



The Regulation and
Quality Improvement
Authority

2010/2011 INSPECTION YEAR

NURSING HOMES

CONTENTS

	Page
1 Background	1
2 Principles underpinning inspection	1
3 Levels of Achievement	4
4 Maturity Matrix	5
5 Guidance:	
• Levels of Achievement	6
• Maturity Matrix	7
• Standards	8
6 Inspection process	21
7 Frequently asked questions	22
8 Appendices:	
• Rhys Hearn Dependency Assessment Tool	24
• Professionals List	26
• Patient information/dependency sheet	27
• Staffing returns	30

1. Background

In April 2009 RQIA introduced a revised approach to inspections of day care settings, domiciliary care agencies, nursing homes and residential homes. The methodology built on existing inspection practice by introducing a number of new elements.

For 2010 - 2011, this approach has been further developed taking into account practice learning during 2009 - 2010.

This document provides guidance about the values underpinning RQIA's inspection approach and gives direction about how staff and providers should use RQIA inspection tools in practice.

RQIA staff should read this guidance in conjunction with the Policy and Procedure for the Inspection of Establishments and Agencies within the Regulated Sector (2008).

2. Principles Underpinning Inspection

RQIA's approach to regulation reflects our 2009 - 2012 Corporate Strategy. This strategy sets out our value proposition:

"RQIA provides independent assurance about the quality, safety and availability of health and social care services in Northern Ireland, encourages continuous improvements in those services and safeguards the rights of service users.

RQIA has identified four core activities to support our vision of being a driving force for positive change in health and personal social services in Northern Ireland:

- **Improving Care:** we encourage and promote improvements in the safety and quality of services through the regulation and review of health and social care.
- **Informing the Population:** we publicly report on the safety, quality and availability of health and social care.
- **Safeguarding Rights:** we act to protect the rights of all people using health and social care services.
- **Influencing Policy:** we influence policy and standards in health and social care.

Consistent with our strategic approach, a number of principles that are characteristic of good regulatory practice have been identified¹. These lead to the following practice recommendations:

2.1 Focus on Outcomes

Inspection should consider “service delivery to the end users of the services rather than concentrating on internal management arrangements”.

This means that, for example, policies and procedures can only be considered to be fully in place when:

(a) the policy or procedure clearly states the desired service user outcomes of the policy or procedure,

and

(b) inspectors are able to access evidence to show how the policy or procedure impacts on the service provided to users.

The criteria in each Minimum Standard often focus on the processes necessary to achieve good outcomes. It is important that inspection staff take steps to identify outcome-based evidence to validate compliance with the standards. The possibility of overlooking outcomes when considering statements such as those within the criteria has been clearly described:

“The risk is that attention becomes focused primarily on minimum standards, inputs and processes, rather than regulation promoting improved outcomes and encouraging the sector to strive for improved standards.”²

2.2 User Perspective

Inspection should “focus on the experience of those for whom the service is provided, as well as on internal management arrangements”.

This recommendation builds on the first point, making it clear that inspectors should place significant emphasis on the directly reported experience of service users. This experience can validate the authenticity of apparent operational arrangements and, where it can be accessed, should be cited in reports as strong evidence of the degree of compliance with standards. This will mean that Inspectors will seek to identify how compliance with a particular criterion should affect service delivery and will then seek verification from users. Comments

¹ Better Regulation Task Force (2003), Principles of Good Regulation.

² Duncan (2007) Journal of Care Services Management, vol. 2, no.1, pp. 17-27, Inspecting for Improvement.

used by users about relevant parts of service delivery should then be quoted or summarised within the report.

2.3 Self-assessment

Service providers are responsible for the quality of care provided and for demonstrating that quality of care. Therefore, it is important to note that it is the responsibility of the provider to demonstrate on the self-assessment how they are meeting both the standard and criteria.

Self-assessment by providers is a key part of the inspection process. It is important that evidence is established to underpin the self-assessment, whether this is cited by the provider in their self-assessment, or identified by the inspector during the inspection.

The practice requirement “inspectors should challenge the outcomes of managers’ self-assessments” makes it clear that, in all instances, inspectors should seek to find evidence that either confirms, or refutes, the provider's self-assessment. Such evidence should be specified in reports.

2.4 Evidence

Reports should specify the evidence that has been taken into account in reaching judgements.

Evidence to underpin the inspector's judgement should be identified during the inspection, and should be cited in the report. The “evidence, whether quantitative or qualitative, should be validated and credible”.

The credibility of evidence can be established primarily by validation - the process of triangulation or corroborating evidence by information from a different source. Credible and validated evidence that a policy on training, for example, is in place could be sought from:

- training records and curriculum
- discussion with staff that indicates that they are appropriately knowledgeable or skilful discussion with service users that indicates the relevant task is being carried out competently.

2.5 Follow-Up Evidence from Previous Requirements and Recommendations

An inspection will commence with the inspector requesting evidence that requirements and/or recommendations from a previous report have been met to the inspector's satisfaction. Thus, it is important for the provider to ensure they are prepared and are able to evidence how these requirements/recommendations have been met in full.

2.6 Core Criteria

RQIA is responding to feedback that assessment of large numbers of criteria and the associated issues of inspection time committed to desktop checking reduce time for getting user/resident feedback.

This has led to the risk of taking too narrow a focus because of time constraints. Accordingly, we have reviewed selected standards for each service type and, where appropriate, have identified a number of core criteria in order to assist the process of the inspection and to ensure sufficient time is available to gather and validate the experience of service users. This approach will also ensure that inspectors take time to review the overall operation of individual services alongside detailed assessment against identified criteria.

