



The Regulation and
Quality Improvement
Authority

2010/2011 INSPECTION YEAR

RESIDENTIAL CARE HOMES

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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:

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

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

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

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 10: Responses to residents are appropriate and based on an understanding of individual resident's conduct, behaviours and means of communication.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
10.1	<p>Inspectors to refer to - Regulation 14 (2) (5) (6), schedule 3 (1), (3 j, k, l, m, q & r) & (4) Schedule 4, (12) (b) of The Residential Care Homes Regulations (Northern Ireland) 2005</p> <ul style="list-style-type: none"> • Review assessment of need to ensure that behaviours which challenge are appropriately recorded with clear concise action planning agreed by service users / family members, behavioural support team if applicable, multi disciplinary team members as required and Registered Manager. • Review staff training records to ensure that staff has knowledge and understanding of how to support and manage behaviours which challenge. • Refer to review records to ensure that action planned to manage challenges is reviewed regularly to ensure that a positive outcome is promoted for the service user. Review statement of purpose to ensure that home is registered for appropriate category of care. • Review care plan to ensure that the care plan illustrates each individual's usual conduct, behaviours and means of communication. 	<ul style="list-style-type: none"> • Discuss that assessment of need, care planning and review is undertaken to fully reflect usual behaviours, conduct and means of communications. • Discuss that behaviours which challenge are appropriately assessed to illustrate triggers for challenging behaviours and plan of action in response to challenges to be followed by staff. • Discuss review process to ensure that response to behavioural challenges are appropriate, effective and creating a positive response for the service user.
10.2	<ul style="list-style-type: none"> • Review policy and procedure for managing behaviours which challenge to ensure that it reflects a process which guides staff to recognise when behaviours are uncharacteristic and to seek out reason for behaviour. • Review records of incidents to ensure appropriate action was taken in reporting to all professionals as required. 	<ul style="list-style-type: none"> • Discuss procedure for managing behaviours which challenge to clearly illustrate how staff will identify uncharacteristic behaviour, seek reason for change, report issue to senior staff and multi-professional teams as required. • Discuss records maintained.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
10.3	<p>Inspectors to refer to - Regulation 14 (2) (5) (6), schedule 3 (1), (3 j, k, l, m, q & r) & (4) Schedule 4, (12) (b) of The Residential Care Homes Regulations (Northern Ireland) 2005</p> <ul style="list-style-type: none"> • Review care plan documentation regarding behavioural issues to ensure that if a consistent approach or response from staff is required that it is clearly documented. • Review care plan records to ensure that with the service user's consent their family member / representative is also informed of the approach to be taken. 	<ul style="list-style-type: none"> • Discuss how behavioural issues requiring a consistent approach from staff are recorded. • Discuss if, with consent from the service user their family member representative is informed of the particular approach to be taken.
10.4	<ul style="list-style-type: none"> • Review multi professional involvement to ensure that behavioural support teams or other specialist support is involved in the management plans. 	<ul style="list-style-type: none"> • Discuss the policy on engaging the support of the multi professional team including behavioural support teams as required.
10.5	<ul style="list-style-type: none"> • Review training provided for staff to ensure that staff are appropriately trained to deliver behavioural support as required. 	<ul style="list-style-type: none"> • Clarify training provided to ensure that staff are all able to meet the needs of the behavioural support plans of each service user.
10.6	<ul style="list-style-type: none"> • Review the management of incidents which occur outside the scope of the service user's care plan to ensure that it is recorded and reported as required to the relevant professionals or services and if appropriate to the service user's representative. Where necessary this is followed by a multi professional review of the service user's care plan. 	<ul style="list-style-type: none"> • Clarify procedure to be taken should an incident occur outside the scope of the care plan, the recording and reporting process including referral to a multi professional for review of the care plan.
10.7	<ul style="list-style-type: none"> • Review policy on restraint ensuring it is only used as a last resort by appropriately trained staff to protect the service user or other persons when other less restrictive strategies have been unsuccessful. • Review records when restraint is used. 	<ul style="list-style-type: none"> • Discuss policy on restraint to illustrate that it is only used as a last resort by appropriately trained staff to protect the service user or other persons when other less restrictive strategies have been unsuccessful. • Clarify records maintained when restraint is used.

