such as curtains and poles.
- Kitchen has been repainted
- Dementia unit has been redecorated

The following issues are required to be addressed;

- New dining room seating should be supplied.
- Replace the flooring in toilet opposite the day room.
- Address the issue of the foul odour detected in the identified shower room.
- Ensure items are not inappropriately stored under stairwells.
- Replace the flooring in the hairdressing room and repair the door.
- Replace the flooring in the identified bedrooms.

- Replace the identified bedroom furniture.
- Clear the identified staircase of unused furniture and ensure that it is thoroughly cleaned.

A requirement is made in the above regard.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mary McKee, registered manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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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**
The Home Manager or her Deputy ensure that a comprehensive preadmission assessment along with all appropriate multi disciplinary assessments, is conducted prior to admission and a holistic care plan devised within eleven days. The MUST tool, Pressure Ulcer risk assessment, Nutritional, Pain and Continence assessments include GAIN Nutritional & Oral Health assessment, food likes/dislikes, food tolerances and allergy sensitivities. Moving and handling risk assesments, Bed type and Bed rail, Pressure relieving mattress assessment, Nurse call assessment, Advanced directives, End of life care plans, Resuscitation status etc. Information is collated from other team members eg care	Compliant

management team is respect of intermediate care admissions, discharge liasion for immediate care needs. A care plan is complete within 11 days of admission. A new resident and their representative are invited to attend a care review within 14 days of admission. A further review is conducted by their care manager from the trust within 8 weeks from admission date and by invitation, attended by their link/ key worker, GP, family representative and home representative. Any party can request to speak with the care manager who is independent to the home in private. A copy of the most recent care plan and care review are maintained in the nurses offices for the resident, their representative or any one with permission to read. The next of kin receives their own signed copy of the care review from their care manager. Each resident has their own named nurse, who is a point of contact for all involved in the care. Additional information or changes to care needs are added or amended as and when they occur during each shift and evaluated by the named nurse.	

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**
Named Nurses are responsible for discussing and planning holistic nursing interventions with the support of all relevant health professionals as required.Treatment plans are delivered and records of same retained in the Home as evidence. Dependancy scales are completed monthly or as needs change and based on these and the homes policies/	Compliant

procedures and multi-disciplinary team input, the appropriate skill mix and staffing levels are maintained at all times. Care plans are developed using dependancy scales to promote independence, rehabilitation and encourage activities within the home. Daily outcomes of actual care delivered is monitored and recorded in the care records. Residents and their next of kin are kept up to date of any changes as per policy. All multi-disciplinary team members are encouraged to record their input/ findings in the care records.	