The core criteria for announced inspections will be clearly identified in advance to service providers. The criteria will then be used thus:

- Providers will continue to complete self-assessment documents for all criteria for report inclusion
- Inspectors will assess all core criteria on inspection. On the basis of the self-assessment return made, or on the basis of their judgement during the inspection, they may select other criteria against which they will inspect if necessary. This may occur if, for example, it is deemed by the inspector that elements of the core criteria have not been achieved.

Criteria which have **not** been identified as core criteria will contribute further to the evaluation of the service from the service user's perspective.

3. Levels of Achievement

3.1 General

The model used by RQIA asks both service providers and inspectors to rate the inspected service's level of achievement for each criterion within the inspected standard. It is important that inspectors make sure that their selected levels are based on evidence.

Guidance for use of these levels can be found in section 5. The assessment should also consider the achievement level that appears appropriate before any possible regulatory action is taken into account.

3.2 Regulatory Action

Normally, where a criterion is not fully achieved, full achievement would be desirable.

For this reason, the following practice should be followed:

- In situations where a criterion is assessed by the inspector as neither "not applicable" nor "fully achieved", in most circumstances either a recommendation or requirement, as appropriate, will be made.
- In a few situations where a criterion is found by the inspector to be neither "not applicable" nor "fully achieved " and where the inspector judges that it would not be appropriate to make a recommendation or requirement, the reasons for deciding not to take regulatory action should be stated in the relevant part of the report.

Regulatory action taken will vary according to the nature and content of each individual Minimum Standard and decisions about enforcement must be reached on an individual case basis.

4. Maturity matrix

The model requires both service providers and inspectors to provide an overall summation of the service's performance against the Maturity Matrix for each Minimum Standard. Guidance on the terms used within the Maturity Matrix can be found in section 5.

4.1 Relationship between Achievement Levels and Maturity Level

Inspectors must bear in mind that the criteria used are to be considered as indicators of compliance with the relevant standard, but not as a checklist which, if complete, proves compliance.

It is also important to recognise that the Maturity Level is not simply an averaging out of achievement levels for each of the criteria. At the same time, evidence of significant degrees of non-compliance with the criteria must impact on consideration of the service's achievement against the standard statement as a whole.

The following points should be considered:

- When one or more criteria are assessed at "partially achieved" or below, services should generally be assessed as "aware", "responding" or "developing" against the overall standard.
- Where there is reason to assess outside the suggested range, the relevant section of the report must contain a clear statement explaining why this decision has been taken.

5. Guidance - Levels of Achievement

Level of Achievement	Definition	Guidance Note	Resulting Action in Inspection Report
Not applicable	The criterion is not applicable to this service setting.	A reason must be clearly stated in the assessment contained within the Inspection Report.	A reason must be clearly stated in the assessment contained within the Inspection Report.
Unlikely to be achieved	The criterion is unlikely to ever be achieved.	A reason must be clearly stated in the assessment contained within the Inspection Report.	A reason must be clearly stated in the assessment contained within the Inspection Report.
Not achieved	The criterion is unlikely to be achieved in full prior to end of March 2011. For example, the service has only started to develop a policy and implementation will not take place until after March 2011.	The definition states that implementation will not occur before end of March 2011. This level should be used in all instances where a plan showing service user impact of the necessary actions by that date cannot be convincingly demonstrated to the inspector.	In most situations this will result in a requirement or recommendation being made within the Inspection Report.
Partially achieved	Work has been progressing satisfactorily and the service is likely to have achieved the criterion prior to end of March 2011. For example, the service has developed a policy and will have completed implementation by end of March 2011.	The definition states that implementation is likely to occur before end of March 2011. This level should be used in instances where a plan showing service user impact of the necessary actions by that date can be convincingly demonstrated to the inspector.	In most situations this will result in a requirement or recommendation being made within the Inspection Report.
Substantially achieved	A significant proportion of action has been completed to ensure the service performance is in line with the criterion. For example, a policy has been developed and implemented but a plan to ensure practice is fully embedded has not yet been put in place.	At this level, the service user impact of the policy/procedure can be demonstrated across the service. However, processes to systematically review the user impact are not yet in place.	In most situations this will result in a requirement or recommendation being made within the Inspection Report.
Fully achieved	Action has been completed that ensures the service performance is fully in line with the criterion. For example, a policy has been developed, implemented, monitored and an ongoing programme is in place to review its effectiveness.	At this level, processes for monitoring, review and reformulation of the necessary actions on the basis of user impact can be demonstrated.	In most situations this will result in an area of good practice being identified and being made within the Inspection Report.

Guidance - Maturity Matrix

Level of Maturity	Definition	Guidance
Aware	The service is aware of the issues to be addressed but are unable to demonstrate decisions/actions to address them.	For the overall standard there is little evidence of a coherent approach to dealing with the practice area.
Responding	The service recognises the key issues and has identified options that are prioritised, although there is no evidence of strategic direction.	A plan has been developed addressing this area, but there is no evidence of service impact of the plan.
Developing	The service is taking steps to address the key issues through the development of strategic plans with evidence of good practice across the organisation.	Across this standard area, a plan is being taken forward with evidence from practice of the impact of policy.
Practising	The strategic agenda is being progressed and monitored by the service with significant evidence of continuous improvement across the organisation.	Good practice in this standard area is being monitored, evaluated, and revised according to the needs of service users.
Leading	The service is leading the strategic agenda through the implementation of innovative practice that is shared across and beyond the organisation to others, enabling realisation of long term sustainability.	In addition to the good practice evident at Practising level, the service is developing innovative practices that can be shown as being made available to other services.

