Secondary Unannounced Care Inspection

Name of establishment:		**Spa Nursing Home**
RQIA number	**:**	**1301**
Date of inspection:		**4 February 2015**
Inspector's name:		**Donna Rogan**
Inspection number:		**IN017285**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Spa Nursing Home
Address:	77-79 Grove Road Ballynahinch BT24 8PW
Telephone Number:	028 97562578
Email Address:	Jocelyn.leyson@spanursing.co.uk
Registered Organisation/ Registered Provider:	Spa Nursing Homes Ltd Mr Chris Arnold, Responsible Individual
Registered Manager:	Ms Jocelyn Leyson-Bagood
Person in Charge of the Home at the Time of Inspection:	Ms Jocelyn Leyson-Bagood
Categories of Care:	NH-I ,NH-PH ,NH-PH(E) ,NH-TI, RC-I, RC-PH, RC-PH(E)
Number of Registered Places:	36
Number of Patients Accommodated on Day of Inspection:	23
Scale of Charges (per week):	£567.00 per week
Date and Type of Previous Inspection:	17 February 2014, Secondary Unannounced Inspection
Date and Time of Inspection:	4 February 2015 10.00-16.30
Name of Inspector:	Donna Rogan

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 to others in groups
- consultation with 3 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
- 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	**18**
Staff	**8**
Relatives	**3**
Visiting Professionals	**0**

6.0 Inspection Focus

Prior to the inspection, the responsible person/acting manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible person/acting 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

Spa Private Nursing Home is registered to accommodate a maximum of thirty-six people.

Bedroom accommodation is provided over three floors. There are two lounges on the ground floor and one on the first floor which is used as the designated smoking area for patients/ residents. The home is situated in extensive well maintained grounds in a rural setting about one mile from Ballynahinch. There is adequate car parking at the front and to the side of the premises.

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

Nursing Care

I	Old age not falling into any other category
PH	Physical disability other than sensory impairment
PH (E)	Physical disability other than sensory impairment over 65 years
TI	Terminally ill

Residential Care

I	Old age not falling into any other category
PH	Physical disability other than sensory impairment
PH (E)	Physical disability other than sensory impairment over 65 years
TI	Terminally ill

The certificate of registration was appropriately displayed.

8.0 Executive Summary

The unannounced inspection of Spa Nursing Home was undertaken by Donna Rogan on 4 February 2015 between 10:00 and 16:30 hours. The inspection was facilitated by Jocelyn Leyson-Bagood, registered manager who was also 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 of 17 February 2014.

As a result of the previous inspection six requirements and six recommendations were issued. The requirements and recommendations were reviewed during this inspection and the inspector evidenced that five of the requirements have been fully complied with. One requirement is restated in relation to the management of care records. This requirement is restated for the third and final time. There were six recommendations issued following the previous inspection. All the recommendations had been observed to be complied with during this inspection. Details of the findings regarding the previous requirements and recommendations can be viewed in the section immediately following this summary.

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 were observed to be treated by staff with dignity and respect. Good relationships were evident between staff and patients. Patients were well groomed, appropriately dressed and appeared comfortable in their surroundings. Those patients who were unable to verbally express their views were also observed to be well

groomed, appropriately dressed in clean matching attire and were relaxed and comfortable in their surroundings.

The inspectors reviewed assessments and care plans in regard to management of continence in the home. Review of patient's care records evidenced that patients and/or their representatives were informed of changes to patient need and/or condition and the action taken. Nursing staff spoken with on the day of the inspection were knowledgeable regarding the management of urinary catheters. Discussion with staff and review of training records confirmed that staff were trained and assessed as competent in urinary catheterisation. There were no areas for improvement identified within this theme.

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 is compliant.

Additional Areas Examined
Care Practices
Complaints
Patient Finance Questionnaire
NMC Declaration
Patients/relatives questionnaires and comments
Staff questionnaires and comments
Environment
Care records

Details regarding the inspection findings for these areas are available in the main body of the report. There were issues raised regarding the management of care records and in particular in relation to the recording of the management of behaviours. The issues raised are stated in section 11.8 and a requirement is restated in this regard. The inspector discussed this requirement in detail with the registered manager and advice was provided. This requirement has been stated for a third and final time.

Conclusion

As a result of this inspection one requirement was made in relation to the environment. Details of the requirement can be found in the quality improvement plan (QIP) of this report.

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

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)	The registered person must make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients' residents' and staff by ensuring that: • An infection control audit of the entire premises is undertaken and: (a) an action plan is developed following each audit (b) necessary improvements are made (c) a re-audit to confirm effectiveness is completed.	The registered manager conducts an audit of the entire premises on a weekly basis. An action plan was observed following each audit. Any actions required were addressed. All audits were followed up on a weekly basis. The registered manager has recently completed infection control audit training.	Compliant
2.	13(8)(a)	The registered person must improve privacy in double bedrooms by ensuring that : each bed space is screened to retain access to privacy to the wash hand basin, light and window. Each bed should be reached without intruding on the screen space of the other patients'/residents' bed.	All double rooms in the nursing home have now been converted into single use. The registered manager will ensure the provision of privacy screens should the occupancy of these bedrooms change.	Compliant

3.	27(2)(b)(d)(n)	The registered person must ensure that • The premises are maintained in a good state of repair externally and internally • All parts of the nursing home are kept clean and reasonably decorated. • Suitable adaptations are made providing facilities to meet all patients' needs.	A review of the environment during this inspection found the home to be in a good state of repair both internally and externally. The registered manager ensures the planned refurbishment programme is maintained and follows up any issues that are required in an action plan which is discussed with the responsible individually on a monthly basis. The infection control audit is also conducted in conjunction with the refurbishment plan. This is to be commended.	Complaint
4.	18(2)(j)	The registered persons must ensure that the home is kept free from offensive odours at all times.	There were no offensive odours detected in the home during this inspection. The inspector commended the cleanliness of the home on this occasion.	Compliant
5.	20(1)(c)(i)	The registered person must ensure that newly appointed staff receives; • a structured programme of induction which takes place over a	The inspector reviewed the induction of two members of staff they were found to be comprehensive and had taken place over a time bound	Compliant

		time bound period • newly appointed staff knowledge and skill is tested in practice during the induction period • newly appointed staff are deemed competent and safe in all areas before being signed off by the registered manager	period. Newly appointed staff knowledge was tested in practice during the induction period. Competency and capability assessments were completed and signed off by the registered manager.	
6.	13(1)(b)	The registered person must ensure that a records are maintained of the behaviours which challenge and include the following: • a description of the incident of concern • when it occurred • who was present • what was happening prior to the incident? • what happened during the incident? • what happened immediately after the incident? • what might have led to the incident? • was the patient's behaviour an attempt to communicate?	A review of one patient's record described as having behaviours which may challenge, evidenced that the record should contain more detail in relation to the behaviour. This was discussed fully with the registered manager who agreed to address this issue as a matter of priority. Details of the findings are set out in section 11.8 of this report. This requirement is stated for a third and final time.	Not compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	10.7	The registered persons must ensure the policy on restraint is revised and updated to reflect Human Rights legislation.	The policy on restraint has been revised and updated to reflect Human Rights Legislation.	Compliant
2.	16.8	The registered manager should ensure that staff are informed of the process to be followed in relation to handling an allegation of abuse against a staff member or volunteer as referenced in "Safeguarding Vulnerable Adults- A Shared Responsibility", October 2010" -Section 4, Resource 4.6	All staff spoken with were aware of the process to be followed should an allegation of abuse occur.	Compliant
3.	10.7	The registered manager must ensure that lap belts are removed at specified intervals as recorded in evidence based guidance and the information is also recorded in the patient's plan of care.	There were no patients in the home using lap belts at the time of inspection. However staff were aware of the process should the use of a lap belt be considered in the future.	Compliant
4.	5.3 11.3	The registered manager should ensure that the repositioning record is developed to enable staff to record both repositioning and the outcome of the patient's skin	The registered manager confirmed that where required the use of repositioning charts are used to record the	Complaint

		assessment during each reposition. In addition, the type of hoist or sling in use for each individual patient should be recorded.	outcome of patients' skin during each reposition. The care records reviewed identified the type of hoist or sling to be used where necessary for patients.	
5.	20.2	The registered manager must ensure that • the frequency of checks is reviewed and increased to daily in keeping with the DHSSPS Nursing Homes Minimum Standards • a risk assessment is completed and consideration is given to the provision of additional emergency equipment on the first floor to ensure it is readily accessible around the home.	A review of the emergency equipment checks evidenced that they were conducted daily and recorded. The registered manager informed the inspector that the provision of additional emergency equipment on the first floor is continually assessed and will provided if necessary.	Compliant

6.	20.3	The resuscitation policy is in line with the Resuscitation Council (UK) guidelines and includes a section on ethical/legal issues, ”Do not resuscitate” situations and the review of resuscitation decisions. The records must be maintained in accordance with the policy. **Ref section , criterion 20.3**	The resuscitation policy has been reviewed and includes a section on ethical/legal issues around, “Do not resuscitate” situations. Records are reviewed in accordance with the policy.	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.

There are currently no ongoing safeguarding issues in the home.

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. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. The continence assessment in use was regularly revised. The assessment viewed by the inspector evidenced the decision making processes used to identify the continence needs of the individual. 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 General Practitioners'' as appropriate. Review of four patients' 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.	Compliance

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	Not validated on this occasion
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 registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the registered manager revealed that registered nurses in the home were deemed competent in female catheterisation, male catheterisation, suprapubic catheterisation and the management of stoma appliances. Care staff completed training in continence care as part of their induction. The promotion of continence and the management of incontinence are completed by all staff at the time of induction. The review of one staff induction training record evidenced this training had been completed and had been validated by the registered manager. Regular audits of the management of continence products are undertaken by the registered manager. The registered manager informed the inspector that the deputy nurse manager is the incontinence link nurse in 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 registered manager and reviewed the complaint record. This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements.

11.3 Patient Finance Questionnaire

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

11.4 NMC Declaration

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

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

11.5 Patients and Relatives Comments

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

"I love it here; it is like we are one happy family"
"the staff are so thoughtful and kind"
"the food is great and we get what we want to eat"
"I'm very content"
"I have no complaints or worries"

There were no issues raised by patients to the inspector during the inspection.

The inspector spoke with three relatives during the inspection. The following comments were made by the relatives visiting on the day of inspection;

“I’m confident my relative is well cared for”
“I am always kept informed if there is anything I need to know”
“The staff are very attentive”
“It’s a well-run home”

There were no issues raised by relatives or their representatives during the inspection to the inspectors.

11.6 Staff Comments

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

The following comments were made to the inspector during the inspection;

“quality of care is of a high standard”
“we are a good team, I enjoy my job thoroughly”
“patients are treated with dignity and respect”
“staff work well together to ensure that the quality of care is delivered to each resident”

There were no issues raised by staff to the inspector during the inspection.

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 comfortably heated and most areas unless otherwise stated were maintained to a good standard of hygiene.

There is a detailed refurbishment plan in place. The registered manager ensures the refurbishment programme is adhered to and completes a schedule of completed works and an action plan of works to be completed within the following month. This action plan is conducted in conjunction with the infection control audit. The overall management of the environment is to be commended. The inspector also commended the cleanliness of the home on this occasion.

11.8 Care Records

The inspector reviewed four care records on this occasion. In general they were being maintained to a good standard. They were regularly reviewed and updated in keeping with the patients’ needs. Areas noted for improvement included the following;

- a description of the incident of concern
- when it occurred

- who was present
- what was happening prior to the incident?
- what happened during the incident?
- what happened immediately after the incident?
- what might have led to the incident?
- was the patient's behaviour an attempt to communicate?

A requirement is made in the above regard for the third and final time.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Jocelyn Leyson-Bagood, 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:

Donna Rogan
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
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Belfast
BT1 3BT

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Donna Rogan **Date**
Inspector/Quality Reviewer

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**
At the time the admission of each resident's in the home, a nurse manager will carry out a pre assessment and gather informations needed in order to validate the needs of each resident's. An up to date assessment from care management team involved is obtained, this information is recorded and retained in residents folder.A holistic assessment of residents needs is completed within 11 days of admission using the validated tools.A nutritional assessment using MUST tool is carried out in all new residents and kept under review. Upon admission of the new resident a body mapping is carried out and a pressure ulcer risk assessment is completed .	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.	
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
On admission a named nurse is allocated who is responsible for planning and implementing nursing care or nursing intervention in order to meet the identified assessed needs of the residents by promoting rehabilitation and independence where possible. Other health professionals are also contacted for advise and support like Tissue Viability nurse, Podiatrist and Dietician if any concerns or problem observe with the residents who have lower limbs or foot ulceration. When resident is at risk, a plan is put in place after consultation with other health care providers in an effort to prevent pressure ulcers from occuring.All staff are made aware of the nursing care plan and all the advise received or recommendations are adhered to by the staff members involving in the care of the resident.	Compliant

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**
A daily nurses report is completed by the nurses on duty to reflect the care provided.Daily evaluation report are signed and dated by the time report is completed.	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**
All nursing interventions, activities and procedures carried out in the home is supported by best practice evident based guidelines. If there is a skin damage a validated pressure ulcer grading tool is used.Appropriate intervention and management in place in order to promote healing and prevent deterioration or infection which could lead to futher skin damage.If necessary the relevant professional bodies will be involve in an effort to have the desired outcome. An up to date nutritional guidelines are available in the home for staff use as reference.	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.	
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 of all interventions, activities and procedures are retained in the home in accordance with the NMC guidelines. Records of all meals provided in the home are retained for inspection and provide details of all meals taken by all residents. A record is kept of all residents who require full assistance at meal times or residents who require daily monitoring due to their health status. Where necessary referrals to relevant professionals are made and records of recommendations retained in resident's notes .Any changes made are also reflected in the care plan.	Substantially 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 • **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**
All care delivered are monitored on a day to day basis.A daily evaluation record is maintained by nurse on duty.A nursing care plan are reviewed on a monthly basis or more often if required. Staff and Management are in daily communication with resident's and their relatives during their visits to the home.They are made aware of any changes and all interventions carried out.The next of kin is contacted either directly on their visits to the home or via telephone to ensure an open communication is established in order to have knowledge and understanding of the care being delevired.	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**
The residents are encourage to participate or get involve in all aspects of reviews carried out by the local trust.if they are able. A copy of reviews carried out and agreement of resident and their representative are maintained in the resident's file. Any changes made and agreed during the care review are reflected in their individual care plan.	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.	
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**
Residents received a nutritious and varied diet providing all the required dietary needs.Advise received from professional bodies is implemented.Menu is in place but there is always great effort to provide resident with the meal of their choice.The cook will communicate directly with residents if they require a special meal.	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:** 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**
Nurses have an up to date knowledge on the management residents with swallowing difficulties.Care staff have also receieved training for swallowing awareness provided by the South Eastern Trust in this area.All meals are provided at conventional times allowing staff sufficient time to assist residents with their meals. Snacks hot and cold drinks are available at all times on request. Fresh water and juices is available at all times. Snacks are given mid-morning,mid-afternoon and the evening to all residents.All staff are aware of the residents with eating difficulties and risk involved.The home has availed training provided by the trust in this fields.	Compliant

Assistance to residents is provided if necessary When a resident needed wound care nurses are trained on wound management that includes wound assessment apply wound care products and dresssings which provided by the local trust.An in house Awareness training on pressure risk and skin care is also given to care assistant in order for them to have knowledge and understanding of skin care.	

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)

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.

Quality Improvement Plan

Secondary Unannounced Care Inspection

Spa Nursing Home

4 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 Jocelyn Bagood, 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(1)(b)	The registered person must ensure that records are maintained of the behaviours which challenge and include the following: • a description of the incident of concern • when it occurred • who was present • what was happening prior to the incident? • what happened during the incident? • what happened immediately after the incident? • what might have led to the incident? • was the patient's behaviour an attempt to communicate? **Ref previous requirements and section 11.8**	Third and final time	A new Behaviuoral form or ABC form was commenced after the inspection. These form gives details of the following. A-antecedent such as what specific activity or event occurred before the challenging behaviour. Causes of the challenging behaviour.B-what behaviour specifically did the person do or say. C-consequence, what happened after.a result of challenging behaviuor. Intervention or action for challenging behaviour is also included and reviewed on a regular basis. This form is being used from the time of inspection.	From the 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	Jocelyn Bagood
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Chris Arnold

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Donna Rogan	01/04/15
Further information requested from provider			