Unannounced Care Inspection

Name of Establishment:	**Longfield Care Home**
RQIA Number:	**1184**
Date of Inspection:	**27 October 2014**
Inspector's Name:	**Bridget Dougan**
Inspection ID:	**IN017155**

The Regulation And Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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1.0 General Information

Name of Home:	Longfield Care Home
Address:	2 Longfield Road Eglinton BT47 3PY
Telephone Number:	028 7181 2552
E mail Address:	longfield@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Health Care Ltd Mr James McCall
Registered Manager:	Mrs Louise McCloskey
Person in Charge of the home at the time of Inspection:	Mrs Cathy Coyle
Categories of Care:	35 NH-I 11 NH-PH, NH-PH(E)
Number of Registered Places:	46
Number of Patients &Residents Accommodated on Day of Inspection:	41
Scale of Charges (per week):	£567 - £609 plus £20 top up fee
Date and type of previous inspection:	30 October 2013 Unannounced Inspection
Date and time of inspection:	27 October 2014: 12.30 hours -16.00 hours
Name of Inspector:	Bridget Dougan

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: amend as relevant

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

5.0 Consultation Process

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

Patients/Residents	**30**
Staff	**8**
Relatives	**3**
Visiting Professionals	**0**

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**8**	**8**
Relatives/Representatives	**3**	**3**
Staff	**6**	**6**

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		
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

Longfield Care Home is conveniently located on the Longfield Road, a short distance from the village of Eglinton, County Londonderry.

The home is a two storey purpose built facility which provides care for up to 46 patients/residents under the following categories of care:

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

Nursing Care

I	Old age not falling into any other category
PH and PH (E)	Physical disability other than sensory impairment over and under 65 years (maximum of eleven persons)

Longfield Care Centre is run and administered by Four Seasons Health Care Ltd.

The care centre comprises of the following:

- 46 single rooms of which 36 have en-suite facilities
- Choice of sitting rooms on each floor
- Two dining rooms
- Activity room
- Prayer room
- Designated smoking area for patients
- Bathroom/shower and toilet facilities
- A main kitchen
- Laundry
- Staff accommodation
- Offices.

Adequate car parking facilities are provided at the front and back of the home. There is a landscaped garden area at the side of the home and a patio area at the back of the home.

Mrs Louise McCloskey is the Registered Manager of the home and has been the registered with RQIA since 01 April 2005.

8.0 Executive Summary

The unannounced inspection of Longfield Care Home was undertaken by Bridget Dougan on 24 October 2014 between 12.30 hours and 16.00 hours. The inspection was facilitated by Mrs Cathy Coyle, nurse in charge, who was available for verbal feedback at the conclusion of the inspection.

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 27 October 2013.

Analysis of pre inspection activity confirmed that any accidents, incidents or complaints were managed in accordance with legislation and the previous Quality Improvement Plan (QIP) was completed and returned within the agreed timescales.

During the course of the inspection, the inspector met with the majority of patients, staff and three relatives. Feedback on the quality of care and services provided was positive. Staff were observed to treat the patients with dignity and respect and all patients appeared comfortable in their surroundings.

Refer to section 11.0 for further details about patients.

Standard inspected:

Standard 19 – Continence management
Patients receive individual continence management and support.

There was evidence that a continence assessment had been completed for patients. This assessment formed part of a comprehensive and detailed assessment of patient needs from the date of admission and was found to be updated on a regular basis and as required. The assessment of patient needs was evidenced to inform the care planning process.

Comprehensive reviews of both the assessments of need and the care plans were maintained on a regular basis and as required in all of the three records reviewed.

Discussion with the nurse in charge confirmed that staff were trained and assessed as competent in continence care and registered nurses had been provided with training in male and female catheterisation.

Policies, procedures and guidelines in the promotion of continence and the management of incontinence were available in the home.

A recommendation has been made for a continence link nurse to be identified in the home.

From a review of the available evidence, discussion with relevant staff and observation, the inspector can confirm that the level of compliance with the standard inspected was compliant. One recommendation has been made.

Review of a sample of staff duty rosters evidenced that the staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients currently in the home. Some staff expressed concerns regarding staffing levels especially on night duty in Faughan Unit (first floor). A recommendation has been made for a review of staffing and the introduction of a twilight shift.

The home's general environment was comfortable and all areas were maintained to a high standard of hygiene. One requirement has been made with regard to the carpets in the lounge and hallway.

The inspector can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a good standard. There were processes in place to ensure the effective management of the standard inspected.

Additional areas were also examined including:

- Complaints
- patient finance pre-inspection questionnaire
- NMC declaration.

Details regarding these areas are contained in section 11.0 of the report.

The inspector reviewed and validated the home's progress regarding the two requirements and one recommendation made at the last inspection and confirmed compliance outcomes as follows: the two requirements had been complied with and the one recommendation was moving towards compliance.

As a result of this inspection, one requirement and two recommendations have been made and a recommendation from the previous inspection has been stated for the second time.

Details can be found throughout the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, relatives, nurse in charge and staff for their assistance and co-operation throughout the inspection process.

The inspector would also like to thank the patients, relatives and staff who completed questionnaires.

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	17 (1)	The registered person shall introduce and ensure systems are maintained for reviewing at appropriate intervals the quality of nursing and other service provision in or for the purposes of the nursing home and that any such review is undertaken not less than annually. (A report on this review should be drawn up and a copy held in the home). Ref Section 6, point 6.8 (additional areas examined)	The inspector reviewed the Annual Quality Report dated 17 February 2014 and can confirm that this requirement has been complied with.	**Compliant**
2	12 (2) (b)	The registered person shall ensure that all aids and equipment used in or for the purpose of the nursing home is properly maintained and in good working order. Ref.20.2	Inspection of the maintenance records for emergency equipment evidenced that this requirement has been complied with.	**Compliant**

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	5.3	It is recommended that the patients' care records be reviewed and updated to address spiritual care, dignified and respectful care after death and communication and support for the patient's family. Wound observation charts should be completed each time dressings are changed. Ref.20.1 &Section, 6 point 6.2 (additional areas examined)	The inspector reviewed four patients care records and was unable to evidence that spiritual care had been addressed for all patients. This aspect of the recommendation will be stated for the second time. There was evidence that would observation charts had been completed each time dressings were changed.	**Moving towards compliance**

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 there is considered to be a breach of regulation as stated in the Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

There have been no notifications to RQIA regarding potential safeguarding of vulnerable adults (SOVA) incidents since the previous inspection.

10.0 Inspection Findings

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

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place; • continence management / incontinence management • stoma care • catheter care. The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence. Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not applicable	
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the nurse in charge and review of training records confirmed that all relevant staff were trained and assessed as competent in continence care. Registered nurses received training in male and female catheterisation and had been deemed competent. The inspector was informed that regular audits of the management of incontinence were included in care plan audits and the findings acted upon to enhance standards of care. It is recommended that the registered manager should consider identifying a continence link nurse within the home.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

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

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

11.2 Complaints

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

The inspector discussed the management of complaints with the acting 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 acting 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 acting manager, were appropriately registered with the NMC.

11.5 Patients/Relatives Comments

During the inspection the inspector spoke with the majority of patients individually. Patients expressed their satisfaction with the quality of care and services provided.
Some comments received from patients:

- "I like it here."
- "I am treated very well."
- "The staff are very good to me."

The inspector spoke with three relatives at the time of the inspection and these relatives also completed questionnaires. All relatives were very complimentary with regard to the care provided to their family members.

Some comments received from relatives:

- "Excellent care and lovely staff."
- "My relative is well cared for and happy in her environment. She enjoys the almost daily activities (Monday to Friday) which she finds stimulating and interesting."

11.6 Staffing and consultation with staff members

Review of a sample of staff duty rosters evidenced that the registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients currently in the home. However discussion with staff evidenced some concerns regarding the staffing levels on night duty on the first floor in Faughan Unit. This is an 18 bedded frail elderly unit and at the time of the inspection there were 16 patients accommodated in the unit. Review of duty rotas and discussion with staff evidenced that one registered nurse and one care assistant were on duty from 20.00 hours to 08.00 hours each day. Staff informed the inspector that the administration of medication was "constantly being interrupted" to assist patients to bed. Staff were concerned regarding the potential for delay or error in the administration of medications. These concerns were discussed with Mrs Coyle, nurse in charge who is also the nursing sister for the home. It was agreed that a review of staffing levels would be undertaken and the introduction of a twilight shift would be considered for Faughan Unit.

Discussion with staff and review of training records evidenced that staff were provided with a variety of relevant training including mandatory training since the previous inspection.

During the inspection the inspector spoke with eight staff members individually and in private. No concerns were expressed by staff. Six staff completed questionnaires. The following are examples of staff comments during the inspection and in questionnaires:

- "I feel the quality of care in the home is very good and staff have good interaction with residents."
- "Good home with good teamwork and excellent care."
- "We don't have time to talk and stay with residents because we are always very busy."

11.7 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a high standard of hygiene. The inspector observed a mal odour in the lounge. This was discussed with the nurse in charge and a requirement has been made for the carpet in the lounge to be deep cleaned /replaced. The inspector observed that the carpet in the hallway was stained in places and a requirement has also been made for this carpet to be deep cleaned/ replaced.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with **Mrs Cathy Coyle, nurse in charge**, 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:

Bridget Dougan
The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Prior to admission to the home, the Home Manager or a designated representative from the home carries out a pre admission assessment. Information gathered 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 relation 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 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	Substantially compliant

when the Manager is satisfied that the home can meet the residents needs will the admission take place. 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. 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. In addidtion to these two documents, the nurse completes risk assessments immedidiately 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, 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. The Home Manager and Regional Manager will complete audits on a regular basis to quality assure this process	
Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.**	

Criterion 11.3 • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
A named nurse completes a comprehensive and holistic assessment of the resident's care needs using the assessment tools as cited in section A, within 7 days of admission. The named nurse devises care plans to meet identified needs 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. 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. 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.	Substantially compliant

The Regional Manager is informed via a monthly report and during the Reg 29 visit. 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

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
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. The resident is assessed on an ongoing 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. 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	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
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. The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading sysytem. 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 ongoing 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. 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 ongoing basis. Staff also refer to FSHC policies and procedures in relation to nutritional care, diabetic care, care of subcuteanous fluids and care of percutaneous endoscopic	Substantially compliant

gastrostomy (PEG). Copies of above documentation or similar is available for reference by all staff..	

Section E

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

Criterion 5.6

- **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.**

Criterion 12.11

- **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.**

Criterion 12.12

- **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.**
  Where a patient is eating excessively, a similar record is kept.
  All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
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. 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.	Moving towards compliance

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 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. 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

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
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	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
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. 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	Moving towards compliance

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1	

• **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
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 ongoing basis. The care plan reflects type of diet, any special dietary needs, 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. 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. 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. 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.	Moving towards compliance

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
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 ongoing basis. The care plan reflects type of diet, any special dietary needs, 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. The home has a 4 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu	Substantially compliant

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. 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. 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	

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

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Secondary Unannounced Care Inspection

Longfield Care Home

27 October 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with **Mrs Cathy Coyle, nurse in charge** either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirement	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	13 (7)	The registered person shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff. Deep clean/ replace the carpets in the main lounge and hallways **Section 11.7**	One	Carpet in main lounge and corridors has been deep cleaned. This will be monitored going forward to identify if further action is required.	Within one month from date of inspection

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.3	It is recommended that the patients' care records be reviewed and updated to address spiritual care, dignified and respectful care after death and communication and support for the patient's family. **Reference: Follow up on previous issues**	Two	Patients care records in relation to spiritual care have been discussed with named nurses and is being addressed in a separate care plan.	Within one week from date of inspection
2	30.1	The registered manager should undertake a review of staffing levels in the home and consider the introduction of a twilight shift in Faughan Unit. **Reference: Section 11.6**	One	Staffing is being reviewed following the completion of a Rhys Hearne and this will be addressed as appropriate	Within two weeks from date of inspection
3	19.4	The registered manager should consider identifying a continence link nurse within the home. **Reference: Criterion 19.4**	One	New Continence Link Nurse has been identified - This taff member will attend all training and is responsible for rolling out new incontinence products	Within one month from date of inspection

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Louise McCloskey
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall DIRECTOR OF OPERATIONS 6.1.15

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

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Bridget Dougan	06 January 2015
Further information requested from provider			