Guidance - Standards

Standard 5: 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.

Criterion	Evidence by (Inspector's guidance) Inspectors to refer to - Regulation 3 (1) (c) 13 (1) - (3), 15, 16, 19 (1) (a) Schedule 3 3 (a) - (r) & 4 (k), and 25 of The Nursing Care Regulations (Northern Ireland) 2005	Provider's guidance for evidencing achievement of standard
5.1	<ul style="list-style-type: none"> • Confirm that a competent nurse from the nursing home who has appropriate training/or is skilled/experienced in assessing patients within a nursing home setting conducted the pre-admission assessment • Review a minimum of four care plans to confirm • Refer to care plan checklist • Discuss admission process and report on the validated assessment tool in use 	<ul style="list-style-type: none"> • Discuss and identify the model of nursing used to assess patients at admission • Confirm that a competent nurse from the nursing home who has appropriate training/or is skilled/experienced in assessing patients within a nursing home setting conducted the pre-admission assessment • Confirm and provide evidence of Trust involvement in regard to a planned admission
5.2	<ul style="list-style-type: none"> • As 5.1 • Current validated assessment tools; pressure (Braden), Falls, Nutrition (MUST or community dietician in N&S HSCT)), bedrails, restraint, wound observations (NICE), continence, pain (ABBEY or validated other) etc • Check the risk assessments have been completed accurately and risks are clearly highlighted • Check where risks have been identified that an action plan to minimise and reduce the risk is implemented. • Sample four care records to evidence that the care plans address the needs identified during the initial assessment and the appropriate guidance when planning care has been considered eg CREST /NICE/Essence of Care 	<ul style="list-style-type: none"> • As 5.1

Criterion	Evidence by (Inspector's guidance) Inspectors to refer to - Regulation 3 (1) (c) 13 (1) - (3), 15, 16, 19 (1) (a) Schedule 3 3 (a) - (r) & 4 (k), and 25 of The Nursing Care Regulations (Northern Ireland) 2005	Provider's guidance for evidencing achievement of standard
5.3	<ul style="list-style-type: none"> • Review sample of four care plans referencing care plan checklist • Determine the arrangements for discussing and agreeing nursing interventions and can they be evidenced and measured? • Are patients and/or relatives aware of their primary./named nurse? Ask a sample of patients and/or consenting relatives present during inspection? • Sample returned professional questionnaires and consult any consenting professional present during the inspection. • Are there arrangements in place for follow up and review of specialist services? 	<ul style="list-style-type: none"> • Discuss named nursing, care planning process and the involvement of other healthcare professionals when their advice and expertise is required.
5.4	<ul style="list-style-type: none"> • Discuss and review re-assessment of care plans, review the records relating to daily evaluation of care delivery, review of risk assessments and individual care plans • Frequency of re-assessment is determined by need • Determine the arrangements for monitoring, reviewing and evaluating needs and care plans to ensure they continue to remain current and relevant to meet patient's individual needs • Sample four patients' care records 	<ul style="list-style-type: none"> • Discuss and provide evidence of frequency of the re-assessment of care plans
5.5	<ul style="list-style-type: none"> • Sample a number of written policies and guidance documents to ensure relevant legislation and published professional regional and national guidance is reflected • Check the arrangements in place for the ongoing assessment/audit and review of policies and procedures including the updating of any newly published evidence and guidance. • Discuss and review care plans. Refer to 5.2 and standard 6.4 relating to case records. 	<ul style="list-style-type: none"> • Discuss and provide evidence of how interventions, activities and procedures are supported by research evidence and guidance. For example: NICE, CREST, NMC, DHSSPS etc.

Criterion	Evidence by (Inspector's guidance) Inspectors to refer to - Regulation 3 (1) (c) 13 (1) - (3), 15, 16, 19 (1) (a) Schedule 3 3 (a) - (r) & 4 (k), and 25 of The Nursing Care Regulations (Northern Ireland) 2005	Provider's guidance for evidencing achievement of standard
5.6	<ul style="list-style-type: none"> • Discuss, sample and review care plans • Records must be maintained in keeping with professional standards and guidance • Sample four care records to check that: <ul style="list-style-type: none"> - they were written as soon as possible after any intervention or event - timed using real time and the 24 hour clock - dated - signed and the signature and designation also recorded • Sample four care records and check that professional advice obtained from allied health care professionals has been legibly recorded and followed • Have recommended aids and equipment been provided? • Refer also to standard 6.2 and 6.3 relating to case records. Clear identified timings must be used AM/PM/ND not acceptable 	<ul style="list-style-type: none"> • Discuss and provide evidence that completion of contemporaneous nursing records are in accordance with best practice.
5.7	<ul style="list-style-type: none"> • Sample a number of records to determine that specific outcomes of care are recorded • Ascertain what benchmarks have been applied • Consult with a number of patients and representatives to determine if they have been involved in ongoing reviews • Discuss and review evidence provided. Refer to 5.4 	<ul style="list-style-type: none"> • Discuss and provide evidence of how outcomes of care are monitored, how this is recorded and how patients and / or their representatives are involved
5.8	<ul style="list-style-type: none"> • Is there evidence that care management reviews are held at least annually? • Discuss and review records pertaining to review meeting held by the Trust. Where are minutes / records of the reviews retained? • Does the outcome of the review discussion affect the patient's care plan; if yes - how? 	<ul style="list-style-type: none"> • Discuss and provide evidence of reviews by the HSC Trust, how patients and / or their representatives contribute and how the result or outcome of the review meeting informs the patient's care plan. • How are patients and /or their representatives kept informed of progress toward agreed goals?