Standard 13 : The home offers a structured programme of varied activities and events, related to the statement of purpose and identified needs of the residents.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
13.1 and 13.2	<p>Inspectors to refer to - Regulation 18 (2) (m) (n), schedule 4 (19) of The Residential Care Homes Regulations (Northern Ireland) 2005</p> <ul style="list-style-type: none"> Review programme of activities to ensure that it provides positive outcomes for service users and is based on their identified needs and interests. The programme should promote healthy living and facilitate social inclusion. 	<ul style="list-style-type: none"> Discuss that programme of activities is based on service users' assessed needs and interests, promoting healthy living and promoting social inclusion. How is this evidenced?
13.3	<ul style="list-style-type: none"> Review all service user involvement in activity programme planning. Reference to service users meetings, satisfaction surveys, suggestion boxes. 	<ul style="list-style-type: none"> Clarify how activity programme is developed to show service users' involvement and how their opinions are gathered.
13.4	<ul style="list-style-type: none"> Review where activity programme is displayed in suitable format and appropriate location so that service users and their representatives can know what is scheduled. 	<ul style="list-style-type: none"> Clarify how services are made aware of activity programme on daily basis referring to display boards, the formats of same and their location etc.
13.5	<ul style="list-style-type: none"> Review availability of activity equipment, aids and support available from staff or others. 	<ul style="list-style-type: none"> Clarify what equipment, aids and support from staff and others is available for the activity programme.
13.6	<ul style="list-style-type: none"> Review the duration and daily timetable of activities to ensure it is suitable to meet the needs and abilities of the service users participating. 	<ul style="list-style-type: none"> Clarify how the needs of the service users are addressed in relation to the duration of each activity and the daily timetable eg are mornings or afternoons better or both?
13.7	<ul style="list-style-type: none"> Review records maintained in respect of activities provided by a person contracted-in to do so by the home. Review evidence of the Registered Manager monitoring effectiveness of activity to confirm that those delivering of facilitating activities have the necessary skills to do so. 	<ul style="list-style-type: none"> Discuss how the home monitors effectiveness of person contracted-in to deliver activities and that this person has necessary skills to do so.
13.8	<ul style="list-style-type: none"> Review how home report to contracted-in person any changes in resident's needs prior to activity commencing and that there is a system in place to receive timely feedback. 	<ul style="list-style-type: none"> Discuss how home report to contracted-in person any changes in residents need prior to activity commencing and that there is a system in place to receive timely feedback.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
13.9	<p>Inspectors to refer to - Regulation 18 (2) (m) (n), schedule 4 (19) of The Residential Care Homes Regulations (Northern Ireland) 2005</p> <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 activity; - names of service users who participated. 	<ul style="list-style-type: none"> • Clarify records maintained which should reflect: <ul style="list-style-type: none"> - all activities undertaken; - name of person leading activity; - names of service users who participated.
13.10	<ul style="list-style-type: none"> • Review activity programme to ensure that a review of the programmes is undertaken at least twice yearly to ensure it meets the service user's changing needs. 	<ul style="list-style-type: none"> • Clarify review procedure for activity programme ensuring that it is evidenced to be undertaken twice yearly to meet the service user's changing needs.