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**
Registered Nurses deliver safe effective care and reassess care daily or as required in accordance with Nursing Home Regulations. During induction all staff are made aware of the correct documentation, and understand their role in relation to documentation and record keeping as per NMC. The home's senior nursing staff conduct audits to ensure standards are maintained and training is provided when needed.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All nursing interventions are evidence based and with consultation of the Resident or next of kin. Validated pressure ulcer grading tools are in use and Nutritional guidelines are adhered to daily. Nursing staff attend regular courses and mandatory updates. The home always aim to use current validate d tools for example crest guidelines MUST, GAIN, NICE, Royal Marsden, HSE, Northern Ireland Wound Care Formulary, RQIA Standards, NMC Guidelines etc.	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**
Contemperaneous records are retained detailing outcomes for Residents with regard to all aspects of their nutritional needs and referrals are made to appropriate professionals as necessary. Daily menus are made available to the residents, and time each day is allocated to seeking the residents choice from the menu. This is recorded and maintained by the catering team. The care team maintain records of daily input/ consumption of all food and drinks. The MUST score is reviewed monthly or as and when needs change and the care plan, documentation and records maintained respond to low/high consumption. Where directed by findings or concern, staff may refer to relevant professionals for further guidance to meet residents needs. Records are maintained to evidence this good practice.	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**
Daily records of Residents care are achieved and plans of care revised as required within agreed timescales. If changes are noted, appropriate actions are taken as per guidelines, regulations and policies, and all relevant persons are informed. Families are encouraged to contribute at annual meetings and at formal reviews. The home manager maintains an open door policy, and can be approached at all times whilst she is within the home. Arrangements can be made to be available any other time. Multi-disciplinary experts are involved in evaluating progress and are encouraged to be involved in all care packages. The home uses external auditors to evaulate case records. The regulation 29 home visit report findings are also used to make improvements to care and training.	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**
The Residents Care Manager will attend the Home annually or more frequently as requested, to review all aspects of the Residents care. Residents and their relatives are encouraged to participate fully. Written records of reviews are retained within the Residents care plan and the Resident or their relative agree to the content of same.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Residents are afforded choice in a nutritious and varied menu plan and therapeutic diets are adhered to. Alternatives to menu planning are available on request. Nutritional Guidelines are used when menus are being seasonally revised, ie Nutritional Guidelines and Menu checklist for Residential- Nursing homes (2014) PHA.	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**
Nurses supervise the nutrtional needs of Residents within the Home and liase with speech and language therapists promptly as required. Meals are served at conventional times with access to snacks when requested. Records of consumption are retained in the Home and care records will evidence the level of assistance each Resident requires.Registered Nurses have completed a Wound Management e learning course and are due to attend Wound Management training on28/05/14 to establish a Wound Care Link Nurse who cascades knowledge throughout the home. Staff are assessed using a nursing competency and capability assesment tool to ensure that their practice is in line	Compliant

with current standards. If they have limitations to their knowledge and skills this is addressed immediately and further education and training is sourced. Through clinical supervision, team meetings and appraisals, Staff professional development and training needs are continually met.	

Provider's Overall Assessment of The Nursing Home's Compliance Level Against Standard 5	**Compliance Level**
	Compliant

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Secondary Unannounced Care Inspection

Greenpark Private Nursing Home

10 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 Mrs McKee, registered manager during the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	20 (1) (a)	The registered persons shall ensure there are four registered nurses on duty from the hours of 08.00 and 14.00. Staffing should be regularly reviewed in keeping with patient/resident's needs. **Ref 11.1**	One	This was addressed immediately. The Homes rota was restructured to ensure that 4 Registered Nurses are on duty every morning and will be regularly reviewed.	From the date of inspection
2	27 (4) (b)	The registered nurse manager shall ensure that the management of smoking in the home by all patients is reviewed to ensure their assessment is up to date and that their car plan is up to date and suited to their current needs. **Ref 11.7**	One	All Residents who smoke have had their risk assessments and care plans revised to reflect individual needs	From the date of inspection
3	27	The registered persons shall ensure the following issues are addressed in relation to the environment. • New dining room seating should be supplied • Replace the flooring in toilet opposite the day room • Address the issue of the foul odour detected in the identified shower room • Ensure items are not inappropriately stored under stairwells • Replace the flooring in the hairdressing room and repair the door	One	Dining room seating has been costed and delivery expected week commencing 20/04/15 All flooring identified will be resurfaced week commencing 13/04/15. Waste clinical bag removed as source of odour in identified bathroom. Drains checked and satisfactory. Infection Control training achieved 25/03/15 All items removed from inappropriate places within the Home.	From the date of inspection

		• Replace the flooring in the identified bedrooms • Replace the identified bedroom furniture • Clear the identified staircase of unused furniture and ensure that it is thoroughly cleaned **Ref 11.8**		Hairdressing room and identified flooring and bedroom furniture replacements to be achieved week commencing 20/04/15 Staircase cleaned and objects removed immediately. This will be monitored during Managers daily walkaround..	

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	Appendix 2	The registered person shall develop a policy and procedure to guide staff regarding urinary and faecal continence/incontinence and constipation care. **Ref 19.2**	One	Policies updated in accordance with current practice.Continence Care Training achived on 25/3/15 and Stoma Care Training achieved on27/03/14	From the date of inspection

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	Mary McKee
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	L McVeigh

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	yes	Donna Rogers	9/4/15
Further information requested from provider			