Criterion	Evidence by (Inspector's guidance) Inspectors to refer to - Regulation 3 (1) (c) 13 (1) - (3), 15, 16, 19 (1) (a) Schedule 3 3 (a) - (r) & 4 (k), and 25 of The Nursing Care Regulations (Northern Ireland) 2005	Provider's guidance for evidencing achievement of standard
5.9	<ul style="list-style-type: none"> • As 5.8 • Sample four patients' care records / files to determine if minutes of care management reviews are available? 	<ul style="list-style-type: none"> • As above

Criterion	Evidence by (Inspector's guidance) Inspectors to refer to - Regulation 13 (1) (a) (b), 14 (1) (a) (b), (2) (a - c) (4), (5), (6), 15, 16, 19 (1) (a) Schedule 3 (k), 25 of The Nursing Care Regulations (Northern Ireland) 2005	Provider guidance for evidencing achievement of standard
6.1	<ul style="list-style-type: none"> • Evidence example • Discuss and review the policy and procedure in place. The policy should include reference to: <ul style="list-style-type: none"> - security of records and their storage - disposal - data protection - freedom of information orders / requests - confidentiality - NMC guidance on records standards - DHSSPS guidance - arrangements for the management and control of computerised records; eg: what happens if the computer “crashes”, who has access to what sections, what are the security risks in relation to access to the system via the internet - ascertain if there are appropriate arrangements in place in relation to the management of records and the audit of patient care records 	<ul style="list-style-type: none"> • Confirm the home has an up to date policy and procedure in place which references best practice standards. • Provide a copy of the policy and procedure which is in place to direct and guide staff
6.2	<ul style="list-style-type: none"> • Review a minimum of four care plans and determine if records are maintained in keeping with professional standards and guidance: <ul style="list-style-type: none"> - Check handwriting is legible, written in black ink and as soon as possible after any nursing intervention or event - Timed using real time and the 24 hour clock - Dated - Signed with the signature and designation of the signatory recorded - Refer to care plan checklist and standard 5.6 	<ul style="list-style-type: none"> • Discuss and provide evidence of how contemporaneous records are kept under review

Criterion	Evidence by (Inspector's guidance) Inspectors to refer to - Regulation 13 (1) (a) (b), 14 (1) (a) (b), (2) (a - c) (4), (5), (6), 15, 16, 19 (1) (a) Schedule 3 (k), 25 of The Nursing Care Regulations (Northern Ireland) 2005	Provider guidance for evidencing achievement of standard
6.3	<ul style="list-style-type: none"> • As above • Observe care records of a minimum of four patients and check that alterations made include: <ul style="list-style-type: none"> - the name and title of the person making the alteration - the signature and date on the original documentation is recorded - following any alteration, the original record remains clear and auditable 	<ul style="list-style-type: none"> • As 6.2
6.4	<ul style="list-style-type: none"> • Observe a sample of care records to ensure that: <ul style="list-style-type: none"> - any assessments or reviews undertaken are recorded - arrangements for future and ongoing care are recorded - information is recorded about the care and treatment given • Discuss and review care plans. Refer to care plan checklist, standards 5.2 and 5.5 	<ul style="list-style-type: none"> • Discuss and provide evidence how care records are reviewed / audited in terms of treatment provided and recommendations made

Criterion	Evidence by (Inspector's guidance) Inspectors to refer to - Regulation 4, 12 (4), 19 (1) schedule 3 (m), 19 (2) schedule 4 (13) of The Nursing Care Regulations (Northern Ireland) 2005	Provider guidance for evidencing achievement of standard
8.1	<ul style="list-style-type: none"> • Confirm and observe what screening method or nutritional tool is used? • Ensure the tool in use is relevant to the client group • Check training records to ensure that staff have received training in relation to the use of the nutritional tool • Sample a number of completed nutritional risk assessments and check they have been accurately completed • Sample care records to ascertain if risks have been identified, and that appropriate care plans been developed and appropriately reviewed • Discuss and review validated tool and system for screening e.g. record of monthly weighs • Review records on admission for baseline nutritional screening, if risk identified then review monthly otherwise • Monthly weighs for <u>all</u> patients • Commonly used validated tools:- MUST, Prideaux, community nutritional screening tool (N&SHSCT) • *Learning Disability Homes have specific nutritional guidelines 	<ul style="list-style-type: none"> • Provide the name of validated tool used and discuss the risk assessment for screening of patients eg record of monthly weights • Are appropriate nutritional guidelines available at the home?
8.2	<ul style="list-style-type: none"> • As 8.1 • Evidence how often screening is repeated when appropriate 	<ul style="list-style-type: none"> • Provide evidence of the frequency of nutritional screening undertaken