Standard 16: Protection of Vulnerable Adults

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
	Inspectors to refer to - Regulation 14 (4) of The Residential Care Homes Regulations (Northern Ireland) 2005	
16.1	<ul style="list-style-type: none"> Review policy document 	<ul style="list-style-type: none"> Policy document to be maintained in accordance with legislation, DHSSPS guidance, regional protocols and local procedures issued by Trusts.
16.2	<ul style="list-style-type: none"> Review induction programme 	<ul style="list-style-type: none"> Discuss induction programme.
16.3 and 16.9	<ul style="list-style-type: none"> Review of training schedule Review training records Review management of incidents to determine that appropriate action has been taken. Review any reported, suspected, alleged or actual abuse within the home recorded. 	<ul style="list-style-type: none"> Discuss content of training programme. Discuss that in formal supervision with of staff to capture evidence of understanding of knowledge. Discuss reporting mechanisms. Discuss frequency of training and evidence of compliance with training schedule.
16.4 and 16.5	<ul style="list-style-type: none"> Review all records of suspected, alleged or actual incidents of abuse for evidence of reporting process. Cross reference with Provider procedures and legislation. Review time line of reporting to ensure that it is within appropriate acceptable limits. Review referral to regulatory bodies NISCC, NMC, Access NI, ISA Vetting and Barring scheme. 	<ul style="list-style-type: none"> Discuss procedure followed when suspected, alleged or actual incidents of abuse are reported illustrating referral to relevant persons and agencies as required. Include NISCC, NMC, Access NI, ISA Vetting and Barring scheme etc. Discuss time line for reporting.
16.6	<ul style="list-style-type: none"> Review investigations concluded to ensure all relevant persons notified of outcome. 	<ul style="list-style-type: none"> Clarify process for notification of all relevant persons / agencies of outcome of investigation.
16.7	<ul style="list-style-type: none"> Review all written documentation in respect of suspected, alleged or actual incidents of abuse. Records should include details of investigation, outcome and actions taken. 	<ul style="list-style-type: none"> Clarify management of records in respect of investigation, outcome and details of action to be taken.
16.8	<ul style="list-style-type: none"> Review documentary evidence of outcomes of investigation where any shortcomings in system have required additional safeguards to be established. 	<ul style="list-style-type: none"> Clarify if comprehensive review of complete investigation and plan of action is undertaken to identify any shortcomings of process and how this could be avoided in future.

