Announced Primary Inspection

Name of Establishment:	**Kingscourt**
Establishment ID No:	**1382**
Date of Inspection:	**03 July 2014**
Inspector's Name:	**Bridget Dougan**
Inspection No:	**17102**

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544

1.0 General Information

Name of Home:	Kingscourt
Address:	928 Antrim Road Templepatrick BT39 0AT
Telephone Number:	028 9443 2046
E mail Address:	info@manorhealthcare.org
Registered Organisation/ Registered Provider:	Manor Healthcare Ltd Mr Eoghain King
Registered Manager:	Mr Brian Campbell
Person in Charge of the Home at the time of Inspection:	Mr Brian Campbell
Registered Categories of Care and number of places:	NH - LD, LD(E) 19
Number of Patients Accommodated on Day of Inspection:	19
Date and time of this inspection:	03 July 2014: 11.30 – 17.30 hours
Date and type of previous inspection:	07 November 2013 Secondary Unannounced

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 is required.

This is a report of a primary announced inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were 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.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

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

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the DHSSPS Nursing Homes Minimum Standards 2008.

The inspection process has three key parts; self-assessment (including completion of self -declaration), pre-inspection analysis and the inspection visit by the inspector.

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

- analysis of pre-inspection information
- discussion with the registered manager
- examination of records

- consultation with stakeholders
- tour of the premises
- evaluation and feedback.

Any other information received by RQIA about this registered provider has also been considered by the inspector in preparing for this inspection.

5.0 Consultation Process

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

Patients	**12**
Staff	**8**
Relatives	**0**
Visiting Professionals	**0**

Questionnaires were provided, during the inspection, to patients, their representatives and staff to seek their views regarding the service. Matters raised from the questionnaires were addressed by the inspector in the course of this inspection.

Issued To	**Number issued**	**Number returned**
Patients	**1 completed as part of an interview**	**1**
Relatives / Representatives	**0**	
Staff	**8**	**6**

6.0 Inspection Focus

The inspection sought to establish the level of compliance achieved regarding the selected DHSSPS Nursing Homes Minimum Standards.

The criteria from the following standards are included;

- Management of Nursing Care – Standard 5
- Management of Wounds and Pressure Ulcers –Standard 11
- Management of Nutritional Needs and Weight Loss – Standard 8 and 12
- Management of Dehydration – Standard 12

An assessment on the progress of the issues raised during and since the previous inspection was also undertaken.

The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.

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

Guidance - Compliance statements		
Guidance - Compliance statements	**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

Kingscourt is located in a residential area in the village of Templepatrick. It is convenient to local shops and public transport.

The two-storey building was originally a private house which has been extended and modified to meet the requirements of a registered nursing home. There are 17 single rooms and one double room.

There is car parking to the front and side of the home and gardens with a paved patio area.

The home is registered to accommodate 19 persons with a learning disability over and under the age of 65 years.

There are adequate number of sitting/dining rooms and toilet / bathroom / shower facilities. These are appropriately located throughout the home.

Catering and laundry services are provided by the home. Car parking facilities are available within the grounds.

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) accurately reflected the categories of care and was appropriately displayed in a prominent position of the home.

Mr Brian Campbell is the registered manager and has been registered with RQIA since 01 April 2005.

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (unannounced) to Kingscourt. The inspection was undertaken by Bridget Dougan on 03 July 2014 from 11.30 to 17.30 hours.

The inspector was welcomed into the home by Mr Brian Campbell, Registered Manager. Mr Campbell was available throughout the inspection and for verbal feedback of the issues identified during the inspection at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector met with patients and staff. The inspector observed care practices, examined a selection of records, issued staff questionnaires and carried out a general inspection of the nursing home environment as part of the inspection process.

The inspector spent a number of extended periods observing staff and patient interaction. Discussions and questionnaires are unlikely to capture the true

experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience.

These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool is designed to help evaluate the type and quality of communication which takes place in the nursing home. A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix two.