Criterion	Evidence by (Inspector's guidance) Inspectors to refer to - Regulation 4, 12 (4), 19 (1) schedule 3 (m), 19 (2) schedule 4 (13) of The Nursing Home Regulations (NI) 2005	Provider guidance for evidencing achievement of standard
8.3	<ul style="list-style-type: none"> • Sample records to evidence that appropriate referral arrangements are in place and have been made • Where risks have been identified that an action plan to minimise and reduce the risk is implemented • Audit a sample of nursing records to ensure that patients who require nutritional assessment and subsequent intervention have a nursing care plan devised in consultation with the patient, implemented and reviewed and the patients' nutritional care and treatment is recorded • That when required patients are onward referred for a dietetic assessment • Audit a sample of records to confirm the outcome of the dietetic assessment is available to the multi-disciplinary team • Discuss the systems for referral and how the instructions are incorporated into care 	<ul style="list-style-type: none"> • Discuss and provide evidence of referral arrangements and associated documentation to evidence the implementation of instructions given • Provide evidence of the Allied Health Professionals available to the home
8.4	<ul style="list-style-type: none"> • Ensure home has copies and uses appropriate nutritional guidelines for the setting. • Documentation audit of food and fluid balance charts to ensure they are completed accurately and totalled for the 24 hour period • Consult nursing and care staff and ascertain they understand the importance of recording and monitoring food and fluid intake, and check how information on nutritional issues is passed on when there is a concern • Consult staff and check the systems in place to identify patients who require additional help and support with eating and drinking • Discuss and renew what information is available for staff, patients and relatives: includes CREST 	<ul style="list-style-type: none"> • Discuss and provide evidence of what information is available within the home for staff, patients and relatives

Criterion	Evidence by (Inspector's guidance) Inspectors to refer to - Regulation 4, 12 (4), 19 (1) schedule 3 (m), 19 (2) schedule 4 (13) of The Nursing Home Regulations (NI) 2005	Provider guidance for evidencing achievement of standard
8.5	<ul style="list-style-type: none"> • As Above • Observe and report on what nutritional information is provided to patients by the home • Consult staff and determine if they know of the regional and national standards for eating well in nursing homes 	<ul style="list-style-type: none"> • Discuss and provide evidence of what information is available within the home for staff, patients and relatives
8.6	<ul style="list-style-type: none"> • Question staff • Observation of staff during mealtimes • Audit a sample of staff training records • Sample patient, relative and staff questionnaires • Review of Diabetic instructions and how these are incorporated into care plans 	<ul style="list-style-type: none"> • Provide evidence of meaningful fluid balance recording ie fluid intake targets set and evaluated daily. Appropriate Plan of action when the deficit occurs • Referral to relevant healthcare professionals
8.7	<ul style="list-style-type: none"> • As Above • Observe if any patients are receiving enteral feeding • Examine care records to ensure that appropriate feeding regimes are in place and adhered to • Audit staff training records to ensure that nurses providing enteral feeding have received appropriate training from a competent trainer 	<ul style="list-style-type: none"> • As Above • Confirm if enteral feeding is undertaken and if so the arrangement for the management of the patients and provision of appropriate staff training

Criterion	Evidence by (Inspector's guidance) Inspectors to refer to - Regulation 12 (4), 19 (1) Schedule 3 3 (m), 19 (2) Schedule 4 (13) of The Nursing Home Regulations (NI) 2005	Provider guidance for evidencing Achievement of standard
12.1	<ul style="list-style-type: none"> • Discuss who devises the menu and how is it quality assured? • Observe the choices available to patients • Check the menu contains a minimum of five portions of fruit and vegetables on a daily basis • Observe that fruit and vegetables offered is provided in a form suitable to each patient's needs eg chopped, mashed, pureed or liquidised • Check if any patient is receiving fortified high calorie meal options with added ingredients eg full cream milk, double cream to porridge, soup and puddings to make them more nourishing • Observe, and consult patients and report if hot and cold fluids are freely available at any time • Consult staff and determine if they are aware of the minimum fluid requirements for individual patients (1500 mls - 8 - 9 cups) (NB) Some patients may have fluid restrictions • Discuss development of menus - how are these quality assured? • Was there diabetic input? • Review record of food served • Review record of variation to planned menu, discuss • Patients' likes and dislikes - what do staff know? Does chef / cook meet patients on admission and when carrying out review of menu? • How are individuals' preferences indicated / reassessed? 	<ul style="list-style-type: none"> • Discuss the development of the home's menus, how are these quality assured • Provide evidence of the record of food served and any variation to the planned menu • Discuss how patients' likes and dislikes are indicated / reassessed and known by staff

Criterion	Evidence by (Inspector's guidance) Inspectors to refer to - Regulation 12 (4), 19 (1) Schedule 3 3 (m), 19 (2) Schedule 4 (13) of The Nursing Home Regulations (NI) 2005	Provider guidance for evidencing achievement of standard
12.2	<ul style="list-style-type: none"> • Discussion and review of evidence if available • Ask a number of patients • Check minutes of patient/relative meetings 	<ul style="list-style-type: none"> • Discuss and provide evidence of how patients are involved in planning menus
12.3	<ul style="list-style-type: none"> • Check that patients receiving pureed meals receive a choice of meals at lunch and tea. • Review of menus • Review of variation planned to menu • Discuss with Chef/cook 	<ul style="list-style-type: none"> • Provide evidence of menu choice • Provide evidence of regular menu review
12.4	<ul style="list-style-type: none"> • Observation of resident dining areas • Provide example • Observe and report 	<ul style="list-style-type: none"> • Discuss the format and display of patient menus
12.5	<ul style="list-style-type: none"> • Observe the patient guide to determine the meal time arrangements including the arrangements for any patient who misses a conventional mealtime • Observe and discuss 	<ul style="list-style-type: none"> • Discuss the arrangements for patient mealtimes and provision of food outside these times
12.6	<ul style="list-style-type: none"> • Observe and discuss with patients and staff • Consult patients and ask if hot drinks such as morning tea and snacks are served outside meal times 	<ul style="list-style-type: none"> • Discuss the home's arrangements for provision of food outside conventional times
12.7	<ul style="list-style-type: none"> • Examine menus for examples of "special occasion" meals • Discuss with patients and staff 	<ul style="list-style-type: none"> • Discuss how the home caters for special occasions eg patient's birthdays
12.8	<ul style="list-style-type: none"> • Discuss arrangements for takeaway foods and ascertain if they are included in home's nutritional policy 	<ul style="list-style-type: none"> • Discuss arrangements for takeaway foods
12.9	<ul style="list-style-type: none"> • Consult patients to determine what choices they are given to meet personal preferences • Observe that food and beverages served are at the correct temperature for patient preference • Observe that food is presented in a form suitable to each patient's needs eg chopped, mashed, pureed or liquidised • Discuss with patients and staff 	<ul style="list-style-type: none"> • Discuss arrangements in place for serving of patients meals in terms of their individual needs.