Standard 17: All complaints are taken seriously and dealt with promptly and effectively.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
17.1 and 17.13	<p>Inspectors to refer to - Regulation 24, schedule 4 (11) of The Residential Care Homes Regulations (Northern Ireland) 2005</p> <ul style="list-style-type: none"> ● Review complaints procedure ensuring that it meets requirements of HSC complaints procedure and is in accordance with relevant legislation and DHSSPS guidance on Complaints in residential and nursing homes. ● Review complaints policy to ensure that 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 is activated. ● Review records of complaints to evidence that correct procedures have been followed. 	<ul style="list-style-type: none"> ● Discuss complaints policy ensuring that it is in line with HSC complaints procedures, relevant legislation and DHSSPS guidance on complaints in residential and nursing homes. ● Discuss that the management of complaints relating to abuse, exploitation or neglect are managed with reference to the Regional "Safeguarding Vulnerable Adults" policy and Procedural Guidance and The Protocol for Joint Investigation of Alleged or Suspected cases of Abuse of Vulnerable Adults is appropriately activated.
17.2, 17.6 and 17.16	<ul style="list-style-type: none"> ● Seek evidence that complaints procedure is: <ul style="list-style-type: none"> - Publicised in facility. - Copy is given to service users and family members. - That complaints information refers clearly how to make a complaint and who to contact outside the organisation if they remain dissatisfied with outcome of investigation. - Information regarding independent advocacy is included. - Ensure that the right to contact NI Ombudsman is included if complainant is not satisfied with the outcome of the complaint investigation. ● Review evidence that organisation enables and encourages service users to make complaints via service users' meetings, relatives' meetings, annual satisfaction surveys etc. 	<ul style="list-style-type: none"> ● Discuss that complaints information is signposted around facility. ● Discuss that a copy of leaflets and guidance on the making of a complaint is made available to all service users and family members. ● Discuss that service users or family members can access support of an Independent Advocate for help in making a complaint. ● Discuss that complaints policy and procedure makes reference to service users being able to access the NI Ombudsman should they remain unsatisfied with the outcome of the home's or Trust's complaints investigation. ● Discuss that service users are encouraged and enabled to make complaints as required evidencing via service users meetings, relatives meetings, annual quality assurance surveys etc.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
17.3 and 17.16	<p>Inspectors to refer to - Regulation 24, schedule 4 (11) of The Residential Care Homes Regulations (Northern Ireland) 2005</p> <ul style="list-style-type: none"> • Review if any resident's have sight or reading difficulties. If so, ask for an example of the format used for these individuals. 	<ul style="list-style-type: none"> • Discuss re any current residents in the home having sight or reading or learning difficulties? If so, discuss other appropriate formats having been devised and made available.
17.4 and 17.16	<ul style="list-style-type: none"> • Review complaints procedure to clarify that documentation refers to: <ul style="list-style-type: none"> - step by step guidance on making a complaint; - the timescales involved; - an outline of the function of RQIA with contact details; - referral information on the function and contact details for NI Ombudsman should the complainant not be satisfied with the outcome of the home or Trust's investigation. 	<ul style="list-style-type: none"> • Discuss that complaints procedure clearly illustrates: <ul style="list-style-type: none"> - step by step guidance on making a complaint; - the timescales involved; - an outline of the function of RQIA with contact details; - referral information on the function and contact details for NI Ombudsman should the complainant not be satisfied with the outcome of the home or Trust's investigation.
17.5	<ul style="list-style-type: none"> • Review customer awareness training to ensure that all staff are aware of how to receive a complaint and report this to the Manager or other appropriate person pass on to appropriate person for management. • Review induction records for evidence that issue is covered. 	<ul style="list-style-type: none"> • Discuss evidence of how staff are trained in customer awareness to ensure they know how to appropriately receive, report and record a complaint from a service user, family member or member of the public.
17.7	<ul style="list-style-type: none"> • Review that the Provider actively encourages contact with independent advocate service. • Review signage to advertise service of independent advocacy. 	<ul style="list-style-type: none"> • Discuss that the organisation promotes and enables service users to access independent advocate. • Discuss if signage re advocacy service displayed.
17.8	<ul style="list-style-type: none"> • Review complaints training for staff who deals directly in the management and investigation of complaints and in the application of the complaints procedure. 	<ul style="list-style-type: none"> • Discuss that extended training in the management and investigation of complaints is provided to all staff directly involved in this task.
17.9	<ul style="list-style-type: none"> • Review complaint records to ensure that complaints are investigated and responded to within 28 days and when not possible that the complainant is kept informed of any delays. 	<ul style="list-style-type: none"> • Discuss that the complaints procedure ensures that complaints are investigated and responded to within 28 days and the complainant is advised of any delays if applicable.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
17.10	<p>Inspectors to refer to - Regulation 24, schedule 4 (11) of The Residential Care Homes Regulations (Northern Ireland) 2005</p> <ul style="list-style-type: none"> Review records of complaints to ensure they include details of all communications with complainants and the result of any investigation with action taken. 	<ul style="list-style-type: none"> Discuss that all records are maintained appropriately to evidence details of all communications with complainants, the result of investigations and the action taken. Does the complaints record state if the complainant is satisfied with the outcome of the home's investigation?
17.11	<ul style="list-style-type: none"> Review complaints and investigations to ensure that the Provider is co-operating with the HSC Trust, RQIA and NI Ombudsman as appropriate. 	<ul style="list-style-type: none"> Discuss that the current policy and procedures reflect a co-operative working relationship with the HSC Trust, RQIA and the NI Ombudsman.
17.12	<ul style="list-style-type: none"> Review policy and procedure to ensure it clearly illustrates that if a complaint relates to a Registered Provider's failure to comply with the statutory regulations, then the complainant should be referred directly to the RQIA for consideration. 	<ul style="list-style-type: none"> Clarify that the current policy and procedure clearly illustrates that if a complaint relates to a Registered Provider's failure to comply with the statutory regulations, then the complainant should be referred directly to the RQIA for consideration.
17.14	<ul style="list-style-type: none"> Review policy to ensure it reflects that when required a summary of all complaints, outcomes and actions taken are made available to RQIA. 	<ul style="list-style-type: none"> Clarify that the policy reflects that when required a summary of all complaints, outcomes and actions taken is made available to RQIA.
17.15	<ul style="list-style-type: none"> Review procedure for dealing with complaints to ensure that the outcomes and actions taken following the investigation are used to improve the quality of services provided (Learning outcomes). 	<ul style="list-style-type: none"> Clarify that the procedure for managing complaints also includes a learning outcome for the organisation as a result of action planned following the completion of investigations.

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, finance questionnaire, fire safety questionnaire, resident dependency form, staffing levels form and professionals list (appendices 1 - 5). 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, residents and relatives as well as guidance regarding the distribution of the questionnaires. Copies of a poster will be included for display in the home advising residents and relatives of the inspection date.

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 other inspection documentation to the Care 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 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 Care 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 Care Team, preferably by email, 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:

<table border="1" style="width: 100%; border-collapse: collapse;"> <tr style="background-color: #e0e0e0;"> <th style="width: 20%;"></th> <th style="text-align: center;">ACHIEVEMENT LEVEL</th> </tr> <tr> <td style="text-align: center;">Not Applicable</td> <td style="text-align: center;">Not Applicable</td> </tr> <tr> <td style="text-align: center;">Unlikely to be Achieved</td> <td style="text-align: center;">Unlikely to be Achieved</td> </tr> <tr style="background-color: #000080; color: white;"> <td style="text-align: center;">Not Achieved</td> <td style="text-align: center;">Not Achieved</td> </tr> <tr> <td style="text-align: center;">Partially Achieved</td> <td style="text-align: center;">Partially Achieved</td> </tr> <tr> <td style="text-align: center;">Substantially Achieved</td> <td style="text-align: center;">Substantially Achieved</td> </tr> <tr> <td style="text-align: center;">Fully Achieved</td> <td style="text-align: center;">Fully Achieved</td> </tr> </table>		ACHIEVEMENT LEVEL	Not Applicable	Not Applicable	Unlikely to be Achieved	Unlikely to be Achieved	Not Achieved	Not Achieved	Partially Achieved	Partially Achieved	Substantially Achieved	Substantially Achieved	Fully Achieved	Fully Achieved	<p style="text-align: center;">Inspection No</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr style="background-color: #800040; color: white;"> <th style="text-align: center;">MATURITY LEVEL</th> </tr> <tr> <td style="text-align: center;">Aware</td> </tr> <tr> <td style="text-align: center;">Responding</td> </tr> <tr> <td style="text-align: center;">Developing</td> </tr> <tr> <td style="text-align: center;">Practising</td> </tr> <tr> <td style="text-align: center;">Leading</td> </tr> </table>	MATURITY LEVEL	Aware	Responding	Developing	Practising	Leading
	ACHIEVEMENT LEVEL																				
Not Applicable	Not Applicable																				
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Fully Achieved	Fully Achieved																				
MATURITY LEVEL																					
Aware																					
Responding																					
Developing																					
Practising																					
Leading																					

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

A: If the inspection date does not suit, please contact the Care 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 Care 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 Care Team administrative staff on (028) 9051 7500 to arrange a new deadline for the documentation.

Q: Contact details for the Care Team

A: CARE TEAM EMAIL ADDRESS - Care.Team@rqia.org.uk

CARE TEAM TELEPHONE NUMBER - (028) 9051 7500

8. Appendices

Appendix 1 - Fire Safety Questionnaire

FIRE SAFETY PRE-INSPECTION AUDIT CHECK LIST 2010/11

DATE OF INSPECTION:

NAME OF FACILITY:

The position with regard to the following issues should be confirmed.

	Yes	No
1 Are copies of the current applicable fire safety standard documents retained on the premises as a reference source for all staff?	<input type="checkbox"/>	<input type="checkbox"/>
2 Is a current valid up to date fire risk assessment available on the premises?	<input type="checkbox"/>	<input type="checkbox"/>
3 Are arrangements in place to carry out regular fire safety audits, regular reviews to the fire risk assessment and regular reviews to the Emergency Fire Plan?	<input type="checkbox"/>	<input type="checkbox"/>
4 Do all staff receive fire training at least twice each year and are records available on the premises to support this training?	<input type="checkbox"/>	<input type="checkbox"/>
5 Are fire drills carried out on a regular basis as required for the ongoing validation of the Emergency Fire Plan and are records available on the premises to support these drills?	<input type="checkbox"/>	<input type="checkbox"/>
6 *1 *2 Are fire doors kept closed particularly at night?	<input type="checkbox"/>	<input type="checkbox"/>
7 Are escape routes kept clear?	<input type="checkbox"/>	<input type="checkbox"/>
8 Are the reports for any previous inspections carried out by the Northern Ireland Fire and Rescue Service available on the premises together with confirmation that any issues highlighted have been addressed?	<input type="checkbox"/>	<input type="checkbox"/>
9 Have all fire safety issues included in the Regulation and Quality Improvement Authority's reports for previous inspections been addressed?	<input type="checkbox"/>	<input type="checkbox"/>
10 Are untoward incident reports regarding fires being sent to the Regulation and Quality Improvement Authority?	<input type="checkbox"/>	<input type="checkbox"/>

- 11 Is there a comprehensive and adequately resourced Emergency Fire Plan on the premises which includes fire safety procedures in relation to the following:
- 11.1 What to do if a fire is discovered.
 - 11.2 How to raise the fire alarm.
 - 11.3 What to do if the fire alarm sounds.
 - 11.4 How to call the Fire and Rescue Services.
 - 11.5 The action to be taken by the person in charge of the premises when the fire alarm activates or a fire is discovered.
 - 11.6 What to do if a person's clothes catch fire.
 - 11.7 What to do if a pan of hot oil or fat catches fire.
 - 11.8 The evacuation procedure for the premises including any necessary Personal Emergency Evacuation Plans (PEEPs)
 - 11.9 The use of first aid fire fighting equipment
 - 11.10 The emergency arrangements should it be necessary to evacuate part or all of the premises
 - 11.11 The procedure for isolating or stopping any processes, power supplies, ventilation systems, gas supplies etc.
 - 11.12 The procedure for meeting the Fire and Rescue service on their arrival and notifying them of any special risks.
12. Are fire safety procedures available on the premises in relation to the following:
- 12.1 Fire prevention
 - 12.2 Smoking (policy, risk assessments and procedures)
 - 12.3 Procedure for purchasing textiles and furniture, bedding and sleepwear, etc.

12.4 Arrangements for carrying out maintenance works with particular reference to 'hot work' eg plumbers welding

13. Are telephone facilities with mobile back up provided in an easily accessible location on the premises?

14. Do textiles and furniture, bedding and sleepwear comply with the current fire retardant standards applicable to the premises?

15. Are the fire risk assessments, the reviews to the fire risk assessments and the fire safety training carried out by an Independent Fire Safety Advisor who is also available to provide fire safety advice as and when required?

*1 Fire doors which are held open with electro magnetic hold open devices or free swing smoke actuated self-closing devices should also be closed at night, particularly the doors to fire hazard rooms, stairs and corridors.

*2 Where keeping fire doors closed presents operational difficulties, advice should be sought from the Fire Risk Assessor for the premises and the Northern Ireland Fire and Rescue Service.

If you have answered **No** to any of the previous questions, please provide further information.

Registered Person

Date

Appendix 2 - Finance Questionnaire

REGULATION AND QUALITY IMPROVEMENT AUTHORITY

FINANCIAL INSPECTIONS SELF AUDIT

Name of Home:

1. The current scale of charges is:
2. Are there contracts for preserved rights, care managed and private residents, signed by resident, witnessed and signed on behalf of home? **Yes / No**
3. Are any supplementary charges paid (ie top-ups)? **Yes / No**
If yes, give details:
4. Number of residents required to pay supplementary charges:
5. Are there records of charges made, payments received and any outstanding balances? **Yes / No**
6. Number of residents in the following categories:
Preserved Rights
- Care Managed
- Privately Funded
7. Number of residents in receipt of mobility allowance:
8. Are resident's mobility allowance managed by staff in the home? **Yes / No**
If yes, how many?
9. How many residents receive personal allowances?
10. Are records kept of the amounts received and the expenditure on behalf of residents? **Yes / No**
11. Are receipts retained for all items purchased by the home on behalf of individual residents? **Yes / No**
12. Are records available of consent of residents to personal allowance being paid to a relative or agent where applicable? **Yes / No**

13. Is there a bank account for all residents' monies separate from business accounts of the home? **Yes / No**
14. When a resident's balance of monies reaches a given amount in the overall bank account or in the safe, is it transferred to an individual savings account? **Yes / No**
15. What is the amount of this threshold? **Yes / No**
16. The maximum total amount of residents' money to be kept in a safe at any time is:
17. Number of residents with individual interest bearing accounts:
18. Are all transactions concerning residents monies evidenced by the resident's signature or, if the resident is not capable of doing so, by the signatures of two members of staff? **Yes / No**
19. Staff permitted to handle monies on behalf of residents are:
.....
.....
20. The arrangements in place to ensure all financial recordings are checked on a regular basis are:
.....
.....
21. Do the home's written financial procedures give clear guidance in respect of all the items mentioned in the self-audit form? **Yes / No**
If no, please clarify:
.....
.....

I wish to confirm that the information provided for this Financial Inspection Self-Audit is correct.

Signed: Date:
Proprietor/Manager

Appendix 3 - 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 4 - Resident dependency

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:

