Unannounced Care Inspection

Name of Establishment:	**Ravenhill**
RQIA Number:	**1384**
Date of Inspection:	**20 November 2014**
Inspector's Name:	**Linda Thompson**
Inspection ID:	**20125**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Ravenhill
Address:	79-81 Shore Road Greenisland BT38 8TZ
Telephone Number:	028 9086 2169
Email Address:	nursemanager@ravenhillpnh.co.uk
Registered Organisation/ Registered Provider:	Ravenhill Private Nursing Home Mr William Trevor Gage
Registered Manager:	Mrs Isabella Christine Kim
Person in Charge of the Home at the Time of Inspection:	Registered nurse Mrs Muriel Stringer initially until arrival of registered manager.
Categories of Care:	RC-I, NH-I, NH-PH
Number of Registered Places:	38
Number of Patients Accommodated on Day of Inspection:	34
Scale of Charges (per week):	£531 - £651
Date and Type of Previous Inspection:	6 November 2013, primary unannounced inspections
Date and Time of Inspection:	20 November 2014 08.30 – 12.30 hours
Name of Inspector:	Linda Thompson

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- Discussion with the Registered Nurse Manager
- Discussion with staff
- Discussion with patients individually and to others in groups
- Consultation with relatives
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- Review of a sample of care plans
- Review of the complaints, accidents and incidents records
- 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	25
Staff	10
Relatives	2
Visiting Professionals	0

Questionnaires were provided (by the inspector), during the inspection, to patients / residents, their representatives and staff to seek their views regarding the quality of the service.

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	5	5
Relatives/Representatives	1	1
Staff	10	10

6.0 Inspection Focus

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the previously notified theme to be inspected. The comments provided by the responsible person/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment submitted 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.

Alternatively 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 inspection also considered the actions taken by the home following the outcome of a significant event audit undertaken by the Northern Health and Social Care Trust (NHSCT). The audit findings identified a number of key learning outcomes which should be considered by the home.

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

Ravenhill Private Nursing Home is a substantial three story dwelling, which has been adapted and extended to create a 38 bedded nursing home. It is situated on the shores of Belfast Lough on the main Belfast to Carrickfergus Shore Road.

Bedroom accommodation is provided in mainly single rooms with double rooms available. Access to the first and second floors is by stairs or passenger lift.

The nursing home is owned and operated by Ravenhill Private Nursing Home.
The responsible individual operating on behalf of the company is Mr William Trevor Gage
The current registered manager is Mrs Isabella Christine Kim

Accommodation for patients/ residents is provided over three floors of the home.
Access to the all floors is via a passenger lift and stairs.

There are a range of toilet, bath and shower facilities on all floors.
Communal lounges and a large dining area are located on the ground floor.

The home's gardens have been landscaped and the view over Belfast Lough provides a very pleasant outlook for patients accommodated in the home.

The home also provides for catering and laundry services on the ground floor.

The home is registered to provide care for a maximum of 38 persons under the following categories of care:

Nursing care

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65

Residential care

I	old age not falling into any other category to a maximum of 5 residents

The Home’s RQIA ‘Certificate of Registration’ was appropriately displayed in the entrance hall of the home.

8.0 Executive Summary

The unannounced care inspection of Ravenhill was undertaken by Linda Thompson inspector on 20 November 2014 between 08.30 and 12.30 hours.

The inspection was initially facilitated by the Mrs Muriel Stringer registered nurse in charge of the home in the absence of the registered manager. Mrs Christine Kim registered manager joined the inspector shortly after commencement.

Ms Kim was available for verbal feedback at the conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection on 06 November 2013.

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

As a result of the previous inspection conducted on 06 November 2013 seven requirements and five recommendations were raised. These were reviewed during this inspection. The inspector evidenced that all requirements and three recommendations were fully complied with. Two recommendations in respect of care records required further improvements and are raised as a requirement as a consequence of this inspection.

Details can be viewed in the section immediately following this summary.

Conclusion

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

The inspector raised concern regarding the management of wound care records. Two previously raised recommendations referring to nursing care records require further improvements and are therefore raised as a requirement to address issues identified. Further details are recorded in the main body of the report.

The home's general environment was well maintained. No malodours were noted throughout the home.

Patients/residents were observed to be treated with dignity and respect.

Therefore, two requirements are made following inspection. These requirements are detailed throughout the report and in the quality improvement plan (QIP).

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

The inspector would also like to thank the patients/residents their representatives and staff who completed questionnaires.

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	15(2)(a)	It is required that the registered person shall ensure as far as reasonably practicable that unnecessary risks to the health or safety of patients are identified and so far as possible eliminated. Therefore individual bedrail risk assessments, to determine if the use of bedrails is an appropriate intervention to maintain patient safety, must be completed prior to the provision of bedrails. The outcome of the assessment should be agreed and recorded with the patient, were appropriate, and/or relatives/representatives.	The inspector can confirm that bed rails risk assessments are completed prior to the use of such equipment.	Compliant

2.	12(1)(a)	It is required that the registered person shall ensure that the treatment provided to each patient meet their individual need. Each patient must have a comprehensive assessment completed to accurately identify what their individual needs are. Pre admission assessments must be reviewed on admission to ensure that accurately reflect the needs of the patients'.	The inspector can confirm that a comprehensive assessment of need is completed for each patient. The pre admission assessment of each patient is used to establish the initial care plan. This care plan is then developed over up to five days to reflect a comprehensive and detailed individualised care plan.	Compliant
3.	17(1)	It is required that the registered person shall ensure that audits are completed on all care records and the outcomes of any deficits identified are addressed. The audit process must be an ongoing process to ensure care records are maintained in keeping with regulatory requirements	The inspector can confirm that the registered manager maintains nursing care record audits on all patient nursing care records. These are maintained on a monthly basis and planned to ensure that a number of records from each primary nurse are audited regularly.	Compliant

4.	15(2)(a)	The assessment of patient need must be kept under review. Records of assessment of need must be reviewed and updated to accurately reflect any changes to the condition of the patient.	The inspector can confirm that the assessment of patient need if reviewed on a regular basis.	Compliant
5	16(1)	A written nursing plan must be prepared in consultation with the patient or patient's representatives as to how the patient's needs in respect of health and welfare are to be met.	The inspector can confirm that the patients care plan is established with full inclusion of the patient.	Compliant
6	19(2) schedule 4(12) (b) & (c)	It is required that incidents of pressure ulcers, grade 2 and above, must be reported to RQIA in accordance with best practice guidelines	The inspection can confirm that reportable events are appropriately managed in line with Regulations.	Compliant

7	19(1)(a), schedule 3, 2(k)	The registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence the care delivered. Repositioning charts must contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning.	The inspector examined the nursing care records of four patients/residents and can confirm that daily progress records were well maintained and reflective of the care delivered. Repositioning charts were maintained and completed within the appropriate time frames.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	16.1	It is recommended that further training is provided for registered nurses in the regional procedure for the protection of vulnerable adults. The training must be reflective of their role and responsibility as the nurse in charge of the home.	The inspector can confirm that safeguarding of vulnerable adults training has been provided to staff as required. Staff were able to respond appropriately to the inspector's questioning on protection issues. The return of questionnaires from staff also confirmed that this training had been delivered.	Compliant
2	10.7	It is recommended that the use of alarm mats is discussed with the patient, where appropriate, and if the patient is unable to give their consent then consultation with relatives and healthcare professionals, if required, in regard to best interest decisions for the patient, should be undertaken and records maintained of the outcome of these discussions.	The inspector can confirm that alarm mats are appropriately identified as restraint and documentation is maintained to support this intervention.	Compliant
3	5.1	It is recommended that at the time of each patient's admission to the home, a nurse carries out and records an initial risk assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs.	The inspector can confirm that appropriate risk assessments are maintained at the time of the patients/residents admission to the home. The risk assessments are used to inform the care planning process.	Compliant

4	5.3	It is recommended that care plans are updated to reflect recommendations made by visiting healthcare professionals.	The inspector was unable to validate full compliance with this recommendation. This is discussed in the management of nursing care records detailed below and is raised as a requirement as a consequence of the inspection.	Moving towards compliance
5	5.3	It is recommended that care plans include the frequency with which dressing require to be renewed.	The inspector was unable to validate full compliance with this recommendation. This is discussed in the management of nursing care records detailed below and is raised as a requirement as a consequence of the inspection.	Moving towards compliance

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

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

Since the previous inspection in November 2013, RQIA have been notified by the home of ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues. The Northern Health and Social Care Trust (NHSCT) safeguarding team have been appropriately involved in the management of SOVA issues under the regional adult protection policy/procedures.

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

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 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'/residents' care records evidenced that bladder and bowel continence assessments were undertaken for all patients. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients'/residents' care plans on continence care. There was evidence in all four patients/residents care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. Review of four patient's/resident's care records and discussion with patients/residents 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 • urinary catheter care The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not applicable	Not applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the registered manager also revealed that all the registered nurses in the home were deemed competent in urinary catheterisation and the management of stoma appliances.	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/residents with dignity and respect. Good relationships were evident between patients/residents and staff.

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

11.2 Complaints

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

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

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

11.3 Patient Finance Questionnaire

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

11.4 NMC Declaration

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

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

11.5 Patients/Residents and Relatives Comments

During the inspection the inspector spoke with 12.patients/residents individually and with the majority of others in smaller groups.

Patients/residents spoken with and the questionnaire responses confirmed that patients/residents were treated with dignity and respect, that staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home.
No concerns were raised by patients/residents throughout the inspection.

A number of comments were received by the inspector. Some of these are detailed below;

"I am very happy here"
"I would of course prefer to be at home but I believe this is the next best thing to being home"
"The food is good and There is always choice"
"The chef is great and visits me every day to make sure everything is good"
"I am able to pass my day very well"
"The staff are very good and will always give me the help I need"

"My friend is very well cared for in the home. I have no concerns regarding her care"
"My mother is very well cared for in Ravenhill. I am always contacted should she become ill"

11.6 Questionnaire Findings/Staff Comments

During the inspection the inspector spoke with 10 staff. The inspector was able to speak to a number of these staff individually and in private. Ten staff completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

Some care staff raised concerns regarding the number of staff available to support patients/residents care needs between 5pm and 8pm. On analysis of staff duty rosters the inspector can confirm that there was sufficient staff available over this period.

The inspector discussed the management of the evening meal with the registered manager, care and catering staff. It was confirmed that at times the evening meal service can commence from 4.40 – 4.45 pm. This early commencement leaves the care staff with insufficient time to have all patients/residents prepared for their meal and places and unnecessary rush to meal preparation. It was agreed at the time of inspection that the evening meal would not be served before 5pm.

Some comments recorded on staff questionnaires are detailed below;

"I feel that the residents at the home are offered a range of activities like games and facials, day trips and parties. Care Assistants here are very caring and friendly towards the residents and would go out of their way to help them"

"I feel that Ravenhill cares for residents and staff and relatives. The home manager Mrs Kim is always available and willing to listen"

"I think that this is one of many nursing homes that do care for their residents and their needs"

"I have worked here for 11 years and feel as though the home does a very good job to satisfy all the needs and daily requirements of the residents".

11.7 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a high standard of hygiene.

11.8 Nursing care records

The inspector sought to validate compliance with two recommendations raised during the November 2013 QIP.

The wound care records of one identified patient failed to identify the frequency of dressing renewal appropriately. The same wound care records also failed to record a care plan which illustrated the directions of the Tissue Viability Nurse of the NHSCT.

The inspector also discussed the advantages of using a photographic record of wound healing.

A requirement is raised.

11.9 Learning outcomes from analysis of significant event report by NHSCT.

Following a patient accident during which a significant injury was sustained, the Northern Health and Social Care Trust undertook an event audit. This audit considered the circumstances surrounding the event and determined what learning, if any, should be undertaken by the home. The findings of the audit were shared with RQIA and the inspector sought to validate that the learnings identified had been actioned within the home.

A number of important actions were identified by the NHSCT as being required following any patient/resident fall in the home. These included;

- Any patient / resident who fall are fully examined where they have fallen to determine injuries sustained. The records of this examination and the findings must be recorded in the patients/residents nursing care records
- Patients/residents who have an unwitnessed fall or a head injury will have head injury observations carried out and recorded
- Incidents of falls and agitation for patients/residents to be documented and analysed for patterns to identify potential risks and reduce the number of falls to a minimum level
- In the days following a patient/resident fall staff will have an increased awareness of the potential for unidentified injuries. Any changes or exacerbation of the patient's/resident's presentation must be investigated and the patient/resident examined to ascertain cause
- Accurate and full recording and communication of all symptoms and behaviours will be completed to censure that all staff are aware of the patients/residents full ongoing presentation.

Whilst a number of these actions have already been addressed the inspector was unable to be provided with a comprehensive policy and procedure to be followed following a patient/resident fall.
A requirement is raised that the registered manager develops a post fall procedure and forward a copy of this to the inspector with the return of the quality improvement plan. The updated procedure must include all the elements detailed above.

The registered manager must also ensure that all staff are trained and familiar with the procedures to be followed.

A requirement is raised.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Christine Kim registered manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
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
Criteron 5.1 Prior to admission to the home the Nurse Manager carries out a pre admission assessment and the information gathered from the patient and their representative, along with detailed care plans and risk assessments from the multidisciplinary hospital team or the placing care management trust staff is collated to form a plan of care. This is detailed on the homes computerised record system Caresys based on the 12 activities of living as listed in the Roper,Tierney, Logue model of nursing. Criteron 8.1 On admission a validated NHSCT Community Nutritional Assessment tool is used to ascertain the nutritional needs and risks for each patient Criteron 11.1 A validated pressure risk assessment is completed on admission or prior to where possible ,which takes into consideration skin integrity, nutrition,pain, mobility and continence. This is used to identify risks and issues of concern to be addressed in the patients care plan	Substantially 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
Criteron 5.3 On admission to the home each new patient is allocated to a named nurse who has responsibility for planning and maintaining a care plan which addresses the individual needs of the patient. This is agreed in conjunction with the patient, their representatve and the multidisciplinary care team (OT, physio, dietitian, GP etc.). Criterion 11.2 There are referral arrangements in place for obtaining support and advice from other health professionals. The home has a very good working relationship with the local trust tissue viability specialist nurse who works closely with our staff in assessing and managing patients wih pressure ulcers. Criteron 11.3 With advice from the tissue viability specialist nurse any patient who is assessed at risk of developing pressure ulcers has an individual plan of care plan in place which directs prevention methods and treatment if required Criteron 11.8 The home has a refferal system in place to obtain expert advice and guidance on treatment and care of patients with lower limb or foot ulceration Criteron 8.3 There are referral arrangements in place with the dietitian from the local trust to obtain advice and guidance in drawing up individual nutritional care plans and this along with advice from the speech and language team is used to develop the care plan which is then adhered to.	Substantially 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**
Criteron 5.4 Daily reassessment of patients is carred out as an ongoing process and any changes recorded. All risk assessments and care needs are reviewed and updated at least monthly.	Substantially compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Criteron 5.5 The home has access to research evidence and guidelines as defined by professional bodies such as NMC, NISCC, RCN and this along with standards set by RQIA, DHSSPS etc is used to support all nursing interventions, activities and procedures Criteron 11.4 The home uses a validated wound grading tool as drafted by the EPUAP for patients who have skin damage and this along with advice from the tissue viability nurse specialist, and information contained in the HNSSB wound management manual is used to implement an appropriate treatment plan. Criteron 8.4 Up to date nutritional guidelines are available to staff for refferal on a daily basis as required	Substantially 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**
Criteron 5.6 Contemporaneous nursing records of all nursing interventions, procedures and activities are maintained in accordance with NMC guidelines including outcomes for patients Criteron 12.11 Detailed records of meals provided and chosed by patients are maintained so that the diet of individual patients can be assessed as satisfactory and if not appropriate action can be taken Criteron 12.12 Where there is concern regarding a patients dietary or fluid intake a record is kept of all food and fluids consumed.This is monitored by the nurses and where necessary a referral is made to the appropriate health professional and a record of the referral and subsequent assessment and advice is kept and discussed with the patient or their representative	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**
Criterion 5.7 The outcome of care delivered is monitored by the nurses on a daily basis and recorded. There are also reviews of care at agreed intervals with the patient and their representatives as deemed necessary and any outcomes from these reviews are recorded,and actioned	Substantially compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Criteron 5.8 Patients along with their representatives are invited and encouraged to take part in formal review meetings arranged ny the care manager from the local trust to review their care and do attend where possible. Criteron 5.9 Minutes of the review meetings are kept and a copy circulated to the home and the patients representative. The outcomes are agreed and any recommendations actioned with appropriate changes made to the care plans. Patients and their representatives are kept informed of progress toward agreed goals	Substantially 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**
Criterion12.1 On admission the patients dietary needs are assessed and their dietary preferences ascertained in discussion with the patient and their representatives. A menu is arranged and reviewed every 6 months in consultation with the local trust dietitian to provide nutritious, varied meals and the patients are offered choices daily from the menu. Criteron 12.3 The menu offers choice for all meals and if the patient would prefer something which is not on the menu they will be accomodated. Choices are also availabe to patients on modified or specific therapeutic diets	Substantially 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
Criterion 8.6 Nursing staff have up to date knowledge and skills and have attended recent training on management of patients with dysphagia. A clear record of recommendations from the speech and language team is kept, made clear to all staff and adhered to. Criteron 12.5 Meals are provided at conventional times which can be flexible to meet the needs of individual patients if required. Snacks are available between meals at set times or on request. Fresh juice and water is availabe in all patients rooms at all times. Criterion 12.10 All staff are made aware of recommendations from the speech and language team and individual dietary needs of all patients. The dining room is well staffed at all meal times and staff aware and trained in management of patients at risk of choking. Patients are assisted as required and adapted utensils available as needed. Criterion 11.7 All nursing staff have recently attended training on wound management and pressure ulcer prevention and management and have the necessary skills and knowledge to carry out wound care and use dressings and wound care products appropriately	Substantially compliant

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

Appendix 2

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

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

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

References

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

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

Quality Improvement Plan

Unannounced Care Inspection

Ravenhill

20 November 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Christin Kim 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.	16(1)	The registered manager must ensure that ; • the nursing care records for the identified patient's wound care are appropriately updated and reflective of the directions of the Tissue Viability Nurse (TVN). • a review the management of wound care records is undertaken. This review should then clarify what records must be maintained in either paper or electronic format. • consider the use of photographs to record wound healing. **Ref section 9 & 11.8**	One	Wound care records for the identified patient have been reviewed and updated as directed to reflect the direction of the Tissue Viability nurse The management of wound care records in general has been reviewed and an appropriate recording sheet to be maintained for all wound care records has been identified . The use of photgraphic recording of wounds to indicate wound progress and healing has been discussed with nursing staff and will be used.	Immediate and ongoing

2.	20(1)(c)(i)	The registered manager must ensure that a post fall procedure be developed. This procedure must capture all of the areas identified by the findings of the NHSCT audit. The registered manager must ensure that all staff are fully aware of the procedures to be followed post fall. **A copy of the post fall procedure should be forwarded to the inspector with the return of the QIP.** **Ref section 11.9**	One	A post fall procedure has been completed as directed and will be returned with the QIP. All nursing staff have read and signed a copy of the document and a copy has been issued for care staff to read and be aware of.	By 20 December 2014

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	Christine Kim
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Trevor Gage

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	Linda Thompson	29/12/14
Further information requested from provider			