Criterion	Evidence by (Inspector's guidance) Inspectors to refer to - Regulation 12 (4), 19 (1) Schedule 3 3 (m), 19 (2) Schedule 4 (13) of The Nursing Home Regulations (NI) 2005	Provider guidance for evidencing achievement of standard
12.10	<ul style="list-style-type: none"> • Review of care records • Discussion with staff • Observation of a meal time 	<ul style="list-style-type: none"> • Discuss arrangements for meal times regarding supervision and appropriate assistance for patients and the provision of aids and equipment
12.11, 12.12 and 12.14	<ul style="list-style-type: none"> • Review nutrition policy • Review record of food served • Review record of variation to planned menu • Review of care plans food and fluid charts • Review of care plans, food and fluid charts as appropriate • Discussion with staff • Review of referral process • Maintenance of individual food records when appropriate 	<ul style="list-style-type: none"> • Discuss and provide evidence of how record of food is maintained • Variations to planned menu, care records, staff knowledge and referral process • Confirm arrangements for the managements of patients who are unable to eat and drink / or refuse a meal
12.13	<ul style="list-style-type: none"> • Review menu cycle • Review menu revisions • Discuss with chef / cook 	<ul style="list-style-type: none"> • Discuss and provide evidence of procedure for reviewing menus and provide a copy of the 3 week menu cycle

Criterion	Evidence by (Inspector's guidance) Inspectors to refer to - Regulation 3 (1) (c) 18 (2) (m) (n) and schedule 19 (2) schedule 4 (19) of The Nursing Home Regulations (Northern Ireland) 2005	Provider guidance for evidencing achievement of standard
13.1, 13.2 and 13.6	<ul style="list-style-type: none"> • Review individual care records in relation to social interests of patients • Review programme of activities and awards • Review records of activity evaluation 	<ul style="list-style-type: none"> • Discuss how patients are assessed in relation to activities • Provide evidence of activity programmes and evaluation of participation of patients
13.3	<ul style="list-style-type: none"> • Discuss with patients and staff 	<ul style="list-style-type: none"> • Discuss patient involvement in the planning of activities
13.4	<ul style="list-style-type: none"> • Observation and discussion with staff and patients 	<ul style="list-style-type: none"> • Discuss arrangements for displaying activity programme
13.5	<ul style="list-style-type: none"> • Observe and report what activity if any is taking place during the inspection • Discussion with patients and staff observation 	<ul style="list-style-type: none"> • Discuss arrangements for the provision of equipment and staff in relation to the activity programme
13.7	<ul style="list-style-type: none"> • Discuss arrangements in respect of activities provided by a person contracted in the home 	<ul style="list-style-type: none"> • Discuss how the management monitor the effectiveness of the person providing the activity and that this person has the necessary skills to do so
13.8	<ul style="list-style-type: none"> • Discuss arrangements for informing the person contracted to provide activities, the changing needs of patients and how feedback is provided 	<ul style="list-style-type: none"> • Discuss how the contracted person providing activities is updated in relation to patients' changing needs and how feedback is provided
13.9	<ul style="list-style-type: none"> • Review records of activities undertaken to ensure that they illustrate: <ul style="list-style-type: none"> - All activities undertaken - Name of person leading the activity - Names of service users who participated 	<ul style="list-style-type: none"> • Records maintained should reflect: <ul style="list-style-type: none"> - All activities undertaken - Name of person leading the activity - Names of service users who participated
13.10	<ul style="list-style-type: none"> • Discuss how regular review is carried out and review evidence 	<ul style="list-style-type: none"> • Discuss and provide evidence of regular review

6. Inspection Process

6.1 Six weeks prior to the inspection date

A member of the admin staff will contact the Registered Manager to confirm the Home's email address.

An email will be sent to the confirmed address containing the notification letter, self assessment document, patient information/dependency form, staffing levels form, Rhys Hearn guidance document, poster and professionals list (appendices 1 - 4). If the Home does not have an email address, the above documentation will be sent to the Registered Manager in hard copy.

The Registered Manager will also receive a package which will include the questionnaires for staff, patients and relatives as well as guidance regarding the distribution of the questionnaires.

A hard copy of the notification letter will also be sent to the Registered Provider so that they are aware of the inspection date.

6.2 Two weeks prior to the inspection

Please return the self assessment document and professionals list to the Nursing team by the date stated on the notification letter to allow time for the Inspector to prepare for the inspection.

6.3 Day of Inspection

During the inspection, the Inspector will be validating the home's completed self assessment document. Please have copies of any evidence stated in the self assessment, and the completed patient information/dependency and staffing levels forms, available on the day of inspection.

The Inspector will ask the Registered Manager to complete a questionnaire regarding the inspection process to be returned to the Nursing Team.