As a result of the previous inspection conducted on 07 November 2013, five requirements and seven recommendations were issued. These requirements and recommendations were reviewed during this inspection. The inspector evidenced that five requirements and six recommendations had been fully complied with. One recommendation has been assessed as moving towards compliance. Details can be viewed in the section immediately following this summary.

Standards inspected:

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. (Selected criteria)

Standard 8: Nutritional needs of patients are met. (Selected criteria)
Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)
Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria)

Inspection Findings:

- **Management of Nursing Care – Standard 5**

The inspector can confirm that at the time of the inspection there was evidence to validate that patients receive safe and effective care in Kingscourt.

The inspector inspected three patients care records and there was evidence of comprehensive and detailed assessment of patient needs from date of admission. A variety of risk assessments were also used to supplement the general assessment tool. The inspector observed that the Walsall and Braden risk assessment tools had been used interchangeably and recommends that for consistency only one of these risk assessment tools is used in assessing the condition of the patients' skin. A recommendation is also made that the Malnutrition Universal Screening Tool (MUST) is used as the tool of choice to identify patients who are at risk of malnourishment. This is in keeping with best practice guidelines.

The assessment of the patient's needs was evidenced to inform the care planning process. However, the inspector observed that two patients risk assessments and care plans had not been reviewed on a regular basis. Two requirements have been made in this regard.

Inspection of three patients care records confirmed that written evidence was maintained to indicate that discussions had taken place with patients, and their representatives in regard to planning and agreeing nursing interventions.

There was also evidence that the referring HSC Trust maintained appropriate reviews of the patient's satisfaction with the placement in the home and the quality of care delivered.

Compliance Level: Moving towards compliance

- **Management of Wounds and Pressure Ulcers –Standard 11**

The inspector was informed by the registered manager that there were no patients with wounds in the home.

There was evidence of appropriate assessment of risk of development of pressure ulcers. Care plans for the management of risks of pressure ulcers were maintained to a professional standard.

Compliance level: Compliant

- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**

The inspector reviewed the management of nutrition and weight loss within the home.

Robust systems were evidenced with risk assessments and appropriate referrals to GP's, speech and language therapists and or dieticians being made as required.

The inspector also observed the serving of the lunch meal and can confirm that the patients were offered a choice of meal and that the meal service was well delivered. Patients were observed to be assisted with dignity and respect throughout the meal.

Compliance level: Compliant

- **Management of Dehydration – Standard 12**

The inspector also examined the management of dehydration during the inspection. The home maintained a record of the fluid balance of those patients assessed at risk of dehydration. In general there was evidence that fluid balance records were maintained appropriately.

Patients were observed to be able to access fluids with ease throughout the inspection. Staff were observed offering patients additional fluids throughout the inspection. Fresh drinking water/various cordials were available to patients in lounges and the dining room. A recommendation was made in relation to the recording of fluids.

Compliance level: Substantially compliant

Patients and staff questionnaires

Some comments received from patients:

- "Everything is very good."
- "I like it here."
- "The food is good."

Some comments received from staff:

- "I feel that the staff at Kingscourt look after the patients very well. We have time to listen and see to their needs, whatever they may be."
- "Staff always strive to ensure patients' everyday needs are met. Additionally they strive to provide meaningful activities for individual patients."
- "The residents in Kingscourt are very well looked after by all the staff. Most staff have worked here a long time and we know each resident well. We have great training to understand all their needs. Kingscourt is a pleasant place to work."

A number of additional areas were also examined

- Records required to be held in the nursing home
- Guardianship
- Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)
- Patient and staff quality of interactions (QUIS)
- Complaints
- Patient finance pre-inspection questionnaire
- NMC declaration
- Staffing and staff comments
- Comments from representatives/relatives *and visiting professionals*
- Environment.

Full details of the findings of inspection are contained in section 11 of the report.

Conclusion

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

The home's environment was generally well maintained and further refurbishment work was in progress. Patients were observed to be treated with dignity and respect. However, areas for improvement were identified in relation to: further re-decoration and provision of facilities for patients, care records and the provision of domestic staffing levels.

Therefore four requirements and two recommendations are made together with one recommendation which has been stated for the second time. These requirements and recommendations are detailed throughout the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, registered manager 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	17 (1)	It is required that the registered person shall introduce and ensure systems are maintained for reviewing at appropriate intervals the quality of nursing and any other service provision.	Discussion with the registered manager and inspection of audit records evidenced that a quality assurance system has been implemented to monitor service provision in terms of accidents/incidents, complaints, infection control, medicines management and care records. Infection control audits were completed quarterly. A recommendation has been made for monthly infection control audits to be completed.	**Compliant**
2	16 (1) (b)	The registered person shall ensure that a written nursing plan is prepared by a nurse in consultation with the patient or patient's representative as to how the patient's needs in respect of his health and welfare are to be met. The patients plan is kept under review.	Inspection of three patients care records evidenced that this requirement has been met.	**Compliant**
3	19 (2)	The registered person shall maintain in the nursing home the records specified in Schedule 4.	Observation of a sample of personnel records evidenced that this requirement has been met.	**Compliant**
4	27 (2) (b)	The registered person shall, having regard to the number and needs of the patients, ensure that-	A refurbishment programme was on-going in the home. New seating had been provided in the lounges and the majority of patients' beds had been replaced. A patient lift had been	**Compliant**

		The premises to be used as the nursing home are of sound construction and kept in a good state of repair externally and internally.	installed and new flooring was being laid in the corridors, office and treatment room.	
5	13 (7)	The registered person shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff.	The inspector was informed by the registered manager that the ground floor carpet had been cleaned since the previous inspection. However, following review new flooring was being laid in this area.	**Compliant**

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	20.1	The registered manager should ensure there is guidance documents such as Resuscitation Council UK 2010 Guidelines on Resuscitation available for staff reference in the home	The inspector can confirm that these is guidance documents were available for staff to reference in the home	**Compliant**
2	20.2	It is recommended that the following emergency equipment is readily available in the home and records maintained of regular checks: Emergency portable oxygen – available and well maintained and includes appropriate fittings and safety notice. Oxygen tubing and a selection of oxygen masks / nasal cannulas patient airways 'Ambu' bag.	The inspector reviewed the emergency equipment available in the home and records maintained of regular checks and can confirm that this recommendation has been met.	**Compliant**
3	20.4	The registered manager should ensure a first aider is available on each shift. This person should be identified on the duty rotas.	Review of three weeks duty rotas evidenced that this recommendation has been met.	**Compliant**
4	25.12	It is recommended that the annual quality review report provides a comprehensive overview of the quality of service provision and includes	The inspector can confirm that this recommendation has been met.	**Compliant**

		evidence of the outcome of the quality assurance survey and information pertaining to compliments and complaints, staff training, supervision and a number of other quality indicators as appropriate. Areas of good practice and areas for improvement should be identified. This report should be prominently displayed in the home and made available to patients and/or their representatives.		
5	16.3	A recommendation has been made that nurse in charge competency assessments include staff awareness of their role in dealing with, and responding to, allegations of suspected abuse and the management of emergency situations.	The inspector reviewed a sample of nurse in charge competency assessments and can confirm that this recommendation has been met.	**Compliant**
6	5.6	The registered manager must ensure that 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.	Inspection of three patients care records evidenced that two patients risk assessments and care plans had not been reviewed on a regular basis. This recommendation will be stated for the second time and compliance followed up during the next care inspection.	**Moving towards compliance**
7	28.4	The registered person should ensure that nurses are provided with training	Discussion with the registered manager and inspection of training records evidenced that	**Compliant**

		on the management of subcutaneous infusions.	this recommendation has been met.	

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

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if there is considered to be a breach of regulation as stated in the Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

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

10.0 Additional Areas Examined

10.1 Documents required to be held in the Nursing Home

Prior to the inspection a checklist of documents required to be held in the home under regulation 19(2) schedule 4 of The Nursing Homes Regulations (Northern Ireland) was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required documents were maintained in the home and were available for inspection. The inspector reviewed the following records:

- The home's statement of purpose
- The patient's guide
- Sample of reports of unannounced visits to the home under regulation 29
- Sample of staff duty rosters
- Record of complaints
- Sample of incident/accidents
- Record of food provided for patients
- Statement of the procedure to be followed in the event of a fire
- Sample of the minutes of patients/relatives and staff meetings.

10.2 Patients under guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection. During the inspection there were no patients in the home who were subject to a guardianship order.

10.3 Human Rights Act 1998 and European Convention on Human Rights (ECHR) DNSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspector discussed the Human Rights Act and the Human Rights Legislation with the registered manager. The inspector can confirm that copies of these documents were available in the home.

10.4 Quality of interaction schedule (QUIS)

The inspector undertook a number of periods of observation in the home which lasted approximately 30 minutes each.

The inspector observed the patients' lunch meal which was served in the dining room.

The observation tool used to record these observations uses a simple coding system to record interactions between staff, patients and visitors.

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix 2.

The staff were observed seating the patients in preparation for their lunch in an unhurried manner.

The staff explained to the patients their menu choice and provided adequate support and supervision.

Observation of care practices during these periods of observation revealed that staff were respectful in their interactions with the patients.

Overall the periods of observations were positive.

10.5 Complaints

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. No complaints were recorded since the previous inspection.

10.6 Patient Finance Questionnaire

Prior to the inspection a patient 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.

10.7 NMC declaration

Prior to the inspection the 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 manager were registered with the NMC.

10.8 Staffing /Staff Comments

On the day of inspection the inspector examined staff duty rosters for three weeks. Inspection confirmed that registered nurses and care staff staffing levels for day and night duty were in accordance with the RQIA's recommended minimum staffing

guidelines. However the inspector observed that only one member of domestic staff was on duty each day from 09.00 – 15.30 hours. Discussion with the staff member evidenced that whilst she did not wish to complain, she was concerned that the high levels of cleanliness could not be maintained with only one member of domestic staff on duty. A requirement has been made for a review of domestic staff provision to ensure that cleaning standards are maintained.

The inspector spoke to eight staff members during the inspection process and reviewed six staff completed questionnaires.

Examples of staff comments were for as follows:

- "I feel that the staff at Kingscourt look after the patients very well. We have time to listen and see to their needs, whatever they may be."
- "Staff always strive to ensure patients everyday needs are met. Additionally they strive to provide meaningful activities for individual patients."
- "The residents in Kingscourt are very well looked after by all the staff. Most staff have worked here a long time and we know each resident well. We have great training to understand all their needs. Kingscourt is a pleasant place to work."

10.9 Patients' Comments

The inspector spoke to 12 patients individually and with others in groups. One patient completed a questionnaire as part of an interview.

Examples of patients' comments were as follows:

- "Everything is very good."
- "I like it here."
- "The food is good."

10. 10 Relatives' Comments

No relatives were visiting in the home at the time of the inspection.

10.11 Environment

The inspector undertook an inspection of the home and viewed a number of patients' bedrooms, communal facilities and toilet and bathroom areas.

The home was clean, warm and comfortable. As stated previously, re-decoration work was underway. A number of issues were identified which require to be addressed:

- patients bedrooms need repainted
- treatment room needs repainted
- two vanity units in patients bedrooms need replaced
- valance sheets were not in place on a number of patients beds
- one patients bed had no head board
- bathroom on first floor had loose tiles around the bath.

One requirement has been made in this regard.

11.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr Brian Campbell, 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:

Bridget Dougan
The Regulation and Quality Improvement Authority
Hilltop
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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.	
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**
5.1 Unless in exceptional circumstances a named nurse completes initial assessments and a draft care plan prior to any admission to the home. This care plan will be informed by assessments of need, professional reports and care planning meetings as part of a pre-admission process led by a multi-disciplinary team of the referring trust. The care plan is validated and signed off by the multi-disciplinary team. prior to admission. In the event of an unplanned or	Compliant

emergency admission initial assessments and an interim care plan will be completed and in place sufficient to meet the immediate care needs of the patient on admission. 5.2 All necessary assessments not in place on admission will be completed within 11 days. 8.1 Nutritional screening is carried out on new admissions or patients deemed at risk using the "MUST" process. 11.1 A pressure ulcer risk assessment and the associated assessments stated in this criterion are carried out only on patients deemed to be at risk on admission in accordance with the multi-disciplinary assessment of need provided by the referring trust. In the case of able bodied and patients with no significant mobility or movement issues this may not be an assessed need.	
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**
5.3 Each patient is allocated a named nurse who is responsible for care planning and interventions based on assessed needs. Where possible the patient and/or their representative is involved in this process. Care plans reflect the promotion of independence and advice/recommendations of relevant health professionals involved. 11.2 Arrangements are in place through our GP Practice for advice and expertise on tissue viability issues in cases of assessed need. 11.3 A documented pressure ulcer prevention and management plan is available and implemented where there is an assessed risk, which includes advice and expertise from our GP Practice & Tissue Viability Nurse. 11.8 Arrangements for this criterion are as stated in 11.2 and 11.3 8.3 Arrangements for dietician referrals are via our GP Practice based on the "MUST" process and treatment/dietary plans recommended by the community dietician are implemented and maintained.	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**
5.4 Re-assessment of all assessed needs or treatment/care plan interventions put in place is ongoing and carried out either daily or at intervals as specified in the care plan.	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**
5.5 Nursing and care interventions and activities are supported by guidelines and best practice protocols and procedures as defined by professional bodies, national standard setting organisations and evidence base where	Compliant

possible. 11.4 A validated pressure ulcer grading tool is available where required. 8.4 Up to date nutritional guidelines are used in menu planning and informing individual nutritional plans.	
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**
5.6 Contemporaneous records are maintained for all nursing/care interventions and activities in accordance with	Compliant

NMC guidelines. 12.11 A detailed record is maintained of all meals offered and served in the home. 12.12 Patient care plans reflect the appetite and dietary requirement/eating habits of the patient together with action taken and interventions recommended.	
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**
5.7 Care outcomes are recorded daily and evaluation of care interventions are reviewed at intervals determined by the care plan or as required, involving patients and/or their representatives as far as possible.	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**
5.8 Patients are facilitated and encouraged to participate in their care and care planning as far as possible and attend multi-disciplinary review meetings where appropriate. 5.9 Reports of all review meetings are retained and all recommendations acted upon and inform changes to care plans where applicable. Patients and/or their representatives are involved and kept informed where possible.	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**
12.1 Diets and meals are nutritous and varied and reflect individual preferences and stated dietary needs. Guidance and recommendations made by dieticians are implemented and records maintained. 12.3 A choice of meals at each mealtime is offered including those on specific diets.	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**
8.6 Patients with swallowing issues are referred to the trust S.A.L.T. and any recommendations/instructions are implemented and adhered to. Nurses have sufficient knowledge and skills in managing feeding techniques for all patients with swallowing difficulties currently residing in the home. 12.5 Meals are provided at conventional times and hot and cold drinks are offered at regular intervals. Fresh drinking water is always available. 12.10 Staff are aware of matters relating to patients dietary and feeding requirements as informed by individual care plans. Sufficient staff are present at mealtimes to provide assistance with the eating and drinking requirements of all residents and any associated risks. Any aids or equipment recommended is made available. 11.7 Nurses have attended training in wound care and have sufficient expertise and skills in wound assessment and management in the event of a patient requiring wound care interventions. Our G.P. Practice prescribe wound care dressings and products and GP practice tissue viability nurse provides advice and guidance.	Compliant

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.

The **Regulation** and **Quality Improvement** Authority

Quality Improvement Plan

Unannounced Primary Inspection

Kingscourt

03 July 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Mr Brian Campbell, Registered Manager either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	20 (1) (a)	The registered person shall, having regard to the size of the nursing home, the statement of purpose and the number and needs of patients: Ensure that at all times suitably qualified, competent and experienced persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients. The registered person must review the domestic staffing arrangements to ensure that cleaning standards are maintained. **Reference: Section 10.8**	One	-ACTION HAS BEEN INITIATED TO INCREASE THE LEVEL OF DOMESTIC STAFFING TO ENSURE ADEQUATE CLEANING STANDARDS ARE MAINTAINED.	Within two weeks from receipt of this QIP
2	27 (2) (d)	The registered person shall, having regard to the number and needs of patients, ensure that the following issues are addressed: • patients bedrooms need repainted • treatment room needs repainted • two vanity units in patients bedrooms need replaced • valance sheets were not in place on a number of patients beds • one patients bed had no head board	One	-A PROGRAMME OF REPAINTING OF AREAS WITHIN THE HOME IS ONGOING TO INCLUDE THE TREATMENT ROOM AND HALLWAYS. THIS WILL NEED TO BE EXTENDED TO BEDROOMS. -ONE VANITY UNIT HAS	Within six weeks from receipt of QIP

		• bathroom on first floor had loose tiles around the bath. **Reference: Section 10.11**		ALREADY BEEN REPLACED. – VALANCE SHEETS WILL BE PROVIDED WITHIN THE TIMESCALE AS WILL THE MISSING HEADBOARD – BATHROOM TILES HAVE BEEN REPLACED	
3	15 (2) (a)	The registered person shall ensure that the assessment of the patients' needs is kept under review. Risk assessments should be reviewed monthly or more frequently having regard to any changes in the patient's condition. **Reference: Section 8.0**	One	– NURSES RESPONSIBLE FOR CARE PLANNING WILL REVIEW RISK ASSESSMENTS AS THE PATIENT'S CONDITION DETERMINES, BUT AT LEAST MONTHLY.	From the date of this inspection
4	16 (2) (b)	The registered person shall ensure that the patients care plan is kept under review. Care plans should be reviewed monthly or more frequently having regard to any changes in the patient's condition. **Reference: Section 8.0**	One	– NURSES RESPONSIBLE FOR CARE PLANNING WILL REVIEW CARE PLANS AS CHANGES TO THE CONDITION OF THE PATIENT'S DETERMINE, BUT AT LEAST MONTHLY.	From the date of this inspection

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.6	The registered manager must ensure that 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. **Reference: Section 9.0 Follow up on previous issues**	Two	CARE PLANS AND RISK ASSESSMENTS AND PATIENT RECORDS WILL BE REVIEWED REGULARLY AND CONTEMPORANEOUS RECORDS MAINTAINED.	From the date of this inspection
2	5.2	It is recommended that for consistency only one validated risk assessment tool such as the Braden risk assessment is used in assessing the patients' risk of developing pressure ulcers. A recommendation is also made that the Malnutrition Universal Screening Tool (MUST) is used as the tool of choice to identify patients who are at risk of malnourishment. **Reference: Section 8.0**	One	- THE 'BRADEN' RISK ASSESSMENT TOOL WILL BE USED FOR ASSESSING PRESSURE ULCER RISK SOLELY. - THE INITIAL RISK ASSESSMENT FORM USED WILL BE REPLACED BY THE (MUST) FORMAT FORM.	From the date of this inspection
3	12.1	The registered manager must ensure that fluid intake charts reflect individualised	One		From the date of this

		patient need and ensure the following: • the total fluid intake for the patient over 24 hours • an effective reconciliation of the total fluid intake against the fluid target established • action to be taken if targets are not achieved • a record of reconciliation of fluid intake in the daily progress notes. **Reference: Section 8.0**		- A REVIEW OF CURRENT RECORD KEEPING IN RELATION TO FLUID INTAKE WILL INCORPORATE THESE RECOMMENDATIONS	inspection

The registered provider / manager is required to detail the action taken, or to be taken, in response to the issue(s) raised in the Quality Improvement Plan. The Quality Improvement Plan is then to be signed below by the registered provider and registered manager and returned to:

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

Signed:		**Signed:**	
Name:	EOGHAIN KING **Registered Provider**	**Name:**	BRIAN CAMPBELL **Registered Manager**
Date	05-09-14	**Date**	08/09/2014.

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	✓	B. Dougan	12/9/14.
Further information requested from provider			