# Unannounced Care Inspection

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| **Name of Establishment:** | **Arches** |
| **RQIA Number:** | **1048** |
| **Date of Inspection:** | **13 January 2015** |
| **Inspectors Names:** | **Heather Sleator and Lorraine Wilson** |
| **Inspection ID:** | **INO17009** |

**The Regulation And Quality Improvement Authority**
**9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT**
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## 1.0 General Information

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| **Name of Establishment:** | Arches |
| **Address:** | 144 Upper Newtownards Road<br>Belfast<br>BT4 3EQ |
| **Telephone Number:** | 028 90 658274 |
| **Email Address:** | archescarehome@fshc.co.uk |
| **Registered Organisation/ Registered Provider:** | Four Seasons Healthcare<br>Mr James McCall |
| **Registered Manager:** | Ms Laura Mallon Connolly |
| **Person in Charge of the Home at the Time of Inspection:** | Ms Laura Mallon Connolly |
| **Categories of Care:** | NH-LD, NH-LD(E), NH-PH, NH-PH(E) |
| **Number of Registered Places:** | 33 |
| **Number of Patients Accommodated on Day of Inspection:** | 25 + 2 patients in hospital |
| **Scale of Charges (per week):** | £577.00 - £639.00 |
| **Date and Type of Previous Inspection:** | Unannounced Primary Inspection<br>3 February 2014 09:30 – 17:00<br>4 February 2014 13:30 – 16:00 |
| **Date and Time of Inspection:** | Unannounced Care Inspection<br>13 January 2015<br>09:30 – 16:30 hours |
| **Name of Inspector:** | Heather Sleator<br>Lorraine Wilson |

## 2.0 Introduction

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

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

## 3.0 Purpose of the Inspection

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

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

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

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

## 4.0 Methods/Process

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

- discussion with the Regional Manager, Lorraine Kirkpatrick
- discussion with the Registered Nurse Manager, Laura Mallon Connolly
- discussion with the Peripatetic Manager, Stella Law
- discussion with staff
- discussion with patients individually and to others in groups
- consultation with one relative
- review of a sample of policies and procedures
- review of a sample of staff training records
- review of a sample of staff duty rotas
- review of a sample of care plans
- review of the complaints, accidents and incidents records
- observation during a tour of the premises
- evaluation and feedback.

## 5.0 Consultation Process

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

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| Patients | **10 individually and the majority of other patients in small groups** |
| Staff | **8** |
| Relatives | **1** |
| Visiting Professionals | **0** |

Questionnaires were provided by the inspector, during the inspection, to staff to seek their views regarding the quality of the service.

| **Issued To** | **Number Issued** | **Number Returned** |
|---|---|---|
| Patients | **0** | **0** |
| Relatives/Representatives | **0** | **0** |
| Staff | **7** | **4 during the inspection** |

## 6.0 Inspection Focus

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible person/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

However, due to workload pressures and contingency measures within the Regulation Directorate, the themes/standards within the self-assessment were not inspected on this occasion.

This inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

**Standard 19 - Continence Management**

**Patients receive individual continence management and support.**

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

| Guidance - Compliance Statements | | |
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| **Compliance Statement** | **Definition** | **Resulting Action in Inspection Report** |
| **0 - Not applicable** | | A reason must be clearly stated in the assessment contained within the inspection report |
| **1 - Unlikely to become compliant** | | A reason must be clearly stated in the assessment contained within the inspection report |
| **2 - Not compliant** | Compliance could not be demonstrated by the date of the inspection. | In most situations this will result in a requirement or recommendation being made within the inspection report |
| **3 - Moving towards compliance** | Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year. | In most situations this will result in a requirement or recommendation being made within the inspection report |
| **4 - Substantially compliant** | Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place. | In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report |
| **5 - Compliant** | Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken. | In most situations this will result in an area of good practice being identified and comment being made within the inspection report. |

## 7.0 Profile of Service

Arches Care Home is situated in a residential area of the Upper Newtownards Road, East Belfast. The home is situated in close proximity to the main road and is accessible to public and private transport, and is convenient to local shops, churches and community groups.

The nursing home is owned and operated by Four Seasons Healthcare Ltd and the current registered manager is Laura Mallon Connolly.

Bedroom accommodation is provided in single rooms and communal areas such as lounges and dining rooms are located on both floors of the home. In addition there are a number of rooms designated for services such as hairdressing, activity provision and a multisensory room for use by patients. A small kitchen is available for the ground floor for patients use. A range of toilet and bathing/showering facilities is also provided throughout both floors of the home.

A kitchen and designated laundry is situated on the ground floor.

Car parking spaces are available within the home's grounds.