6.4 Post inspection

It is the aim of the Authority to issue the draft report within 4 weeks of the inspection date to the Registered Manager and Registered Provider.

Please complete the Quality Improvement Plan completing the actions taken by the Registered Provider section, in detail, and return to the Nursing Team by the date stated on the letter.

If no amendments are received in writing by the date stated, the report will be considered as final and will be made available to the public if requested.

7. Frequently Asked Questions

Q: Can word count and spell check be used in the self assessment document?

A: Due to the limitations of Microsoft Word, word count and spell check cannot be used in the self assessment document when drop downs are being used. If you wish to use these facilities, it is possible to copy information from a word document into the self assessment document.

Q: How do you complete the self assessment document?

There is a grey text box inserted in the Provider's self assessment box for each criterion as shown below.

PROVIDER'S SELF-ASSESSMENT
Please outline (in no more than 200 words) how you...
Criterion Assessed:
10.1 Staff have knowledge and understanding of each individual resident's usual co... of communication. Responses and interventions of staff promote positive outcomes...
Provider's Self Assessment:
Please enter the establishment's evidence for the above criterion here.
Inspection Findings: FOR RQIA INSPECTORS USE ONLY

Drop down menus have been inserted for the achievement levels for each criterion and maturity matrix for the four standards as shown below:

	ACHIEVEMENT LEVEL	
IS	<div style="border: 1px solid black; padding: 2px;">Not Applicable ▾</div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;"> Not Applicable Unlikely to be Achieved Not Achieved Partially Achieved Substantially Achieved Fully Achieved </div>	Inspection No <div style="background-color: #800040; color: white; padding: 5px; text-align: center; font-weight: bold;">MATURITY LEVEL</div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;"> Aware ▾ Aware Responding Developing Practising Leading </div>

Q: The inspection date on the notification letter does not suit.

A: If the inspection date does not suit, please contact the Nursing Team administrative staff on (028) 9051 7500 as soon as the problem arises. It may be possible to reschedule the inspection with agreement from the Inspector.

Q: I am unsure what evidence to record in the self assessment document for each criterion.

A: Guidance regarding the evidence RQIA are looking for under each standard is contained in section 3 of the guidance booklet, however if you are still unclear please contact the Inspector carrying out the inspection or the duty Inspector.

Q: I am having problems completing the documentation on line or emailing the returns to RQIA.

A: Please contact the Nursing Team administrative staff on (028) 9051 7500 to discuss your problems. If necessary the documentation can be returned on paper.

Q: I am unable to complete the inspection documentation by the date stated on the notification letter:

A: RQIA ask for the documentation to be returned 2 weeks before the inspection to allow time for pre-inspection preparation. If you cannot return the documentation by the stated date, please contact the Nursing Team administrative staff on (028) 9051 7500 to arrange a new deadline for the documentation.

Q: Contact details for the Nursing Team

A: NURSING TEAM EMAIL ADDRESS - Nursing.Team@rqia.org.uk

NURSING TEAM TELEPHONE NUMBER - (028) 90517500

8. Appendices

Appendix 1 -

RHYS HEARN DEPENDENCY ASSESSMENT TOOL

CARE GROUP

- A Self Caring
- B Low Dependency
- C Medium Dependency
- D High Dependency

CARE GROUP CHARACTERISTICS

- A SELF CARING:** Typically a person in this care group:
1. Is continent
 2. Does not require assistance in the toilet
 3. Can feed him/ herself
 4. Can wash him/ herself
 5. Can walk without assistance, but may use a stick/ zimmer /tripod
 6. Can manage own affairs
 7. Can make needs known
- B LOW DEPENDENCY:** Typically a person in this care group:
1. Is continent, but may have the occasional 'accident'
 2. Can usually manage in the toilet, but may need supervision
 3. Can feed him/ herself
 4. May need supervision or assistance with washing
 5. May need supervision or assistance with dressing
 6. Walks without assistance, but probably uses a stick/ zimmer/ tripod
 7. Can manage own affairs with little assistance
 8. Can make needs known
- C MEDIUM DEPENDENCY:** Typically a person in this care group:
1. Is occasionally incontinent
 2. requires assistance in the toilet
 3. Can feed him/ herself, but may need minimal help
 4. Needs supervision or assistance with washing
 5. Needs help with dressing
 6. Needs to use a walking aid or be assisted, may use a wheelchair
 7. Requires assistance with financial affairs
 8. Has difficulty making needs known

- D HIGH DEPENDENCY:** Typically a person in this care group:
1. Is sometimes doubly incontinent
 2. Requires assistance in the toilet, uses a commode or requires incontinent care
 3. Requires assistance or has to be fed
 4. Requires washing
 5. Requires dressing
 6. Walks with assistance or is bedfast/ chairfast
 7. Cannot manage own affairs
 8. Cannot make needs known

Rhys Hearn 1970

PATIENT DEPENDENCY

The dependency level of the patients can be used to ensure a standard approach in deciding the staffing levels and appropriate qualifications of staff in a nursing or residential home.

Care Group A - Estimated Direct Care Required per Day - 1 Hour

A person who is deemed to be in Care Group A may be regarded as largely capable of "self care".

Care Group B - Estimated Direct care Required per day - 2 Hours

A person who is deemed to be Care Group B may be regarded as requiring "average care".

Care Group C - Estimated Direct Care Required per Day - 3 Hours

A person who is deemed to be Care Group C may be regarded as needing "above average care".

Care Group D - Estimated Direct Care Required per Day - 4 Hours

A person who is deemed to be Care Group D may be regarded as needing "maximum nursing care".

