Unannounced Primary Care Inspection

Name of Establishment:	**Mountvale Nursing Home**
Establishment ID No:	**1491**
Date of Inspection:	**5 June 2013**
Inspector's Name:	**Sharon McKnight**
Inspection No:	**13325**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Home:	Mountvale Nursing Home
Address:	5 Brewery Lane Meeting Street Dromore Co Down BT25 1AH
Telephone Number:	028 9269 9480
E mail Address:	nursemanager@mountvalepnh.co.uk
Registered Organisation/ Registered Provider/Responsible individual:	Mountvale Private Nursing Home Ltd Mr William Trevor Gage
Registered Manager:	Mrs Linda Kennedy
Person in Charge of the Home at the Time of Inspection:	Mrs Linda Kennedy
Categories of Care:	Nursing NH - I NH - PH NH - PH (E) RC - I (Max 5 persons)
Number of Registered Places:	51
Number of Patients Accommodated on Day of Inspection:	45 Nursing 5 Residential
Scale of Charges (per week):	£537 - £577 Nursing / Physical disability £426 Residential
Date and Type of Previous Inspection:	20 June 2012 Primary Announced Inspection
Date and Time of Inspection:	5 June 2013 09 50 – 17 15 hours
Name of Lead Inspector:	Sharon McKnight

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.

This is a report of a primary 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 Residential Care Homes Regulations (Northern Ireland)2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)
- The Department of Health, Social Services and Public Safety's (DHSSPS)Residential Care Homes 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 Minimum Standards.

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

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

- analysis of pre-inspection information
- discussion with the registered manager
- examination of records
- consultation with stakeholders
- file audit
- 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 to the following users of the service, carers, health and social care professionals and staff:

Patients	**14 individually and with the majority generally**
Staff	**6**
Relatives	**4**
Visiting Professionals	**0**

Questionnaires were provided, prior to the inspection, to staff to find out 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**
Staff	30	11

6.0 Inspection Focus

The inspection sought to establish the level of compliance achieved with respect to the selected DHSSPS Nursing Homes Minimum Standards and a thematic focus incorporating selected standards and good practice indicators. An assessment on the progress of the issues raised during and since the previous inspection was undertaken.

Themes and Standards Inspected:

- Theme 1: Assessing and Monitoring the Quality of Service Provision
  The quality and safety of services provided in the home is monitored by the registered provider in line with regulations and minimum standards to ensure that the needs of patients/residents are met.
- Theme 2: Safeguarding of Vulnerable Adults
  Patients are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.
- Standard 5 and 11: 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.

The registered provider and the inspector have 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		
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

Mountvale Private Nursing Home is located centrally in Dromore, County Down and is close to main transport routes and local amenities.

The home can provide care for a maximum of 51 persons. Five of the 51 beds are registered to support residential care if required. When beds are available, respite care is regularly provided. The home no longer provides a day care service.

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

Nursing Care

NH - I Old age not falling into any other category
NH - PH Physical disability other than sensory impairment - under 65 years
NH - PH (E) Physical disability other than sensory impairment – over 65 years

Residential Care

RC - I Old age not falling into any other category. Maximum of 5 residents

The facility is a two storey building comprising of 47 single bedrooms and two double bedrooms, three sitting rooms, visitor's area, two dining rooms, kitchen, laundry, toilet/washing facilities, staff accommodation and offices.

Car parking is provided to the front of the home.

8.0 Summary of Inspection

A primary unannounced inspection of Mountvale was undertaken by the inspector for the home, Sharon McKnight, on 5 June 2013 from 09 50 – 17 15 hours.

The inspector was welcomed into the home by the registered manager Ms Linda Kennedy. Verbal feedback of the issues identified during the inspection was given to Ms Kennedy at the conclusion of the inspection.

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

As part of the inspection process 30 questionnaires were forwarded to the home for completion by staff. Eleven were returned. The inspector arranged with the registered manager to meet and speak with the staff on duty.

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

The recommendations made as a result of the previous inspection was also examined and assessed as compliant. The outcome of the action taken can be viewed, in detail, in the section following this summary.

Theme 1: **Assessing and Monitoring the Quality of Service Provision the quality and safety of services provided in the home is monitored by the registered provider in line with regulations and minimum standards to ensure that the needs of patients/residents are met.**

Review of four recent Regulation 29 reports confirmed that Mr Trevor Gage, responsible individual, conducted unannounced visits on a monthly basis in accordance with The Nursing Homes Regulations (NI) 2005.

Regulation 29 reports evidenced that Mr Gage:

- interviewed a selection of patients
- interviewed a selection of patient representatives/relatives
- interviewed a selection of staff on duty at the time of the visit
- inspected the premises and identified areas for improvement
- reviewed the record of events, for example incidents and accident records
- reviewed the record of complaints
- review reports, for example RQIA inspections, Southern Health and Social Care Trust annual review

- evidenced that deficits were identified and an action plan developed to address the deficits.

The reports clearly stated that the areas in the previous action plan had been reviewed and any follow up action required and/or taken was recorded.

The inspector reviewed the home's annual quality review report completed for the period 1 April 2012 – 31 March 2013. The report contained details in relation to the operation of the home and quality initiatives undertaken throughout the year.

The registered manager confirmed that service user questionnaires had been completed by patients and/or their representatives in March 2013. The areas surveyed included the cleanliness of the home, choice and presentation of meals, staff availability and approachability, laundry service, range of activities, complaints and how visitors were received into the home. Comments received are included in the main body of the report.

The inspector can confirm that the home is assessed as compliant with this theme.

Theme 2 Safeguarding of Vulnerable Adults
Patients are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

The registered manager confirmed that policies and procedures in relation to the safeguarding of vulnerable adults were available in the home. Policies and procedures were reflective of legislation, current DHSSPS guidance, regional protocols and local procedures issued by the Health and Social Care Trusts (HSCT), including recruitment procedures. Relevant guidance documents and the policies and procedures were available to staff in the home. Guidance documents available to staff included the Safeguarding Vulnerable Adults Regional Adult Policy and Procedural Guidance.

Discussion with six staff evidenced that they had received training on, and had an awareness of, the safeguarding vulnerable adult policies, procedures and guidelines, commensurate with their role and responsibility.

Review of the staff training records evidenced that staff training in safeguarding of vulnerable adults (SOVA) was provided during induction and on an annual refresher basis thereafter. This training included information on protection from abuse, the indicators of abuse and responding and reporting to suspected, alleged or actual abuse.

Discussion with the registered manager evidenced that she was knowledgeable of how to identify, report, respond to and record all suspected, alleged or actual incidents of abuse in accordance with current regional guidance. Review of incidents and discussion with the manager evidenced that all incidents reported to RQIA were appropriately managed in accordance with SOVA regional guidance.

Notifications to RQIA since the last inspection indicated that reporting and action taken by management and staff in the home in response to adult safeguarding issues were in accordance with procedures and legislative requirements. No short comings have been highlighted. The registered manager had established systems in place to review all incidents and accidents on a monthly basis.

There was a policy and procedure in place for the management of restraint. The policy was reflective of legislative guidance that restraint is only used as a last resort and when it is the only practicable means of securing the welfare of that or any other patient. The document "Let's talk about restraint" Rights, risk and responsibility (RCN 2008) was available in the home.

The inspector discussed with the registered manager that a number of patients required the use of bed rails, safety lap straps and alarm mats to help maintain their safety and that, as these types of equipment impacted on patients' freedom of movement, these were deemed as restraint. The inspector reviewed the care records of five patients. Records reviewed evidenced that restraint was managed in keeping with best practice guidance.

The inspector reviewed the care records of one patient who used a lap strap on their personal wheelchair. Records evidenced discussion with the patient's relative and agreement that the use of the lap strap was in the patient's best interest.

Review of the complaint records, incident records and discussion with the registered manager evidenced that complaints were appropriately assessed to ensure any safeguarding issue contained therein were referred to the designated officer for safeguarding within the Trust in an appropriate and timely manner.

There was a policy on whistle blowing available in the home. Review of this evidenced that the policy was reflective of current guidance and discussion with staff evidenced that they were aware of how to report poor practice, concerns regarding care delivered and suspected or alleged abuse.

The inspector can confirm that the home is assessed as compliant with this theme.

Standard 5 and 11 **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.**

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

if the patient for admission had a pressure ulcer, wound and any skin condition.

Specific validated assessment tools such as moving and handling, Braden Scale, Malnutrition Universal Screening Tool (MUST), bedrails, falls and continence were also completed on admission. A recommendation is made in regard to the completion of pain assessments.

The inspector observed that a named nurse system was operational in the home. Review of records and discussion with patients and/or their representatives evidenced that patients and/or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions.

Care records reviewed contained evidence of communication with relatives. This included evidence that relatives had knowledge of care plans and that relatives were informed of changes to patients' conditions, as appropriate.

The inspector reviewed four patient's care records in regard to skin care and wound management. Pressure ulcers were graded using an evidenced based classification system and dressing regimes were recorded in patients' care plans on wound management. The care records contained an initial wound assessment and an assessment of the wound following each dressing renewal. Review of open wound observation charts evidenced that dressing regimes were being adhered to. Areas for improvements were identified in care records with requirements and recommendations made.

Review of the records of incidents revealed that pressure ulcers, grade 2 and above, were reported to the RQIA in accordance with best practice guidelines "The prevention and treatment of pressure ulcers" issued by the National Institute for Health and Clinical Excellence (NICE).

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. One registered nurse spoken with was knowledgeable regarding the referral process.

The inspector observed that documents such as Health and Social Care Board, Northern Ireland (HSCNI), Wound Care Formulary, April 2011 and evidence based research were available to staff in the home.

The registered manager informed the inspector that they completed competency assessments with registered nurses in regard to pressure area care. The assessment included a review of nurses' knowledge of assessing patient risk, referral process to TNV services, the supply of pressure relieving equipment, care plans and knowledge of best practice guidelines. The registered manager informed the inspector that a ½ day training for registered nurses in wound care was arranged for 18 June 2013.

The inspector can confirm that the home is assessed as substantially compliant with this standard.

Additional Areas Examined

Complaints
Patient Finance Questionnaire
Declaration of NMC Registration
Patients/residents views
Relatives views
Staff questionnaires
Meals and mealtimes
General environment.

Details regarding these areas are available in the main body of the report.

Inspection conclusion

The inspector spoke with 14 patients individually and with the majority generally. Patients spoken with commented positively in regard to staff and the care they receive and that they were happy in the home.

Staff and patient interaction and communication demonstrated that patients were treated courteously, with dignity and respect. Good relationships were evident between staff and patients. The inspector evidenced that there were effective processes in place to assess and monitor the quality of service provision.

The inspector spoke with the relatives of four patients. Relatives expressed high levels of satisfaction with the standard of care, staff, facilities and services provided in the home.

Discussion with six staff evidenced that they had an awareness of the safeguarding vulnerable adult procedures and guidelines, commensurate with their role and responsibility.

The delivery of care to patients was evidenced to be of a good standard. There were processes in place to ensure the effective management of skin integrity and the prevention of pressure ulcers within the home.

In total, two requirements and two recommendations were made as a result of this inspection. Compliance with the requirements and recommendations issued will assist in further enhancing the standard of care provided within the home.

The inspector would like to thank Ms Kennedy, patients, relatives and staff for their assistance, helpful discussions and hospitality throughout the inspection.

9.0 Follow-Up on Previous Issues

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	5.3	It is recommended that patients and/or their representatives are involved in discussing and agreeing nursing intervention. Records should be maintained of this consultation.	Care records reviewed contained evidence that patients and/or their representatives were involved in discussing and agreeing nursing intervention.	**Compliant**
2	29.4	It is recommended that the record of supervision is further developed to include the agreed action to be taken where concerns regarding practice are identified. A review of any action plan from the previous supervision should be discussed at the beginning of all supervision sessions.	The inspector reviewed the template of supervision which included a section to record any agreed action to be taken to address concerns. The registered manager confirmed that action plans were reviewed at the beginning of supervision sessions as recommended.	**Compliant**

3	30.4	It is recommended that the competency record for registered nurses is further developed to include the duties and responsibilities of the registered nurse in charge of the home in the absence of the manager. eg incident notifications, management of POVA, management of outbreaks, management of emergency situations i.e. Power failure, water failure, and generator maintenance.	The inspector reviewed the current record of competency for registered nurses in charge of the home in the absence of the manager. The assessment had been developed to include, for example, the reporting of allegations of abuse, contacting the out of hours social work team and the reporting to senior managers within the home.	**Compliant**
4	25.11	It is recommended that audit process is further developed to include completion of action plan, where appropriate, a record of the action taken and re-audit of the area to ensure compliance.	Review of the record of care plan audits evidenced that there was a record that action had been taken to check compliance.	**Compliant**
5	25.12	It is recommended that the action plan from the previous visit by the registered provider should be reviewed at the next visit and all areas commented on.	The inspector reviewed the four most recent action plans and observed that the areas in the previous action plan had been reviewed and any follow up action required and/or taken was recorded.	**Compliant**

Section 10: Inspection findings

Section A	
Theme 1: Assessing and Monitoring the Quality of Service Provision. **The quality and safety of services provided in the home is monitored by the registered provider in line with regulations and minimum standards to ensure that the needs of patients/residents are met.**	
Who carries out the Regulation 29 unannounced visit and how often: **Criterion Assessed:** Regulation 29.—(1) Where the registered provider is an individual, but not in day-to-day charge of the nursing home, he shall visit the home in accordance with this regulation. (2) Where the registered provider is an organisation or partnership, the nursing home shall be visited in accordance with this regulation by – (a) the responsible individual or one of the partners, as the case may be; . (b) another of the directors or other persons responsible for the management of the organisation or partnership; or (c) an employee of the organisation or the partnership who is not directly concerned with the conduct of the nursing home. (3) Visits under paragraph (1) or (2) shall take place at least once a month or as agreed with the Regulation and Improvement Authority and shall be unannounced.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
The Registered Provider carries out an unannounced visit on a monthly basis in accordance with Regulation 29	Compliant
Inspection Findings:	
Review of four recent Regulation 29 reports confirmed that Mr Trevor Gage, responsible individual, conducted unannounced visits on a monthly basis in accordance with The Nursing Homes Regulations (NI) 2005.	Compliant

Section B	
Theme 1: Assessing and Monitoring the Quality of Service Provision. **The quality and safety of services provided in the home is monitored by the registered provider in line with regulations and minimum standards to ensure that the needs of patients/residents are met.**	
The content and process of Regulation 29 unannounced visit: **Criterion Assessed:** Regulation 29 (4) The person carrying out the visit shall – (a) interview, with their consent and in private, such of the patients and their representatives and persons working at the nursing home as appears necessary in order to form an opinion of the standard of nursing provided in the home; (b) inspect the premises of the nursing home, its record of events and records of any complaints; and (c) prepare a written report on the conduct of the nursing home.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
The Registered Provider carries out an unannounced monthly visit which incorporates criteria a, b and c	Compliant
Inspection Findings:	
Regulation 29 reports evidenced that Mr Gage: • interviewed a selection of patients • interviewed a selection of patient representatives/relatives • interviewed a selection of staff on duty at the time of the visit • inspected the premises and identified areas for improvement • reviewed the record of events, for example incidents and accident records • reviewed the record of complaints • review reports, for example RQIA inspections, Southern Health and Social Care Trust annual review • evidenced that deficits were identified and an action plan developed to address the deficits. The reports clearly stated that the areas in the previous action plan had been reviewed and any follow up action required and/or taken was recorded.	Compliant

Section C	
Theme 1: Assessing and Monitoring the Quality of Service Provision. **The quality and safety of services provided in the home is monitored by the registered provider in line with regulations and minimum standards to ensure that the needs of patients/residents are met.**	
Availability of the Regulation 29 unannounced visit report: **Criterion Assessed:** Regulation 29 (5) and (6) (5) The registered provider shall maintain a copy of the report required to be made under paragraph (4)(c) in the home and make it available on request to – (a) the Regulation and Improvement Authority; (b) the registered manager; (c) the patient or their representative; (d) an officer of the Trust in the area of which the nursing home is situated. (6) In the case of a visit under paragraph (2) – (a) where the registered provider is an organisation, to each of the directors or other persons responsible for the management of the organisation; and (b) where the registered provider is a partnership, to each of the partners.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
Copies of the Visit Report are kept in the Nurse Manager's office and is available on request	Compliant
Inspection Findings:	
Discussion with the registered manager confirmed that Mr Gage discussed the outcome of the Regulation 29 unannounced visit. A copy of the report along with any action required was received following the visit.	Compliant

Section D	
Theme 1: Assessing and Monitoring the Quality of Service Provision. **The quality and safety of services provided in the home is monitored by the registered provider in line with regulations and minimum standards to ensure that the needs of patients/residents are met.**	
Standard 25.12 **Criterion Assessed:** The registered person monitors the quality of services in accordance with the home's written procedures, and completes a monitoring report on a monthly basis. This report summarises any comments made by patients about the quality of the service provided, and any actions taken by the registered person or the registered manager to ensure that the organisation is being managed in accordance with minimum standards.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
The quality and safety of services provided in the home is monitored by the registered provider in line with regulations and minimum standards to ensure that the needs of patients/residents are met. This is all recorded in the Monthly Report.	Compliant
Inspection Findings:	
Please refer to section a, b and c.	Compliant

Section E	
Theme 1: Assessing and Monitoring the Quality of Service Provision. **The quality and safety of services provided in the home is monitored by the registered provider in line with regulations and minimum standards to ensure that the needs of patients/residents are met.**	
Standard 25.13 **Criterion Assessed:** The quality of services provided is evaluated on at least an annual basis, a report prepared and follow-up action taken. Key stakeholders are involved in this process.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
A Report is produced annually including follow-up action taken	Compliant
Inspection Findings:	
The inspector reviewed the home's annual quality review report completed for the period 1 April 2012 – 31 March 2013. The report contained details in relation to: • occupancy levels • management arrangements • staffing • complaints • patients and relatives comments • summary of the 2013 patient/relative survey • summary of a patient survey of the provision of activities • inspections undertaken in the home and outcomes. The registered manager confirmed that service user questionnaires had been completed by patients and/or their representatives in March 2013. The areas surveyed included the cleanliness of the home, choice and presentation of	Compliant

meals, staff availability and approachability, laundry service, range of activities, complaints and how visitors were received into the home. Comments received included: "….no unpleasant smells which is a credit to all…." "….I have recommended the home to my friends…." "….very friendly and helpful at all time…." "….I have always felt very welcome…." Issues were raised in regard to laundry and limited choice of meals. The registered manager confirmed that issues raised were discussed generally at a relatives' meeting.	

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

INSPECTOR'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

Theme 2 – Safeguarding of Vulnerable Adults **Patients and residents are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.**	
Standard 16.1 **Criterion Assessed:** Procedures for protecting vulnerable adults are in accordance with, DHSSPS guidance, regional protocols and local procedures issued by the Health and Social Care Board and Trusts.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
Patients and residents are protected from abuse, or the risk of abuse, and their human rights are respected and upheld**.** Policies and Procedures are in place to support staff	Substantially Compliant
Inspection Findings:	
The registered manager confirmed that policies and procedures in relation to the safeguarding of vulnerable adults were available in the home. Policies and procedures were reflective of legislation, current DHSSPS guidance, regional protocols and local procedures issued by the Health and Social Care Trusts (HSCT). Relevant guidance documents and the policies and procedures were available to staff in the home. Guidance documents available to staff included, Safeguarding Vulnerable Adults Regional Adult Policy and Procedural Guidance. Review of policies and procedures revealed that procedures to guide staff on how to respond, report and record a safeguarding vulnerable adult incident were in place. Procedures for responding to allegations made against staff and how to report poor practice, also known as 'whistle blowing', were also available. Discussion with six staff evidenced that they had received training on, and had an awareness of, the safeguarding vulnerable adult policies, procedures and guidelines, commensurate with their role and responsibility.	Compliant

Theme 2 – Safeguarding of Vulnerable Adults **Patients and residents are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.**	
Standard 16.2 **Criterion Assessed:** The procedures for protecting vulnerable adults are included in the induction programme for staff.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
All new staff receive training in Protecting Vulnerable Adults	Substantially Compliant
Inspection Findings:	
The inspector discussed the details of the staff induction with the registered manager who confirmed that the procedures for safeguarding vulnerable adults were included in the induction programme for new staff. Discussion with six staff evidenced that they were knowledgeable regarding their role and function in safeguarding vulnerable adults. Thirty questionnaires were forwarded by RQIA to the home for distribution to staff prior to the inspection. Eleven completed questionnaire were returned. All of the respondents confirmed that they received an induction when they commenced employment and that this induction included information on safeguarding vulnerable adults and whistle blowing.	Compliant

Theme 2 – Safeguarding of Vulnerable Adults **Patients and residents are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.**	
Standard 16.3 **Criterion Assessed:** Staff have completed training on and can demonstrate knowledge of: • Protection from abuse • Indicators of abuse • Responding to suspected, alleged or actual abuse • Reporting suspected alleged or actual abuse.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
Training is provided on Protection from abuse, Indicators of abuse, Responding to suspected, alleged or actual abuse and Reporting suspected alleged or actual abuse on an annual basis	Compliant
Inspection Findings:	
Review of the staff training records evidenced that staff training in safeguarding of vulnerable adults (SOVA) was provided during induction and on an annual refresher basis thereafter. This training included information on protection from abuse, the indicators of abuse and responding and reporting to suspected, alleged or actual abuse. Review of staff training records in relation to SOVA evidenced that all staff had undertaken training in the protection of vulnerable adults in the past twelve months. Discussion with six staff confirmed that the content of the training reflected their roles and responsibilities in regard to the safeguarding of vulnerable adults.	Compliant

Theme 2 – Safeguarding of Vulnerable Adults **Patients and residents are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.**	
Standard 16.4 **Criterion Assessed:** All suspected, alleged or actual incidents of abuse are reported to the relevant persons and agencies in accordance with procedures and legislation.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
All suspected, alleged or actual incidents of abuse are reported to the relevant persons and agencies in accordance with procedures and legislation.	Compliant
Inspection Findings:	
Discussion with the registered manager evidenced that she was knowledgeable of how to identify, report, respond to and record all suspected, alleged or actual incidents of abuse in accordance with current regional guidance. Review of incidents and discussion with the manager evidenced that all incidents reported to RQIA were appropriately managed in accordance with SOVA regional guidance. Discussion with one registered nurse confirmed that they were knowledgeable of the correct procedures to follow if they were made aware of suspected or actual allegations of abuse toward patients. Discussion with three care assistants and two domestic staff confirmed that they were aware of how to report any suspicions or concerns they might have regarding abuse of patients. Staff spoken with were aware of the home's policies and procedures on whistle blowing and their role in reporting concerns of poor practice.	Compliant

Theme 2 – Safeguarding of Vulnerable Adults **Patients and residents are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.**	
Standard 16.5 **Criterion Assessed:** All suspected, alleged or actual incidents of abuse are fully and promptly investigated in accordance with procedures.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
All suspected, alleged or actual incidents of abuse are fully and promptly investigated in accordance with procedures.	Substantially Compliant
Inspection Findings:	
Refer to criterion 16.4	Compliant

Theme 2 – Safeguarding of Vulnerable Adults **Patients and residents are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.**	
Standard 16.8 **Criterion Assessed:** Where shortcomings in systems are highlighted as a result of investigation, identified safeguards are in place.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
If shortcomings in systems are highlighted as a result of investigation , identified safeguards would be put in place	Substantially Compliant
Inspection Findings:	
Notifications to RQIA since the last inspection indicated that reporting and action taken by management and staff in the home in response to adult safeguarding issues were in accordance with procedures and legislative requirements. No short comings have been highlighted. The registered manager had established systems in place to review all incidents and accidents on a monthly basis.	Compliant

Theme 2 – Safeguarding of Vulnerable Adults **Patients and residents are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.**	
Standard 16.9 **Criterion Assessed:** Refresher training on the protection of vulnerable adults is provided for staff at least every three years.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
Refresher training on the protection of vulnerable adults is provided for staff annually.	Compliant
Inspection Findings:	
Review of the staff training records evidenced that staff training in safeguarding vulnerable adults was provided during induction and on an annual refresher basis thereafter.	Compliant

Theme 2 – Safeguarding of Vulnerable Adults **Patients and residents are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.**	
Standard 10.7 **Criterion Assessed:** Restraint is only used as a last resort by appropriately trained staff to protect the patient or other persons when other less restrictive strategies have been unsuccessful. Records are kept of all instances when restraint is used.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
Any forms of restraint are discussed with Care Management and family and only used when necessary. Records are kept when restraint is used	Substantially Compliant
Inspection Findings:	
There was a policy and procedure in place for the management of restraint. The policy was reflective of legislative guidance that restraint is only used as a last resort and when it is the only practicable means of securing the welfare of that or any other patient. The document "Let's talk about restraint" Rights, risk and responsibility (RCN 2008) was available in the home. The inspector discussed with the registered manager that a number of patients required the use of bed rails, lap belts and alarm mats to help maintain their safety and that, as these types of equipment impacted on patients freedom of movement, these were deemed as restraint. The registered manager confirmed that prior to the use of bedrails and lap belts consent was gained from the patient, where appropriate. If the patient was unable to give their consent then consultation with relatives and healthcare professionals in regard to best interest decisions for the patient, was undertaken and records maintained of the outcome of these discussions. The inspector reviewed the care records of five patients who required bed rails or an alarm mat. Care records contained individual risk assessments, care plans and evidence of consultation with relatives and healthcare professionals. The inspector reviewed the care records of one patient who used a lap strap on their personal wheelchair. Records evidenced discussion with the patient's relative and agreement that the use of the lap strap was in the patient's best interest.	Compliant

Theme 2 – Safeguarding of Vulnerable Adults **Patients and residents are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.**	
Standard 17.3 **Criterion Assessed:** Where a complaint relates to abuse, exploitation or neglect, the Regional 'Safeguarding Vulnerable Adults Policy and Procedural Guidance and the associated Protocol for Joint Investigation of Alleged or Suspected cases of abuse of vulnerable adults should be activated.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
Staff are knowledgeable in reporting and responding to allegations of abuse	Substantially Compliant
Inspection Findings:	
Discussion with the registered manager evidenced that she was knowledgeable of how to assess complaints to identify any safeguarding issues contained therein and how to refer them to the designated officer for safeguarding in accordance with SOVA regional guidance. Review of the complaint records, incident records and discussion with the registered manager evidenced that complaints were appropriately assessed to ensure any safeguarding issue contained therein were referred to the designated officer for safeguarding within the Trust in an appropriate and timely manner.	Compliant

Theme 2 – Safeguarding of Vulnerable Adults **Patients and residents are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.**	
Standard 25.20 **Criterion Assessed:** There is a written policy on "Whistle Blowing", and written procedures that identify to whom staff report concerns about poor practice.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
There is a written policy on "Whistle Blowing", and written procedures that identify to whom staff report concerns about poor practice.	Substantially Compliant
Inspection Findings:	
There was a policy on whistle blowing available in the home. Review of this evidenced that the policy was reflective of current guidance. Review of the returned pre inspection staff questionnaires confirmed that the member of staffs had received information during induction on whistle blowing and received training on whistle blowing procedures. Discussion with one registered nurse, three care staff and two domestic staff evidenced that they were aware of how to report poor practice, concerns regarding care delivered and suspected or alleged abuse.	Compliant

Theme 2 – Safeguarding of Vulnerable Adults **Patients and residents are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.**	
Standard 25.21 **Criterion Assessed:** There are appropriate mechanisms to support staff in reporting concerns about poor practice.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
Staff are encouraged and supported to report concerns about poor practice.	Substantially Compliant
Inspection Findings:	
Discussion with the registered manager and review of the "whistle blowing" policy confirmed that there were appropriate systems in place to support staff in reporting concerns regarding poor practice.	Compliant

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

INSPECTOR'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

STANDARD 5- NURSING CARE

Patients receive safe, effective nursing care based on an 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.

The focus of inspection within Standard 5 will be 'wound care'.

Standard 5.1 **Criterion Assessed:** At the time of each patient's admission to the home, a nurse carries out and records an initial risk 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.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
At the time of each patient's admission to the home, a nurse carries out and records an initial risk 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.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector reviewed two patient care records which evidenced that at the time of each patient's admission to the home, a registered nurse carried out initial risk assessments and developed agreed plans of care to meet the patient's immediate care needs. Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), bedrails, falls and continence were also completed on admission. It is recommended that all patients have a baseline pain assessment completed and an on-going pain assessment where indicated. Information recorded on admission confirmed if the patient for admission had a pressure ulcer, wound and any skin condition.	Substantially Compliant

STANDARD 5- NURSING CARE **Patients receive safe, effective nursing care based on an 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.** **The focus of inspection within Standard 5 will be 'wound care'.**	
Standard 5.2 **Criterion Assessed:** A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
Care Plans are completed within 11 days of admission using validated assessment tools	Substantially Compliant
Inspection Findings:	
Review of two patients' care record evidenced that a comprehensive holistic assessment of the patients care needs, using validated assessments tools, was completed within 11 days of patient's admission to the home. As previously discussed there was no evidence that a pain assessment had been completed for either patient. A recommendation has been made.	Substantially Compliant

STANDARD 5- NURSING CARE **Patients receive safe, effective nursing care based on an 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.** **The focus of inspection within Standard 5 will be 'wound care'.**	
Standard 11.1 **Criterion Assessed:** 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.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
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.	Substantially Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Review of two patient's' care records evidenced that the pre admission assessment included the patients Braden score. Review of these care records also evidenced that a pressure ulcer risk assessment was completed at the time of admission to the nursing home. The assessment tool used was the Braden pressure ulcer risk assessment. Additional assessments for nutrition and continence were also completed at the time of admission to the nursing home. As previously discussed care records did not contain a completed pain assessment and a recommendation has been made.	Substantially Compliant

STANDARD 5- NURSING CARE **Patients receive safe, effective nursing care based on an 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.** **The focus of inspection within Standard 5 will be 'wound care'.**	
Standard 5.3 **Criterion Assessed:** 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 professionals.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
There is a Primary Nurse system in place and they are responsible for planning and agreeing interventions with the patient and their relatives, 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 professionals.	Substantially Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector observed that a named nurse system was operational in the home. Review of records and discussion with patients and/or their representatives evidenced that patients and/or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Care records reviewed contained evidence of communication with relatives. This included evidence that relatives had knowledge of care plans and that relatives were informed of changes to patients' conditions, as appropriate.	Substantially Compliant

Care records inspected reflected advice provided by health care professionals such as dieticians, speech and language therapists (SALT), physiotherapists and occupational therapists (OT)). The inspector reviewed four patient's care records in regard to skin care and wound management. Pressure ulcers were graded using an evidenced based classification system and dressing regimes were recorded in patients' care plans on wound management. The care records contained a body map which recorded the location, an initial wound assessment and an assessment of the wound following each dressing renewal. The assessment recorded after each dressing renewal included appearance of the wound margin, wound bed, surrounding skin colour, odour, pain, swabs taken and frequency of dressing changes. This detail of assessment is good practice and was commended by the inspector. Review of open wound observation charts evidenced that dressing regimes were being adhered to. Care plans for patients who were assessed as at high risk of developing pressure ulcers, and which specified the pressure relieving equipment required, were in place. Care plans were in place for wounds which included the dressing regime and the frequency with which the dressing were required to be renewed. One care plan indicated that a patient had two wounds. However discussion with a registered nurse evidenced that a previous wound was healed and there was currently only one wound which was being actively treated. It is required in accordance with The Nursing Homes Regulations (Northern Ireland) 2005, regulation 16(2)(b) that the patient's plan is kept under review. Care plans must be reviewed and updated to accurately reflect the needs of the patient. The inspector noted in one patient's care record, that only one care plan had been devised which prescribed generic care for two identified wounds. It is recommended in keeping with best practice that a separate care plan is devised for each individual wound. A daily repositioning chart was in place for patients with wounds and for those patients assessed as at risk of developing pressure ulcers. A review of repositioning charts for three patients revealed that the charts for two patients did not evidence that the repositioning regimes prescribed in the care plan were adhered to. Several charts did not contain the date the form was completed. It is required in accordance with the Nursing Homes Regulations (Northern Ireland) 2005, regulation 19(1)(a), schedule 3, 2(k) that the registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence care delivered and the date the record was completed. Patients' weights were recorded on admission and on a monthly basis or more often if required.	

Patients' nutritional status was also reviewed on at least a monthly basis or more often if required. Daily records were maintained regarding patients' daily food and fluid intake. There was evidence in the care records that patients' continence needs were addressed in accordance with the outcome of continence assessments and the care prescribed in care plans. As previously discussed generally care records did not contain a completed pain assessment and a recommendation has been made. Review of the records of incidents revealed that pressure ulcers, grade 2 and above, were reported to the RQIA in accordance with best practice guidelines "The prevention and treatment of pressure ulcers" issued by the National Institute for Health and Clinical Excellence (NICE).	

STANDARD 5- NURSING CARE **Patients receive safe, effective nursing care based on an 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.** **The focus of inspection within Standard 5 will be 'wound care'.**	
Standard 11.2 **Criterion Assessed:** There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
All trained staff are aware of how to contact the Tissue Viability Team for advice and support	Substantially Compliant
Inspection Findings:	
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. One registered nurse spoken with was knowledgeable regarding the referral process and explained that support would be sought from the TVN team if the wound was complex or was not improving/healing.	Compliant

STANDARD 5- NURSING CARE **Patients receive safe, effective nursing care based on an 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.** **The focus of inspection within Standard 5 will be 'wound care'.**	
Standard 11.3 **Criterion Assessed:** 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 professionals.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
Where a patient is assessed as "at risk" of developing pressure sores, a prevention programme is put into place.	Substantially Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Discussion with one registered nurse 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. Discussion with staff evidenced that advice was sought from the relevant healthcare professionals as required and recommendations made recorded clearly in individual care records	Compliant

STANDARD 5- NURSING CARE **Patients receive safe, effective nursing care based on an 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.** **The focus of inspection within Standard 5 will be 'wound care'.**	
Standard 5.4 **Criterion Assessed:** Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans	Substantially Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Review of four patients' care records evidenced that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Nursing staff, on both day and night shifts, recorded evaluations in the daily progress notes on the delivery of care, including wound management for each patient. Assessments and care plans were reviewed and updated on at least a monthly basis or more often if required. Review of care records in relation to wound care evidenced that an assessment of the wound was recorded following each dressing renewal.	Compliant

STANDARD 5- NURSING CARE **Patients receive safe, effective nursing care based on an 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.** **The focus of inspection within Standard 5 will be 'wound care'.**	
Standard 5.5 **Criterion Assessed:** All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.	Substantially Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Examination of records evidenced that validated assessment tools such as the Braden pressure ulcer risk assessment and the MUST nutritional risk assessment were in place. The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care were used to inform and guide care practice in line with evidence based research. The inspector observed that documents such as Health and Social Care Board, Northern Ireland (HSCNI), Wound Care Formulary, April 2011 and evidence based research were available to staff in the home. Discussion with the registered manager and a registered nurse confirmed that they had a good awareness of these guidelines and policies and procedures.	Compliant

STANDARD 5- NURSING CARE **Patients receive safe, effective nursing care based on an 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.** **The focus of inspection within Standard 5 will be 'wound care'.**	
Standard 11.4 **Criterion Assessed:** A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.	Substantially Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Review of patient care records evidenced that the registered nurses assessed pressure ulcer risk using Braden pressure risk assessment tool. Care records evidenced that registered nurses graded pressure ulcers in accordance with the European Pressure Ulcer Advisory Panel (EPUAP). Treatment plans devised in conjunction with specialist healthcare professionals were implemented.	Compliant

STANDARD 5- NURSING CARE **Patients receive safe, effective nursing care based on an 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.** **The focus of inspection within Standard 5 will be 'wound care'.**	
Standard 5.6 **Criterion Assessed:** 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.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
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	Substantially Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Review of four patient care records evidenced that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient. These statements reflected wound management intervention for patients if required. Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patient's status or to indicate communication others concerning the patient. As previously discussed in criterion 5.3 it is required that repositioning charts are accurately maintained to evidence the care delivered and the date the record was completed. Entries were noted to be dated and timed. Care records are maintained electronically within the home. Staff entry their name on completion of the record. The authenticity of the registered nurses identity can be validated through their electronic log in and password.	Substantially Completed

STANDARD 5- NURSING CARE **Patients receive safe, effective nursing care based on an 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.** **The focus of inspection within Standard 5 will be 'wound care'.**	
Standard 5.7 **Criterion Assessed:** 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.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
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	Substantially Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Review of four patient care records evidenced that the outcome of care delivered was monitored and recorded on at least a daily basis or more often if required. Care records examined evidenced that care plan reviews were carried out on a monthly basis or more often as deemed appropriate. There was appropriate evaluation of treatment and evidence of the patient's condition since the previous review.	Compliant

STANDARD 5- NURSING CARE **Patients receive safe, effective nursing care based on an 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.** **The focus of inspection within Standard 5 will be 'wound care'.**	
Standard 11.7 **Criterion Assessed:** 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.	**COMPLIANCE LEVEL**
Provider's Self Assessment:	
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. Latest guidance on wound care is available to staff	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The registered manager informed the inspector that they completed competency assessments with registered nurses in regard to pressure area care. The assessment included a review of nurses' knowledge of assessing patient risk, referral process to TNV services, the supply of pressure relieving equipment, care plans and knowledge of best practice guidelines. The registered manager informed the inspector that a ½ day training for registered nurses in wound care was arranged for 18 June 2013. The registered nurse spoken with was knowledgeable regarding the needs of the patients and was familiar with the prescribed wound care regimes.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Provider to complete

INSPECTOR'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Substantially Compliant

11.0 Additional Areas Examined

11.1 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 complaints were being pro-actively managed.

11.2 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.

11.3 Declaration of NMC Registration

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.

11.4 Stakeholder Participation

Patient/resident views

The inspector spoke with 14 patients individually and with the majority generally. Patients spoken with commented positively in regard to staff and the care they receive and that they were happy in the home. Those patients who were unable to verbally express their views were well groomed and appropriately dressed and appeared relaxed and comfortable in their surroundings.

Relatives' views

The inspector spoke with the relatives of four patients. Relatives expressed high levels of satisfaction with the standard of care, staff, facilities and services provided in the home.

Staff questionnaires

Thirty questionnaires were forwarded by RQIA to the home for distribution to staff prior to the inspection. Eleven completed questionnaire were returned. All of the respondents confirmed that they received an induction when they commenced employment and that this induction included information on safeguarding vulnerable adults and whistle blowing.

Nine respondents indicated that they were either very satisfied or satisfied that patients were afforded privacy, one was dissatisfied and one did not express an opinion. Seven staff indicated that they were either very satisfied or satisfied that patients were treated with dignity and respect; three did not express an opinion. Eight staff were very satisfied or satisfied that they had time to listen and talk to the patients, two indicated that they were dissatisfied and one did not express an opinion. All of the respondents indicated that care was based on individual needs and wishes.

11.5 Meals and mealtimes

The inspector observed the serving of lunch. Meals were served in the dining rooms on both floors or, by patient's choice , in their bedroom. The menu on the day of the inspection was a choice of tomato soup and sandwiches or grilled salmon with salad and chips.

The meals were nicely presented and smelt appetising. Patients requiring a meal pureed were served the meal in a manner that allowed different foods and flavours to be recognised. The inspector observed that those patients who required assistance received support in a timely way. Staff were observed sitting with patients offering encouragement with their meal.

11.6 General environment

The inspector undertook a general inspection of the home and examined a number of patients' bedrooms, lounges, bathrooms and toilets at random. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was appropriately heated throughout.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Linda Kennedy 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:

Sharon McKnight
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Quality Improvement Plan

Unannounced Primary Inspection

MOUNTVALE NURSING HOME

5 June 2013

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

The specific actions set out in the Quality Improvement Plan were discussed with Ms Kennedy either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	16(2)(b)	The patient's plan must be kept under review. Care plans must be reviewed and updated to accurately reflect the needs of the patient. **Ref section 10, criterion 5.3**	One	Identified Care Plan was updated on the day of Inspection and Care Plans will continue to be audited monthly.	On-going from the date of inspection
2	19(1)(a) Schedule 3, 2(k)	The registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence the care delivered and the date the record was completed. **Ref section 10, criterion 5.3 & 5.6**	One	Meeting held on the 12th and 13th June for staff to discuss the use of repositioning charts and the imprtance of filling them in properly	On-going from the date of inspection

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	Criterion 5.1	It is recommended that all patients have a baseline pain assessment completed and an on-going pain assessment where indicated. **Ref section 10, criterion 5.1, 5.2, 5.3 &11.1**	One	Discussed at Trained Staff meeting on the 13/06/13.	On-going from the day of inspection
2	Criterion 5.3	It is recommended in keeping with best practice that a separate care plan is devised for each individual wound. **Ref section 10, criterion 5.3**	One	The identified Care Plan was revised on the day of Inspection	On-going from the day 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	Linda Kennedy
Name of Responsible Person / Identified Responsible Person Approving Qip	Trevor Gage

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

QIP Position Based on Comments from Registered Persons		Yes	No	Inspector	Date
A.	Quality Improvement Plan response assessed by inspector as acceptable	X		Linda Thompson	28 August 2013
B.	Further information requested from provider		X		