Access to the home for wheelchair users is via the front door of the home. A lift is available for access to the first floor.

The home is registered to provide care for a maximum of 33 persons under the following categories of care:

<u>Nursing care</u>

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| LD | learning disability |
| LD (E) | learning disability over 65 years |
| PH | physical disability other than sensory impairment under 65 |
| PH (E) | physical disability other than sensory impairment over 65 years |

## 8.0 Executive Summary

The unannounced inspection of Arches Care Home was undertaken by Heather Sleator and Lorraine Wilson on 13 January 2015 between 09.30 and 16.30 hours.

The inspection was facilitated by Laura Mallon Connolly, registered manager, who was available for verbal feedback at the conclusion of the inspection.

Ms Lorraine Kirkpatrick, regional manager and Ms Stella Law, peripatetic manager were also in attendance for the inspection feedback.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection on 3 and 4 February 2014.

RQIA had received information from the commissioning trust in relation to their concerns regarding moving and handling practices of staff and of the equipment in use, specifically the number of divan style beds being used. The inspectors reviewed information relating to the identified issues during the inspection.

As a result of the previous inspection 10 recommendations were issued. These were reviewed during this inspection and the inspectors evidenced that eight recommendations had been fully complied with. The remaining two recommendations have been subsumed into a requirement of this inspection. Details can be viewed in the section immediately following this summary.

The inspectors can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a good standard and patients were observed to be treated by staff with dignity and respect. Good relationships were evident between staff and patients. Patients were well groomed, appropriately dressed and appeared comfortable in their surroundings. Those patients who were unable to verbally express their views were also observed to be well groomed, appropriately dressed in clean matching attire and were relaxed and comfortable in their surroundings.

The inspectors reviewed assessments and care plans in regard to management of continence in the home. Review of patient's care records evidenced that patients and/or their representatives were informed of changes to patient need and/or condition and the action taken. Areas for improvement were identified with the care records and a recommendation has been made.

Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.

Policies, procedures and guidelines in the promotion of continence and the management of incontinence were available in the home. The inspectors observed information on display entitled the "taboo of incontinence"; signposting information had also been included. This was good practice.

Nursing staff spoken with on the day of the inspection were knowledgeable regarding the management of continence. The inspectors were informed that there were no patients who required catheter care. The registered manager informed that catheter care had not been an identified patient need from she was appointed in 2013.There have also been six registered nurses (learning disability) recently appointed to the home It is recommended that consideration is given by the registered manager for registered nurses to attended training and gain competency in male and female catheterisation.

The inspectors observed moving and handling practices, reviewed staff training records and observed the type of beds and equipment available in the home. Requirements have been made regarding equipment, for example; the introduction of a programme to replace beds assessed as not fit for purpose and upgrading of fall out mats. The focus of replacement should commence with divan style beds and beds where third party bed rails are being used.

The review of compliance attained in respect of recommendations made at the previous inspection included restrictive practice. The inspectors reviewed the assessment and care planning processes operational in the home regarding the use of restrictive practice. Improvements were identified in relation to the review of risk assessment and the area of 'consent' .Evidence was present of patients' representatives giving written consent for the use of bed rails and/or lap belts. A requirement has been made that registered nurses undertake training in this area so as where restrictive practice is in use, it is in accordance with best practice guidance. It is expected that care records include a record of the assessment process, together with evidence of the involvement of the patient, their representative/relative and whether there is agreement with the assessment outcome.

The inspectors observed a wheelchair and lap belt used by a patient to be in need of cleaning. The registered manager agreed to address this issue immediately.

**Additional Areas Examined**

Care Practices
Moving and Handling
Restrictive practice
Complaints
Patient Finance Questionnaire
NMC Declaration
Patients and Relatives Comments
Questionnaire Findings/Staff Comments
Environment

Details regarding the inspection findings for these areas are available in section 11.0, additional areas examined, of the report.

As a result of this inspection, three requirements and five recommendations were made. Details can be found in the quality improvement plan (QIP) of this report.

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

## 9.0 Follow-Up on Previous Issues

| No. | Minimum Standard Ref. | Recommendations | Action Taken - As Confirmed During This Inspection | Inspector's Validation of Compliance |
|---|---|---|---|---|
| 1 | 10.7 | It is recommended that staff adhere to best practice guidelines regarding restrictive practices. Staff should implement care interventions regarding the release of lap belts and records maintained in relation to this. | The inspectors were unable to verify this recommendation had been fully addressed. The inspectors reviewed the care records where restrictive practice was observed to be in use i.e. lap belts. The outcome being individual patient records must reflect evidence based practice, and nursing staff must ensure that the risk assessment for the use of any restrictive practice is reviewed on at least a monthly basis.<br><br>This recommendation has been subsumed into a requirement. | This recommendation has been subsumed into a requirement. |
| 2 | 10.7 | It is recommended all staff undertake deprivation of liberty training. | The inspectors verified this recommendation had been addressed. The review of the staff training records evidenced 67% of staff had undertaken this training. There has been a turnover of staff and newly appointed staff had yet to complete this training. | Compliant |

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| 3. | 10.7 | It is recommended that where any form of restrictive practice is prescribed evidence is present of consultation with the patient and/or their representative. | The inspectors were unable to verify this recommendation had been fully addressed. The review of two patients' care records evidenced the patients representative had signed a 'consent' form regarding the use of, for example, lap belts or bedrails. Professional/regulatory guidance should be adhered to regarding best interest decisions. Registered nurses should undertake training regarding the use of restrictive practice.<br><br>This recommendation has been subsumed into a requirement. | This recommendation has been subsumed into a requirement |
| 4 | 11.7 | It is recommended that all registered nurses undertake training in relation to wound care management. | The inspectors verified this recommendation had been addressed. There had been newly appointed registered nurses therefore a new team of staff. Two registered nurses undertook wound care management training in May 2014.<br><br>Confirmation was provided by the registered manager that the newly appointed nursing staff will be completing this training on 16 February 2015. | Compliant |

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| 5 | 30.4 | It is recommended that wound care management is included in the competency and capability assessment of the nurse in charge of the home. This should be validated by the registered manager. Wound care management should also be included in the induction training programme of registered nurses. | The inspectors verified this recommendation had been addressed. The review of four competency and capability assessments of registered nurses evidenced competency had been validated by the registered manager. | Compliant |
| 6 | 11.3 | It is recommended that where a patient requires wound care management the following should be in evidence;<br>• body mapping chart<br>• initial wound assessment chart<br>• on-going wound assessment chart<br>• photography of the wound<br>• re-positioning chart should comment on the status of the patients skin | The inspectors verified this recommendation had been addressed. The review of nursing care records in respect of wound management evidenced all required documentation was present and completed in accordance with best practice guidelines. | Compliant |

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| | | • information leaflets are given to patients and/or their representative. | | |
| 7 | 25.11 | It is recommended the registered manager establishes an effective system of audit if care records, including wound care management. The registered manager should ensure a system of re-audit is also established where shortfalls have been identified. | The inspectors verified this recommendation had been addressed. A system of auditing care records had been implemented by the registered manager. Evidence of re-audit to ensure remedial action had been taken was present. | Compliant |
| 8 | 12.11 | It is recommended that the record of meals provided and nutritional intake of patients is diligently and accurately recorded. | The inspectors verified this recommendation had been addressed. The review of patients nutritional and fluid intake recording evidenced this was consistently and accurately recorded. | Compliant |

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| 9 | 1.1 | It is recommended the values that underpin the standards inform the philosophy of care and staff consistently demonstrate the integration of these values within their practice. | The inspectors verified that this recommendation had been addressed. The learning disability framework of practice has been adopted. A recruitment drive has secured six learning disability nurses and the registered manager discusses and monitors individual staff members' performance at supervision. | Compliant |
| 10 | 32.3 | It is recommended the general environment is enhanced for patients through the use of appropriate signage and aids to orientation.<br><br>Consideration should also be given to curtaining for the upstairs lounge, in accordance with fire safety regulations. | The inspectors verified this recommendation had been addressed. The environment evidenced financial investment. Lounge and dining rooms had been redecorated and refurbished. Orientation aids were also in evidence. The inspectors were informed the refurbishment programme remains on-going. | Compliant |

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

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

Prior to this inspection, RQIA had received information from the commissioning trust in respect of staff moving and handling practices and concerns about the type of beds in use. These issues were reviewed as part of this inspection.

Since the previous inspection of 3 and 4 February 2014, RQIA have been notified by the home of ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues. The BHSCT safeguarding team are managing the SOVA issues under the regional adult protection policy/procedures. Four safeguarding investigations remain 'open'.

Multi agency investigations are currently ongoing, involving the Police Service for Northern Ireland (PSNI) and the trust. Other trusts have been informed by BHSCT as relevant. RQIA are not part of the investigatory process. However, RQIA have been kept informed at all stages of the investigations by the trust and have attended multi agency strategy meetings as deemed appropriate. RQIA and BHSCT maintain regular liaison about the home.