The following is an example using this formula for a Nursing Home providing accommodation for 60 patients with patient dependency levels as shown.

Care Group D - High Dependency	= 36 patients x 4 hours = 144 care hours
Care Group C - Medium Dependency	= 12 patients x 3 hours = 36 care hours
Care Group B - Low Dependency	= 6 patients x 2 hours = 12 care hours
Care Group D - High Dependency	= 6 patients x 1 hours = 6 care hours

Total: = 198 care hours for a 24 hour period

To calculate minimum staffing provision for 7 days, multiply 198 by 7

Total hours for one week: 1386 hours

Please note that 35% of the total care hours must be deployed to Registered Nurse Provision.

Appendix 2 - Professionals List

REGULATION AND QUALITY IMPROVEMENT AUTHORITY

PROFESSIONALS WHO FREQUENTLY VISIT THE ESTABLISHMENT EXCLUDING GENERAL PRACTITIONERS

NAME OF ESTABLISHMENT:

DATE:

PLEASE WRITE CLEARLY IN BLOCK CAPITALS AND PROVIDE FULL
NAMES AND ADDRESSES (INCLUDING POSTCODES)

NAME AND FULL POSTAL ADDRESS	NATURE OF PROFESSION
Name: Address: Postcode:	
Name: Address: Postcode:	
Name: Address: Postcode:	
Name: Address: Postcode:	
Name: Address: Postcode:	

Signed _____

Position _____

Appendix 3 - Patient information/dependency sheet

PATIENT/RESIDENT INFORMATION/DEPENDENCY SHEET

Name of Home:

Category of Home:

Date of Completion of Return:

Number of beds (as on Registration Certificate)

Number of Nursing beds occupied

Number of Residential beds occupied

Categories of care (as on Registration Certificate)

Number of beds vacant (day submitting return)

Number of registered Day Care places

NURSING HOME

Age range No over 65 No under 65

Dependency as per Rhys Hearn. If comparable assessment tool used please state:

.....

A Self care

B Low dependency

C Medium dependency

D High dependency

RESIDENTIAL HOME

Age range No over 65 No under 65

Assessment

Dependency as per CAPE assessment tool. If comparable assessment tool used please state:

As far as possible indicate the number of residents in each of the following categories

A Independent/self care

B Low dependency

C Medium dependency

D High dependency

E Maximum dependency

1 MOBILITY

Please detail the number of residents who:

(a) are fully mobile and require no assistance with walking

(b) use a walking aid/ zimmer only

(c) require physical support from one staff member

(d) use a walking aid/ zimmer and also require support from staff

(e) require assistance from two staff

(f) are confined to a wheelchair but can propel themselves

(g) are confined to a wheelchair and require staff assistance

(h) are bedfast/chairfast

- (i) use a wheelchair for transferring within the home and going outside the home - with help
- (j) use of wheelchair - self propelled

2 FEEDING

Please detail the number of residents who:

- (a) can feed themselves, without assistance
 - (b) require only verbal prompting
 - (c) require to have food cut-up but can feed themselves
 - (d) require limited physical assistance by staff e.g. support to hold cup
 - (f) require to be fed
 - (g) are fed by an alternative route
- please specify:

3 BATHING

Please detail the number of residents who:

- (a) can bath without aid or assistance of any kind
- (b) require minimal assistance/intervention from one staff member
- (c) require one staff member to be in attendance throughout bathing process
- (d) require the assistance of two staff (lifting in/out only)
- (e) require the assistance of two staff throughout the bathing process

4 DRESSING

Please detail the number of residents who:

- (a) can dress themselves fully without assistance
- (b) require only minimal assistance with buttons etc.
- (c) need assistance with certain items of clothing
- (d) are completely dependent upon staff for help with clothing

5 TOILETING

Please detail the number of resident who:

- (a) can attend to their toileting needs independently
 - (b) require verbal prompting or reminding to use the toilet
 - (c) require minimal assistance from staff e.g. buttons
 - (d) require assistance from staff due to frailty or disability
 - (e) are incontinent
 - (f) are doubly incontinent
 - (g) are on a toileting programme
 - (h) have had their condition assessed in relation to incontinence
- specify assessment tool used:

6 MENTAL STATE

- (a) No. diagnosed who are suffering from dementia/
 - (b) Alzheimer's Disease
 - (c) No. in Guardianship (Mental Health (NI) Order 1986)
 - (d) No. diagnosed as having mental ill health
 - (e) No. diagnosed as having learning disabilities
 - (f) No. with behavioural problems
- Please describe behaviour problem:
-

-
- 7 INFECTION CONTROL**
- (a) Number of residents diagnosed with
- (b) MRSA
- (c) Clostridium difficile
- (d) Other Health Care Aquired Infection (Please describe)
- 8 PRESSURE SORES**
- Number of residents diagnosed with pressure sores
- Grade 1 - Non blanching erythema of skin, skin unbroken
- Grade 2 - Partial thickness skin loss. An abrasion, blister
or shallow ulcer
- Grade 3 - Full thickness skin loss. Extends down to but
not through deep facia
- Grade 4 - Deep cavity into subcutaneous tissue.
Extensive damage to muscle, tendon or bone possible
- 9 NUMBER OF RESIDENTS RECEIVING ENTERAL FEEDS**
- 10 DIABETES**
- Number of residents with diabetes
- Type 1
- Type 2
- 11 NUMBER OF RESIDENTS ON SUBCUTANEOUS FLUIDS**
- 12 NUMBER OF RESIDENTS ON INTRAVENOUS FLUIDS**

Signed:

Designation:

