



The Regulation and
Quality Improvement
Authority

Unannounced Care Inspection

Name of Establishment:	Pond Park Care Home
RQIA Number:	1282
Date of Inspection:	10 February 2015
Inspector's Name:	Karen Scarlett
Inspection ID:	17104

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Pond Park Care Home
Address:	2 Derriaghy Road Lisburn BT28 3SF
Telephone Number:	028 92672911
Email Address:	pond.park.m@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons (Bamford) Ltd Mr James McCall/ Dr Maureen Claire Royston (Registration pending)
Registered Manager:	Ms Suzanne Scott
Person in Charge of the Home at the Time of Inspection:	Ms Suzanne Scott
Categories of Care:	NH-I, NH-PH, NH-PH(E), NH-TI, RC-I
Number of Registered Places:	58
Number of Patients Accommodated on Day of Inspection:	52 (49 nursing and 3 residential)
Scale of Charges (per week):	£481.00 residential and £581 nursing Top up range £15 – 40
Date and Type of Previous Inspection:	22 August 2014, Enforcement monitoring inspection
Date and Time of Inspection:	10 February 2015 11.05 – 16.00
Name of Inspector:	Karen Scarlett

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 Registered Nurse Manager
- Discussion with staff
- Discussion with patients individually and with others in groups
- Consultation with relatives
- 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
- Review of care record audits
- Observation during an inspection of the premises
- Evaluation and feedback

5.0 Consultation Process

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

Patients	8 and with others in groups
Staff	6
Relatives	2
Visiting Professionals	0

Questionnaires were provided during the inspection, to patients' representatives and 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	10	9

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

Pond Park Care home is situated in the semi-rural area of Pond Park, Lisburn at the junction of the Antrim Road and Derriaghy Road. It is centrally located within the local community and is very convenient to shops and community services. The nursing home is owned and operated by Four Seasons (Bamford) Ltd

The current registered manager is Ms Suzanne Scott who has been registered with RQIA since May 2014.

Accommodation for patients is provided over three floors of the home. The lower ground is now a dementia care unit with its own separate entrance. The ground floor and first floors of the home house the majority of patients. Access to all floors is via a passenger lift and stairs.

Communal lounge and dining areas are provided in the dementia unit on the lower ground floor and across the ground floor of the home. The home also provides for catering and laundry services on the lower ground floor. A number of communal sanitary facilities are available throughout the home.

The parking facilities within the grounds of the home adequately meet the needs of current visitors and staff of the home. Public transport facilities are located directly outside the home.

The home is registered to provide care for a maximum of 58 persons under the following categories of care:

Nursing care

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
PH (E)	physical disability other than sensory impairment over 65 years
DE	dementia care to a maximum of 11 patients accommodated within the dementia unit on the lower ground floor.
TI	terminally ill

Residential care

I	old age not falling into any other category Limited to four residents in rooms 21, 22, 24 and 25.
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8.0 Executive Summary

The unannounced inspection of Pond Park Care home was undertaken by Karen Scarlett on 10 February 2015 between 11.05 and 16.00. The inspection was facilitated by Suzanne Scott, registered manager, who was available for verbal feedback at the conclusion of the inspection.

The focus of this inspection was to assess compliance with Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection on 22 August 2014.

A number of documents are required to be returned to RQIA prior to inspection. These were returned within the required time frame and offered the required assurances.

The patients were found to be well presented and comfortable in their surroundings. Patients spoken with were very positive about the staff and the care provided. No issues were raised by patients. Two relatives spoken with made largely positive comments regarding the care in the home. One relative raised concerns about communication with nursing staff in the home and was unaware of the named nurse system. The registered manager agreed to raise this at the upcoming relatives meeting. For further information on patients and relatives refer to section 11.5.

The home's compliance with standard 19: continence care was assessed. There was evidence that a continence assessment had been completed for all 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 the records reviewed.

Discussion with the registered manager confirmed that staff were trained and assessed as competent in continence care.

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 policies to be updated to reflect current best practice guidelines.

A recommendation has been made that regular audits of the care records be undertaken to include management of incontinence and the findings acted upon to enhance standards of care.

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 substantially compliant. Two recommendations have been made in relation to the standard. For further information refer to section 10.0.

Discussion with staff and the returned questionnaires confirmed that staff had received induction and training and they cited good team work and the support of management within the home. One staff member was of the opinion that they could not spend as much time talking with patients as they would like. An examination of the duty rota evidenced that staffing was sufficient to meet the assessed needs of the patients.

The majority of patients' bedrooms, bathrooms and communal areas were inspected and were found to be generally well maintained and presented to a good standard of hygiene. The corridor carpet in Pond park suite was found to be in need of replacement and one damaged bathroom door in this suite is also in need of repair or replacement. A requirement has been made in this regard. A number of items were noted to be stored in bathrooms in a manner inconsistent with best practice in infection prevention and control. A requirement has been made in this regard. For further information on the environment of the home refer to section 11.7.

A selection of care records was reviewed and these were generally maintained to a good standard. However, a number of improvements are required in relation to pain assessment and evaluation, completion of "Do not attempt cardio-pulmonary resuscitation" (DNACPR) forms and wound care charts. A total of three recommendations have been made in regards to care records.

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 and patients/residents were observed to be treated by staff with dignity and respect.

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

The inspector reviewed and validated the home's progress regarding the one requirement made at the last inspection on 22 August 2014 and this was found to be compliant.

As a result of this inspection, two requirements and five recommendations were made.

Details can be found under Section 10.0 and 11.0 in the report and in the quality improvement plan (QIP).

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

The inspector would also like to thank the 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.	13(7)	<p>The registered person must ensure that the identified bathroom on the ground floor is maintained <u>out of use</u> until appropriate urgent remedial actions are taken to address the identified issues.</p> <ul style="list-style-type: none"> • All wall surfaces must be intact • The pipework boxing at the rear of the cistern must be replaced • Urinals and commode pots should be appropriately stored • Boxes of incontinence products must not be stored on the floor • Linen bags must not be overfilled • The floor of the bathroom should be free from stored items to facilitate ease of cleaning and minimise the risk of cross infection. <p>Ref section 7.0</p>	The specified bathroom has undergone refurbishment and the issues have been addressed.	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.

Since the previous inspection on 22 August 2014 RQIA have been notified by the home of one ongoing investigation in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues. The NHSCT safeguarding team are managing the SOVA issues under the regional adult protection policy/procedures. RQIA are being kept informed of the progress of the investigation by the NHSCT.

RQIA is satisfied that the registered manager has dealt with SOVA issues in the appropriate manner and in accordance with regional guidelines and legislative requirements.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed:	COMPLIANCE LEVEL
<p>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.</p>	
Inspection Findings:	
<p>Review of four patients' care records evidenced that bladder and bowel continence assessments had been undertaken for all four 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The care plans reviewed addressed the patients' assessed needs in regard to continence management.</p> <p>Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available.</p>	<p>Compliant</p>

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 (2007)
- colostomy and ileostomy management (2009)
- catheter care and management (2010)
- bowel continence (2009)

A recommendation has been made that these policies are updated to reflect current best practice guidelines.

The inspector can also confirm that the following guideline documents were in place:

- RCN continence care guidelines
- RCN catheter care guidelines
- NICE guidelines on the management of urinary incontinence
- NICE guidelines on the management of faecal incontinence
- NICE guidelines on the management of lower urinary tract infection

Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.

Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT
Patients receive individual continence management and support

<p>Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.</p>	<p align="center">COMPLIANCE LEVEL</p>
<p>Inspection Findings: Not applicable.</p>	<p align="center">Not applicable</p>
<p>Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.</p>	<p align="center">COMPLIANCE LEVEL</p>
<p>Inspection Findings: Discussion with the registered manager and staff confirmed that staff were trained and assessed as competent in continence care. Discussion with the manager revealed that all the registered nurses in the home were deemed competent in female catheterisation and the management of stoma appliances. A number of nurses were also deemed competent in male catheterisation.</p> <p>The support of a continence nurse from the SEHSCT is available to staff.</p> <p>A recommendation is made that regular audits of care records are undertaken to include continence management and the findings are acted upon to enhance standards of care (refer to section 11.8).</p>	<p align="center">Substantially compliant</p>

<p>Inspector's overall assessment of the nursing home's compliance level against the standard assessed</p>	<p align="center">Substantially compliant</p>
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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.

The serving of the lunchtime meal was briefly observed in the Pond park unit. The patients were noted to be seated comfortably at the tables and were chatting with each other and with staff. The patients reported that they were enjoying their meal and staff were offering prompt assistance as required. One patient complained that their clothing was uncomfortable and they was immediately escorted to their room and made comfortable by a care assistant.

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

The inspector spoke with eight patients individually and with the majority of others in smaller groups. Patients spoken with confirmed that they were treated with dignity and respect, that staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home. 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:

"I would rather be at home but I am quite happy here."

"My favourite meal is breakfast. The porridge is really good."

"If I call they are here within seconds."

"Sometimes I have to wait for the bell but I am OK. The staff are very good."

Two relatives made positive comments regarding the care in the home. One relative stated that they couldn't fault the care and that the staff were very friendly. Another relative commented that staff were very kind and answered the buzzer quickly. However, this relative was concerned about communication and continuity of staff within the home. They were unaware that a named nurse system was in place within the home. This was discussed with the registered manager who agreed to raise this at an upcoming relatives meeting.

11.6 Questionnaire Findings/Staff Comments

The inspector spoke with six staff including registered nurses, care assistants and ancillary staff. The inspector was able to speak to a number of these staff individually and in private. Nine 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 all were either very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect. One staff member was of the opinion that they would like more time to spend with patients. Staff commented on the good team work in the home and the approachability of their manager.

No issues were raised by staff and an examination of the duty rota evidenced that staffing was sufficient to meet the assessed needs of the patients.

Examples of staff comments were as follows;

"I think the care given to patients is great here."

"The residents are treated with dignity and respect."

"I feel we all work well as a team and care about our work."

"My line managers are always approachable."

11.7 Environment

The inspector 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 carpet outside the dining room in Pond Park suite was found to be in need of replacement and this had already been identified by the registered manager. One bathroom door in this suite was found to be damaged and in need of repair or replacement. A requirement has been made in this regard.

There were also a number of items stored in the bathrooms on bid lids, radiators and shelves including, but not limited to, wipes, bags, commode seats and continence pads. This is not in accordance with best practice in infection prevention and control and a requirement has been made that these items are removed and that this practice should cease.

11.8 Care Records

A selection of care records were reviewed and these were generally maintained to a good standard. However, a number of improvements are required in relation to pain assessment and evaluation, completion of "Do not attempt cardio-pulmonary resuscitation" (DNACPR) forms and wound care charts.

Care plans were completed for those patients on analgesia in the four records examined. However, baseline pain assessments were found to be inconsistently completed for patients on admission. The assessments were also found to be inconsistently reviewed. The home's policy recommends that pain assessments are carried out on admission and evaluated monthly thereafter. A recommendation has been made in this regard.

In the four care records reviewed, two were found not to have DNACPR assessments completed. The expressed wishes of the patient must be clearly documented to enable clear decision making and actions to be taken in the event of a cardiac arrest. A recommendation has been made in this regard.

In three care records examined wound care charts were found to be either not completed or insufficiently completed to enable a judgement to be made on the progress of the wound healing. A recommendation is made that a wound care chart is commenced for all identified wounds and that this is consistently and accurately completed.

An examination of the care record audits revealed that the issues with pain assessment and the DNACPR status had been identified. However, these audits had not been completed since August 2014. A recommendation has been made that care record audits are completed monthly and the findings fed back to staff in order to improve the standards of record keeping (refer to section 10.0).

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Suzanne Scott, 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:

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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.	
<p>Criterion 5.1</p> <ul style="list-style-type: none"> 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. <p>Criterion 5.2</p> <ul style="list-style-type: none"> A comprehensive, holistic assessment of the patient’s care needs using validated assessment tools is completed within 11 days of admission. <p>Criterion 8.1</p> <ul style="list-style-type: none"> Nutritional screening is carried out with patients on admission, using a validated tool such as the ‘Malnutrition Universal Screening Tool (MUST)’ or equivalent. <p>Criterion 11.1</p> <ul style="list-style-type: none"> 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. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulations 12(1) and (4); 13(1); 15(1) and 19 (1) (a) schedule 3</p>	
Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section	Section compliance level
<p>5.1 On admission to the Home a registered nurse carries out an assessment using information from care management team and agreed plan of care is drawn up to meet the patients immediate care needs.</p> <p>5.2 An indepth holistic assessment is carried out and completed within 11 days of admission addressing patients care needs.</p> <p>8.1 MUST screening carried out on each patients admission.</p> <p>11.1 Full assessment including continence, pain and nutritional needs are carried out prior to admission if possible and further assessment on admission.</p>	Compliant

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.	
<p>Criterion 5.3</p> <ul style="list-style-type: none"> • 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. <p>Criterion 11.2</p> <ul style="list-style-type: none"> • There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability. <p>Criterion 11.3</p> <ul style="list-style-type: none"> • 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. <p>Criterion 11.8</p> <ul style="list-style-type: none"> • 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. <p>Criterion 8.3</p> <ul style="list-style-type: none"> • 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 : Regulations 13 (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
<p>5.3 Each resident has a named nurse on admission who will plan their relevant care with the help of the family and friends. The care plan includes referral to and advice from relevant Health Professionals where appropriate.</p> <p>11.2 Referrals take place in a timely manner to the multidisciplinary team when required.</p> <p>11.3 All residents assessed as being at risk from developing pressure ulcers have a patient centred prevention and treatment care plan drawn up which is agreed with all relevant personnel.</p> <p>11.8 Any patient's lower limb or foot ulcerations are referred to the GP, Podiatrist and TVN immediately and their specific treatment and medication attended to.</p>	<p>Compliant</p>

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 <ul style="list-style-type: none"> • Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16</p>	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
All residents are reassessed daily and also on monthly basis where nursing care plans are updated when required.	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.	
<p>Criterion 5.5</p> <ul style="list-style-type: none"> All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. <p>Criterion 11.4</p> <ul style="list-style-type: none"> A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented. <p>Criterion 8.4</p> <ul style="list-style-type: none"> There are up to date nutritional guidelines that are in use by staff on a daily basis. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)</p>	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
<p>5.5 Nurses adhere to RQIA minimum standards, NMC standards and FSHC policies and procedures in regard to intervention and activities and procedures.</p> <p>11.4 The Braden tool is used to assess patients with skin damage and appropriate treatment plan implemented when required.</p> <p>8.4 Patients are assessed at regular intervals with dietician and guidelines are adhered to.</p>	Compliant

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.	
<p>Criterion 5.6</p> <ul style="list-style-type: none"> 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. <p>Criterion 12.11</p> <ul style="list-style-type: none"> 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. <p>Criterion 12.12</p> <ul style="list-style-type: none"> 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. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25</p>	
Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section	Section compliance level
<p>5.6 All nursing records are updated and recorded in a timely fashion according to NMC guidelines. All records are patient centred and include activities and procedures and predicted outcomes.</p> <p>12.11 We adhere to a four weekly menu plan. A choice sheet is completed daily where the diet for each resident is recorded and maintained for required period of time.</p> <p>12.12. When a patient is unable or chooses not to eat or eat excessively a daily food chart is kept and acted upon accordingly. All situations are discussed individually with the patient and or family member and reported to the nurse in charge. Referrals are made to relevant professionals as and when required and evidence maintained.</p>	Compliant

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 <ul style="list-style-type: none"> 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
5.7 All patient care delivered is monitored and recorded daily in the care file. Organised reviews are planned at regular intervals the result of which are acted upon accordingly with involvement of patients and representatives.	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.	
<p>Criterion 5.8</p> <ul style="list-style-type: none"> 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. <p>Criterion 5.9</p> <ul style="list-style-type: none"> 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. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)</p>	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
<p>5.8 If appropriate all patients are encouraged to attend their regular reviews accompanied by their next of kin or family member. These multi disciplinary reviews are scheduled by the care manager and are attended by the multi disciplinary team if required.</p> <p>5.9 The minutes from each review meeting are kept in the resident's care file. Changes discussed and required are acted on appropriately. Goals and targets are discussed with patients and their representatives on a regular basis.</p>	Compliant

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.	
<p>Criterion 12.1</p> <ul style="list-style-type: none"> 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 dietitians and other professionals and disciplines. <p>Criterion 12.3</p> <ul style="list-style-type: none"> 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. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)</p>	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
<p>12.1 Each individual patient has a diet plan which includes their dietary requirements and preferences. Any guidance provided by dietitians and SALT team are adhered to.</p> <p>12.3 At each meal time there is a choice of two alternatives. At any time when this is not acceptable to any patient an alternative meal is provided. Specific diet requirements are met on a daily basis.</p>	Compliant

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:
 - risks when patients are eating and drinking are managed
 - required assistance is provided
 - 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
<p>8.6 Instructions are provided by speech and language therapists when required for individual patients. Nurses complete regular training and updating in feeding techniques with patients with swallowing difficulties</p> <p>12.5 We provide meals at conventional times and in between meal times hot and cold snacks are available or as required. Fresh drinking water and juice is provided at all times.</p> <p>12.10 Each individual patientshas a care plan regarding nutrition. Adequate staff are present at meal times to ensure assistance is provided if required, necessary aids and equipment are available and at risk patients are monitored.</p> <p>11.7 A Wound Link nurse is in place in Pond Park to liaise with TVN when required. The Wound Link Nurse attends training and updates when provided by FSHC or the Trust. Every nurse in Pond Park is aware of the procedure of contacting the TVN when their input is required. All nursing staff have the ability to carry out a wound assessment and apply wound care products and dressings. The link nurse has commenced an 'in house' training programmes for all trained staff.</p>	<p>Unlikely to become compliant</p>

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	COMPLIANCE LEVEL
	Compliant

Appendix 2

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

<p>Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.</p>	<p>Basic care: (BC) – basic physical care e.g. bathing or use of 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.</p>
<ul style="list-style-type: none"> • 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 <input type="checkbox"/> 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 	<p>Examples include: Brief verbal explanations and encouragement, but only that the necessary to carry out the task</p> <p>No general conversation</p>

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	Negative (NS) – communication which is disregarding of the residents’ dignity and respect.
<p>Examples include:</p> <ul style="list-style-type: none"> • 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 	<p>Examples include:</p> <ul style="list-style-type: none"> • 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
Unannounced Care Inspection

Pond Park Care Home

10 February 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 Ms Suzanne Scott during 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.

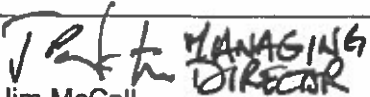

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of 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.	13 (7)	<p>Items stored on bins, radiators and cisterns in the bathrooms must be removed in accordance with best practice in infection prevention and control.</p> <p>Ref: section 11.7</p>	One	All items have been removed from bins, radiators and cisterns in bathrooms. Plastic drawers have been provided to store these items	From the date of inspection
2.	27 (2) (b and d)	<p>The premises of the home must be kept in a good state of repair and be reasonably decorated. This is particularly in relation to:</p> <ul style="list-style-type: none"> • Stained and worn carpet outside the dining room in pond park suite • A damaged bathroom door in pond park suite <p>Ref: section 11.7</p>	One	<p>Carpet is being replaced with wooden flooring.</p> <p>Damaged door in Pond Park Suite has been repaired.</p>	10 May 2015

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.	26.6	<p>The following specified policies must be reviewed and updated as required and ratified by the responsible person:</p> <ul style="list-style-type: none"> • continence management • colostomy and ileostomy management • catheter care and management • bowel continence <p>Ref: section 10.0 of report</p>	One	In progress	10 May 2015
2.	25.11	<p>Care records should be regularly audited to ensure they are consistent with the home's policies and procedures and appropriate actions taken to enhance the quality of care.</p> <p>Ref: section 10.0 and 11.8</p>	One	Plan in place to ensure audit process is being implemented.	10 April 2015
3.	5.4	<p>Re-assessment of patients' needs should be an ongoing process and be carried out daily and at agreed time intervals. This is in relation to:</p> <ul style="list-style-type: none"> • Pain assessments must be carried out, documented and kept under regular review to ensure that these needs are met and the effectiveness of any analgesia is documented. 	One	Pain assessments in place in each care file	10 May 2015

		Ref: section 11.8			
4.	20.1	Do not attempt cardio-pulmonary resuscitation forms must be completed in accordance with the expressed wishes of the patient/ representative. Ref: section 11.8	One	Trained staff have been informed that this procedure must be implemented immediately.	10 May 2015
5.	5.6	When a patient requires wound care, a wound care chart should be kept accurately and reflect the care prescribed by the registered nurse or specialist. Ref: section 11.8	One	Trained staff have been informed that this procedure must be implemented immediately.	10 April 2015

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	Suzanne Scott
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	 MANAGING DIRECTOR Jim McCall  J. WATSON 24/3/15.

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	J Scarlett	27/3/15
Further information requested from provider			