## 10.0 Inspection Findings

| STANDARD 19 - CONTINENCE MANAGEMENT<br>Patients receive individual continence management and support | |
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| **Criterion Assessed:**<br>19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort. | **COMPLIANCE LEVEL** |
| **Inspection Findings:** | |
| Review of four patients' care records evidenced that bladder and bowel continence assessments were undertaken for four patients. The outcome of these assessments, including the type of continence products to be used, was incorporated three patients' care plans on continence care. However, improvements are required and a recommendation has been made. The areas for improvement were;<br>• bowel assessment should evidence the use of the Bristol Stool assessment, for example; reference was made to a patient experiencing episodes of constipation. There was no reference to the Bristol Stool assessment being used to classify the type of stool to aid treatment<br>• monthly evaluations should include a review of a patient's bowel assessment<br>• care plans should be updated as and when need changes, for example; one patient's elimination care plan had not been updated to reflect the patient was now using continence products to manage continence since discharge from hospital in November 2014<br>• where records state a specific test/screening is to be undertaken evidence should be present that this has been completed, for example; bowel screening was to be completed for two patients, however information that this had taken place was not in evidence in two care records<br>• patients progress records did not evidence that bowel function was being consistently monitored and recorded<br><br>The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate.<br><br>Review of four patient's care records and discussion with patients evidenced that either they or their | Substantially Compliant |

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| representatives had been involved in discussions regarding the agreeing and planning of nursing interventions.<br><br>Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home. | |

| STANDARD 19 - CONTINENCE MANAGEMENT<br>Patients receive individual continence management and support | |
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| **Criterion Assessed:**<br>19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis. | **COMPLIANCE LEVEL** |
| **Inspection Findings:** | |
| The inspector can confirm that the following policies and procedures were in place;<br><br>• continence management / incontinence management<br>• stoma care<br>• catheter care<br><br>Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.<br><br>A recommendation has been made for the following guidelines to be readily available to staff and used on a daily basis:<br>• British Geriatrics Society Continence Care in Residential and Nursing Homes<br>• NICE guidelines on the management of urinary incontinence<br>• NICE guidelines on the management of faecal incontinence | Substantially Compliant |

| STANDARD 19 - CONTINENCE MANAGEMENT<br>Patients receive individual continence management and support | |
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| **Criterion Assessed:**<br>19.3 There is information on promotion of continence available in an accessible format for patients and their representatives. | **COMPLIANCE LEVEL** |
| **Inspection Findings:** | |
| The inspector observed information on display entitled the taboo of incontinence; signposting information had also been included. This was good practice. | Compliant |
| **Criterion Assessed:**<br>19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances. | **COMPLIANCE LEVEL** |
| **Inspection Findings:** | |
| Discussion with the registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the manager revealed that with the exception of herself the remaining registered nurses were not deemed competent in female catheterisation and the management of stoma appliances. It was agreed that when this training became available via the local health and social care trust a proportionate number of registered nurses would attend. A recommendation has been made in this regard. The inspectors acknowledged that catheter care has not needed to be a focus of patient care in the home, to date.<br><br>The registered manager informed that one of the newly appointed registered nurses is keen to develop his/her knowledge and skills in this area of care and once training has been completed will be the designated continence link nurse for the home.<br><br>Regular audits of the management of incontinence are undertaken and the findings acted upon to enhance already good standards of care. | Substantially Compliant |

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

## 11.0 Additional Areas Examined

### 11.1 Care Practices

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

Patients were well presented with their clothing suitable for the season. Patients observed were observed to be clean and well presented. One patient was observed not wearing socks or footwear; it was recorded in their care plan that this was the patient's preference when indoors. Staff were observed to respond to patients' requests promptly. The demeanour of patients indicated that they were relaxed in their surroundings.

### 11.1.2 Moving and Handling

RQIA had received information from the commissioning trust in relation to their concerns regarding moving and handling practices of staff in the home and of the equipment in use, specifically the number of divan style beds being used. The inspectors reviewed information relating to the identified issues during the inspection.

The inspectors observed the type of beds in use. Profile beds were in evidence as were hospital style beds and a number of divan style beds. Some of the beds observed had third party bedrails attached and fall out mats were also in evidence.

Fall out mats are in use when patients are assessed at risk of falls, however despite the assessed risks, very few of the beds observed were low to the floor.

It was the inspectors professional opinions, that the fall out mats in use, were no longer, fit for purpose. A requirement has been made in relation to the replacement of the fall out mats in use in the home.

The Department of Health, Social Services and Public Safety (DHSSPS) issued guidance for the use of third party bedrails. The guidance details specific maintenance procedures for these bedrails whilst in use. A requirement has been made that a replacement programme of beds, deemed not fit for purpose, is implemented and in the interim period the home must adhere to DHSSPS guidance procedures for the use of third party bedrails.

The inspectors reviewed staff training records in relation to moving and handling. Staff are required to complete both a practical and written competency assessment. The review of the training records evidenced all staff had completed the written component. However, the practical component did not evidence full compliance. The Director of Quality from Four Seasons Healthcare, Ms Joanne Strain, spoke to the inspectors at the time of inspection and gave assurances that the information given by the registered manager i.e. 89% of staff had completed the practical component was correct. Ms Strain stated that due to incompatibility of the computer system between Northern Ireland and the rest of the United Kingdom, the information required was not being recorded on the system and was being retained manually by the managers of homes.

The inspectors observed two moving and handling procedures and evidenced that there was good engagement with the patient to advise them what was happening; staff were evidenced encouraging the patient, and promoting their independence. The review of four patients' care records evidenced registered nurses had completed risk assessment re: moving and handling and corresponding care plans, where appropriate. Nursing staff had identified the type of hoist and sling to be used, for all transfers on an individual basis.

### 11.1.3 Restrictive Practice

At the previous inspection a recommendation had been made that staff adhere to best practice guidance regarding the use of any restrictive practice. The review of patients care records evidenced improvement in this area is necessary. For example;

- the risk assessment for the use of restrictive practice should evidence regular review. The risk assessment viewed in one patient's care record did not evidence review from 28 March 2013.
- evidence was present in patients' care records of consent forms being signed, by the patient's representative, for the use of bed rails and/or lap belts. However, the evidence should include the consultation process which occurred and whether the patient, their representative and nominated relative agree or disagree with the assessment outcome for the use of bed rails or lap belts. . This is in accordance with best practice guidance.

A requirement has been made that all registered nurses undertake training regarding restrictive practice and best practice guidance is adhered to.

The review of patients' care records did evidence that the multidisciplinary team had been involved/consulted. Evidence was present in the care management review of the use of any restrictive practice being discussed. However, in some cases a care management review had not taken place on an annual basis therefore the information was not current.

## 11.2 Complaints

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

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

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

## 11.3 Patient Finance Questionnaire

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

### 11.4 NMC Declaration

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

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

### 11.5 Patients and Relatives Comments

During the inspection the inspectors spoke to 10 patients individually and to others in groups. These patients expressed high levels of satisfaction with the standard of care, facilities and services provided in the home. A number of patients were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients' comments were as follows:

"enjoyed the pantomime."
"I like it here."
"Laura is nice."
"My room is pretty."

The inspectors spoke with one relative. The relative confirmed they were satisfied with all aspects of care afforded in the home and was happy to speak to staff if/when they had any issues. The relative also stated;

"I would recommend this home to anyone"
"staff are excellent"

### 11.6 Questionnaire Findings/Staff Comments

During the inspection the inspectors spoke with eight staff including registered nurses, care staff and ancillary staff. The inspectors were able to speak to a number of these staff individually and in private. Four staff completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

Examples of staff comments were as follows;

"home manager is very good, residents needs are always first place for the manager."
"I believe we all strive as a good team here to make our residents happy, safe and secure in their home."
"I really enjoy working in this home as everyone works together and are very helpful. Staff are very helpful and friendly."
"a lot more activities in this home compared to others"
"staff encourage patients to be independent".

## 11.7 Environment

The inspectors undertook an inspection of the premises and viewed the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas.

A Parker bath had been recently purchased and installed. The home was comfortable and all areas were maintained to a high standard of hygiene and cleanliness.

Many areas of the home had benefitted from investment. The dining rooms on both floors had been redecorated and were observed to be attractive and homely. A number of toilet/bathrooms had also been decorated and did not appear as clinical as before. The registered manager stated the main lounge on the first floor is scheduled for further upgrading in the near future. This is commendable.

The inspectors observed an extractor fan in a toilet on the ground floor which was dusty, impeding the flow of air. The registered manager stated she would ensure the fan was cleaned.

## 12.0 Quality Improvement Plan

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

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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

**Appendix 1**

| Section A | |
|---|---|
| **Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.** | |
| **Criterion 5.1**<br>• **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.**<br>**Criterion 5.2**<br>• **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.**<br>**Criterion 8.1**<br>• **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.**<br>**Criterion 11.1**<br>• **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.**<br><br>**Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3** | |
| **Provider's assessment of the nursing home's compliance level against the criteria assessed within this section** | **Section compliance level** |
| Prior to admission to the home, the Home Manager or a designated representative from the home carries out a pre admission assessment. Information gleaned from the resident/representative (where possible), the care records and information from the Care Management Team informs this assessment. Risk assessments such as the Braden Tool are carried out, if possible, at this stage. Following a review of all information a decision is made in regard to the home's ability to meet the needs of the resident. If the admission is an emergency admission and a pre admission is not | Substantially compliant. |

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| possible in the resident's current location then - a pre admission assessment is completed over the telephone with written comprehensive, multidisciplinary information regarding the resident being faxed or left into the home. Only when the Manager is satisfied that the home can meet the residents needs will the admission take place.<br><br>On admission to the home an identified nurse completes initial assessments using a patient centred approach. The nurse communicates with the resident and/or representative, refers to the pre admission assessment and to information received from the care management team to assist her/him in this process.<br>There are two documents completed within twelve hours of admission - an Admission Assessment which includes photography consent, record of personal effects and a record of 'My Preferences' and a Needs Assessment which includes 16 areas of need - the additional comments section within each of the 16 sections includes additional necessary information that is required to formulate a person centred plan of care for the Resident.<br><br>In addition to these two documents, the nurse completes risk assessments immediately on admission. These include a skin assessment using the Braden Tool, a body map, an initial wound assessment (if required), a moving and handling assessment, a falls risk assessment, bed rail assessment, a pain assessment and nutritional assessments including the MUST tool, FSHC nutritional and oral assessment. Other risk assessments that are completed within seven days of admission are a continence assessment and a bowel assessment,<br>Following discussion with the resident/representative, and using the nurse's clinical judgement, a plan of care is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations. This can be evidenced in the care plan and consent forms.<br><br>The Home Manager and Regional Manager will complete audits on a regular basis to quality assure this process. | |

| Section B | |
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| **Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.** | |
| **Criterion 5.3**<br>• **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.**<br>**Criterion 11.2**<br>• **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.**<br>**Criterion 11.3**<br>• **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.**<br>**Criterion 11.8**<br>• **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.**<br>**Criterion 8.3**<br>• **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.**<br><br>**Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16** | |
| **Provider's assessment of the nursing home's compliance level against the criteria assessed within this section** | **Section compliance level** |
| A named nurse completes a comprehensive and holistic assessment of the resident's care needs using the assessment | Substantially compliant. |

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| tools as cited in section A, within 7 days of admission. The named nurse devises care plans to meet identified needs and in consultation with the resident/representative. The care plans demonstrate the promotion of maximum independence and focuses on what the resident can do for themselves as well as what assistance is required. Any recommendations made by other members of the mutidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable.<br><br>Registered nurses in the home are fully aware of the process of referral to a TVN when necessary. There are referral forms held in a designated file in the nurse's office, the Tissue Viability Nurse's details are also held in this file - name, address and telephone no. Once the form has been sent it, is then followed up by a telephone call to the TVN where advice can be given prior to their visit. Referrals are also made via this process in relation to residents who have lower limb or foot ulceration to either the TVN or a podiatrist. If necessary, a further referral is made to a vascular surgeon by the G.P, TVN or podiatrist.<br><br>Where a resident is assessed as being 'at risk' of developing pressure ulcers, a Pressure Ulcer Management and Treatment plan is commenced. A care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. The care plan will give due consideration to advice received from other multidisciplinary members. The treatment plan is agreed with the resident/representative, Care Management and relevant members of the MDT. The Regional Manager is informed via a monthly report and during the Reg 29 visit.<br><br>The Registered Nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Dietician referral forms are held within the home. These forms can be completed by staff in the home and faxed directly to the dietician for referral. The dietician is also available over the telephone for advice until she is able to visit the resident. All advice, treatment or recommendations are recorded on the MDT form with a subsequent care plan being compiled or current care plan being updated to reflect the advice and recommendations. The care plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in the home and other members of the MDT are kept informed of any changes. | |

| Section C | |
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| **Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.** | |
| **Criterion 5.4**<br>• **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.**<br><br>**Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16** | |
| **Provider's assessment of the nursing home's compliance level against the criteria assessed within this section** | **Section compliance level** |
| The Needs Assessment, risk assessments and care plans are reviewed and evaluated at a minimum of once a month or more often if there is a change in the resident's condition. The plan of care dictates the frequency of review and re assessment, with the agreed time interval recorded on the plan of care.<br>The resident is assessed on an on-going daily basis with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the Home Manager's attention.<br><br>The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted. | Substantially compliant |

| Section D | |
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| **Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.** | |
| **Criterion 5.5**<br>• **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.**<br>**Criterion 11.4**<br>• **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.**<br>**Criterion 8.4**<br>• **There are up to date nutritional guidelines that are in use by staff on a daily basis.**<br>**Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)** | |
| **Provider's assessment of the nursing home's compliance level against the criteria assessed within this section** | **Section compliance level** |
| The home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to.<br><br>The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading system. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an on-going wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime or if the condition of the pressure ulcer changes. | Substantially compliant |

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| There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', ' PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff to refer to on an on-going basis. Staff also refer to FSHC policies and procedures in relation to nutritional care, diabetic care, care of subcutaneous fluids and care of percutaneous endoscopic gastrostomy (PEG). | |

| Section E | |
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| **Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.** | |
| **Criterion 5.6**<br>• **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.**<br>**Criterion 12.11**<br>• **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.**<br>**Criterion 12.12**<br>• **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.**<br>**Where a patient is eating excessively, a similar record is kept.**<br>**All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.**<br><br>**Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25** | |
| **Provider's assessment of the nursing home's compliance level against the criteria assessed within this section** | **Section compliance level** |
| Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are comtemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines - Record keeping:Guidance for nurses and midwives.<br><br>Records of the meals provided for each resident at each mealtime are recorded on a daily menu choice form. The Catering Manager also keeps records of the food served and include any specialist dietary needs.<br><br>Residents who are assessed as being 'at risk' of malnutrition, dehyration or eating excessively have all their food and fluids recorded in detail on a daily basis using a FSHC food record booklet or fluid record booklet. These charts are | Substantially compliant |

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| recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. The nurse utilises the information contained in these charts in their daily evaluation. Any deficits are identified with appropriate action being taken and with referrals made to the relevant MDT member as necessary. Any changes to the resident's plan of care is discussed with them and/or their representative.<br><br>Care records are audited on a regular basis by the Manager with an action plan compiled to address any deficits or areas for improvement - this is discussed during supervision sessions with each nurse as necessary. | |

| Section F | |
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| **Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.** | |
| **Criterion 5.7**<br>• **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.**<br><br>**Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16** | |
| **Provider's assessment of the nursing home's compliance level against the criteria assessed within this section** | **Section compliance level** |
| The outcome of care delivered is monitored and recorded on a daily basis on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan of care or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their represenatatives are involved in the evaluation process. | Substantially compliant. |

| Section G | |
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| **Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.** | |
| **Criterion 5.8**<br>• **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.**<br>**Criterion 5.9**<br>• **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.**<br><br>**Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)** | |
| **Provider's assessment of the nursing home's compliance level against the criteria assessed within this section** | **Section compliance level** |
| Care Management Reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the resident's file.<br>Any recommendations made are actioned by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals. | Substantially compliant |

| Section H | |
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| **Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.** | |
| **Criterion 12.1**<br>• **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.**<br>**Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.**<br>**Criterion 12.3**<br>• **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.**<br>**A choice is also offered to those on therapeutic or specific diets.**<br><br>**Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)** | |
| **Provider's assessment of the nursing home's compliance level against the criteria assessed within this section** | **Section compliance level** |
| The home follows FSHC policy and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs on admission and review on an on-going basis. The care plan reflects type of diet, any special dietary needs, and personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if necessary.<br><br>The home has a 4 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives - residents meetings, one to one meetings and food questionnaires. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied.<br><br>Copies of instructions and recommendations from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs. | Substantially compliant |

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| Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything from the daily menu an alternative meal of their choice is provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room, with the 4 week menu displayed in a menu display folder and on the wall outside the kitchen. | |

| Section I | |
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| **Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.** | |
| **Criterion 8.6**<br>• **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.**<br>**Criterion 12.5**<br>• **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.**<br>**Criterion 12.10**<br>• **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:**<br>o **risks when patients are eating and drinking are managed**<br>o **required assistance is provided**<br>o **necessary aids and equipment are available for use.**<br>**Criterion 11.7**<br>• **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.**<br><br>**Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20** | |
| **Provider's assessment of the nursing home's compliance level against the criteria assessed within this section** | **Section compliance level** |
| The Speech and Language therapist and dietician give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document - 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for feeding, equipment to use and assistance required. The kitchen receives a copy of the SALT's recommendations and this is kept on file for reference by the kitchen. Special diets are displayed on a white board in the kitchen. | Substantially compliant |

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| Meals are served at the following times:-<br>Breakfast - 9am-10.30am<br>Morning tea - 11am<br>Lunch - 12.40pm-12.50pm<br>Afternoon tea - 3pm<br>Evening tea - 4.50pm<br>Supper - 7.30pm-8pm<br>There are variations to the above if a resident requests to have their meals outside of these times. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. There are foods available outside of these times for those residents who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedrooms, these are replenished on a regular basis.<br><br>Any matters concerning a resident's eating and drinking are detailed on each individual care plan - including for e.g. likes and dislikes, type of diet, consistency of fluid, any special equipment required and if assistance is required. A diet notification form is completed for each resident with a copy given to the kitchen and one held in the care file. Meals are not served unless a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Appropriate aids such as plate guards and specialised cutlery are available as necessary and as indicated in the plan of care.<br><br>Each nurse has completed an education e-learning module on pressure area care. The home has a link nurse who has received enhanced training, to provide support and education to other nurses within the home on an ad hoc basis. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the home have a competency assessment completed. Competency assessments have a quality assurance element built into the process. | |

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

The Regulation and Quality Improvement Authority

# Quality Improvement Plan

## Unannounced Care Inspection

### Arches

### 13 January 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with Laura Mallon Connolly, registered manager and Lorraine Kirkpatrick, regional manager, at the conclusion of the inspection visit.

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

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

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

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

**Statutory Requirements**

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

| No. | Regulation Reference | Requirements | Number Of Times Stated | Details Of Action Taken By Registered Person(S) | Timescale |
|---|---|---|---|---|---|
| 1 | 14.4 | The registered person is required to ensure registered nurses undertake training in restraint/restrictive practice in accordance with best practice guidelines.<br><br>**Ref: 11.1.3, restrictive practice** | One | Deprivation of Liberty training has been arranged for several dates in the home during the month of April 2015 to ensure that all nurses and care staff undertake training in restraint/ restrictive practice. | Four months |
| 2 | 27 (2) (c) | The registered person must ensure any equipment used in the home is fit for purpose and up to current standard;<br><br>fallout mats should be upgraded to an improved quality.<br><br>**Ref: 11.1.2, moving and handling** | One | All fallout mats have been replaced with new ones in the Home. | Three months |
| 3 | 18 (2) (c) | The registered person must ensure any equipment used in the home is fit for purpose and up to current standard;<br>• A replacement programme should be implemented regarding beds which are no longer fit for purpose. Consideration should be given to prioritising divan style beds and beds with third party bedrails in place.<br><br>**Ref: 11.1.2, moving and handling** | One | A programme of replacing the divan beds and upgrading the identified profiling beds in the Home has commenced. | From the time of this inspection |

**Recommendations**

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

| No. | Minimum Standard Reference | Recommendations | Number Of Times Stated | Details Of Action Taken By Registered Person(S) | Timescale |
|---|---|---|---|---|---|
| 1 | 19.1 | It is recommended that the assessment and care planning process in relation to elimination ( urinary and bowel) includes the following;<br>• bowel assessment should evidence the use of the Bristol Stool assessment. The Bristol Stool assessment should be used to classify the type of stool to aid treatment<br>• monthly evaluations should include a review of a patient's bowel assessment<br>• care plans should be updated as and when need changes, for example; on return from hospital<br>• where records state a specific test/screening is to be undertaken evidence should be present that this has been completed, for example; bowel screening<br>• patients progress records should evidence that bowel function is consistently monitored and recorded<br>• **Ref: criterion 19.1** | One | The needs assessments and care plans are currently being reviewed in the Home in relation to elimination(urinary and bowel) to include the following:<br><br>-Bristol Stool assessment is now being used.<br>-Monthly evaluations now include a review of the patient's bowel assessment<br>-Care plans are being updated as and when needs change<br>-Where a specific test/screening is to be carried out-this is being completed.<br><br>-Patients progress records now evidence that bowel function is consistently monitored and recorded.<br>The Home Manager will continue to monitor compliance by carrying out care audits | From the time of this inspection |

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| 2 | 19.2 | It is recommended the following guidelines to be readily available to staff and used on a daily basis:<br><br>• British Geriatrics Society Continence<br>• Care in Residential and Nursing Homes<br>• NICE guidelines on the management<br>• of urinary incontinence<br>• NICE guidelines on the management<br>• of faecal incontinence<br><br>**Ref: criterion 19.2** | One | The recommended guidelines listed are all now available in the Home. | One month |
| 3 | 19.4 | It is recommended that registered nurses undertake training in male and female catheterisation.<br><br>**Ref: criterion 19.4** | One | Dates have been planned for all nurses to undertake training in male and female catheterisation in March and April 2015. | Four months |
| 4 | 10.7 | It is recommended that until beds with third party bedrails are replaced. The guidance issued by DHSSPS in relation to bed rail management should be adhered to and evidence present of the adherence.<br><br>**Ref: 11.1.2, moving and handling** | One | The identified beds have all been replaced. | From the time of this inspection |

**Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:**

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| **NAME OF REGISTERED MANAGER COMPLETING QIP** | Laura Mallon |
| **NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP** | Carol Cousins |

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

**Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:**

| | |
|---|---|
| **NAME OF REGISTERED MANAGER COMPLETING QIP** | |
| **NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP** | |

| **QIP Position Based on Comments from Registered Persons** | **Yes** | **Inspector** | **Date** |
|---|---|---|---|
| Response assessed by inspector as acceptable | X | Heather Sleator | 06/03/15 |
| Further information requested from provider | | | |