Unannounced Care Inspection

Name of Establishment:	**The Cottage**
RQIA Number:	**1399**
Date of Inspection:	**4 February 2015**
Inspector's Name:	**Aveen Donnelly and Sharon Loane**
Inspection ID:	**18657**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 General Information

Name of Establishment:	The Cottage Nursing Home
Address:	25 Lodge Park, Coleraine, BT52 1UN
Telephone Number:	0287034 4280
Email Address:	gemma@conwaygroup.co.uk
Registered Organisation/ Registered Provider:	Conway Group Healthcare Mr Jarlath Conway
Registered Manager:	Miss Kathleen Margaret Holmes
Person in Charge of the Home at the Time of Inspection:	Sister Paula Melvil
Categories of Care:	NH-I, NH-PH, NH-PH(E), NH-TI, NH-DE
Number of Registered Places:	67
Number of Patients Accommodated on Day of Inspection:	64
Scale of Charges (per week):	£596 - £631
Date and Type of Previous Inspection:	2 December 2013 Pre–Registration Inspection
Date and Time of Inspection:	4 February 2015 10:00 – 17:15
Name of Inspector:	Aveen Donnelly and Sharon Loane

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year are required.

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- discussion with the registered provider
- 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 regulation 29 visits
- 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 inspectors spoke with:

Patients	6
Staff	6
Relatives	0
Visiting Professionals	0

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

Issued To	Number Issued	Number Returned
Patients	7	4
Relatives/Representatives	6	2
Staff	10	6

6.0 Inspection Focus

RQIA undertook this inspection following a review of issues identified from information that was shared with RQIA. 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.

On this occasion an inspection of the home was undertaken.

Concerns identified were as follows:

- Wound dressings were not being changed.
- Patients were sitting in wheelchairs for long periods.

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible person/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report. However, due to workload pressures and contingency measures within the Regulation Directorate, the themes/standards within the self-assessment were not inspected on this occasion.

In addition, this inspection also sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard 19 – Continence Management and to assess progress with the issues raised during and since the previous inspection.

Standard 19 - Continence Management - Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

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

Guidance - Compliance Statements		
Compliance Statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report.
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report.
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report.
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report.
4 - Substantially compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report.
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

The Cottage is a purpose built, single story building, located in a quiet area on the periphery of Coleraine town. The home is bright and spacious. Accommodation for patients is provided on both floors of the home. Access to the first floor is via a passenger lift and stairs.

Communal lounge and dining areas are provided throughout the home. Catering and laundry services are located on the ground floor. A number of communal sanitary facilities are available throughout the home.

Access to the home is via a long driveway. There are ample car parking facilities to the front and a landscaped garden to the rear of the home.

The home had been originally registered to accommodate 41 patients requiring nursing care. In 2013 the home was extended and extensively developed. The Cottage Care Home now has a self-contained unit which specialises in dementia care and has been specifically designed to enhance the quality of life for patients with dementia.

The home is registered to accommodate 67 patients requiring nursing care under the following categories of care:

<u>Nursing care</u>

I	Old age not falling into any other category
PH	Physical disablement under 65 years of age
PH(E)	Physical disablement over 65 years of age
TI	Terminal illness for a maximum of three patients
DE	Dementia (maximum of 14 patients accommodated in the dementia unit)

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) was appropriately displayed in the home. Ms Kathy Holmes is the registered manager for the home.

8.0 Executive Summary

This summary provides an overview of the care practices examined during an unannounced care inspection. The unannounced inspection was undertaken by Aveen Donnelly and Sharon Loane on 4 February 2014, from 10:00 to 17:15. The inspectors were welcomed into the home by Gemma Hayes, the home administrator. Ms Kathy Holmes, registered manager and Ms Therese Conway, Director of Conway Group Healthcare, joined the inspection later and both received verbal feedback at the conclusion of the inspection.

The focus of the inspection was the DHSSPS Nursing Homes Minimum Standard 19 – Continence Management. The inspection also sought to assess progress with the issues raised during and since the previous inspection and on issues raised from information that had been shared with RQIA. This information raised concerns in relation to patients sitting in wheelchairs for long periods and wound dressings not being changed.

As a result of the previous inspection conducted on 24 March 2014, two requirements and two recommendations were made. These were reviewed during this inspection. Both requirements had been fully complied with. The recommendation in relation to the management of fluid intake has not been addressed and a requirement has been made in this regard. The recommendation in relation to the dating and signing of trust documentation has been stated for the second time. Details can be viewed in the section immediately following this summary.

During the course of the inspection, the inspectors met with patients and staff. Care practices were observed, a selection of care records were examined and a general inspection of the nursing home environment was undertaken. Patients were well presented and appeared comfortable in their surroundings. Staff were observed interacting positively with patients. The home was presented to a high standard of décor and all areas were maintained to a high standard of hygiene. The patients and staff spoken with commented positively on the care and services provided. However, two questionnaires were submitted to RQIA after the inspection, one of which raised concerns with regards to delays in patients having to wait a long time to have their incontinence needs met. Sections 11.4 and 11.5 provide further detail about patients' and staff views.

On the day of inspection, the inspectors were informed of two ongoing safeguarding of vulnerable adults investigations that had not been notified to RQIA. A requirement has been made to address this.

Care practices were deemed to be substantially compliant with standard 19: continence management. Practices observed and the care records supported that patients' continence needs had been met with respect and dignity. A recommendation has been made with regards to the need for continence assessments and care plans to be reviewed and regularly updated. A recommendation has also been made that the Bristol Stool Guidance is referenced for recording bowel function in care plans and progress notes. The registered manager confirmed that training in catheterisation has been planned for registered nurses. However, a recommendation has been made to ensure that this is addressed.

From observation of care practices, inspectors were able to substantiate the concerns raised with RQIA regarding patients sitting for long periods in wheelchairs and also noted that several patients had their lap belts secured. Three requirements and a recommendation have been made to address these matters.

There was evidence that prescribed creams and thickening agents were being used for patients, other than for whom they were prescribed. A requirement has been made to address this.

A review of the care records confirmed that repositioning records were not maintained to a satisfactory standard. Significant gaps of up to 7.5 hours were identified and this occurred frequently between 18:00 and 23:00. A review of care records also revealed that wound assessments and care plans had not been updated and there was one wound assessment that had not been completed in 27 days. The information that was shared with RQIA prior to the inspection, raised concerns that wound dressings were not being changed. The inspectors substantiated this element of the complaint. A review of progress notes identified that there were significant gaps in the recording of changes to wound dressings. A requirement and a recommendation have been made to address this.

A review of the complaints records identified that the outcomes of complaints were not consistently recorded and a recommendation has been made to address this.

As a result of this inspection, seven requirements and seven recommendations have been made; one recommendation has been stated for the second time. Details can be found in the main body of the report and attached quality improvement plan (QIP). To enable the requirements to commence from the date of inspection, urgent action information was issued to the home manager on conclusion of the inspection, with regards to the management of wounds and restraints.

The inspectors would like to thank the patients, registered manager, registered nurses and staff for their assistance and co-operation throughout the inspection process. The inspectors would also like to thank the patients, relatives and staff who completed questionnaires.

9.0 Follow-up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	14(2)(c)	It is required that at the time of each patient's admission to the home, the following information should be completed on the day of admission to the home: • a validated nursing assessment such as Roper, Logan and Tierney • a validated bedrail assessment • a validated pressure risk assessment such as Braden Pressure Ulcer risk • a validated nutritional risk assessment such as MUST • a validated falls risk assessment • a validated safe moving and handling assessment • an assessment of the patient's skin integrity or body map	The care records of a recently admitted patient confirmed that all outlined assessments were completed. This requirement has been addressed.	Compliant

		assessment record. In addition a pain assessment should be undertaken for any patient receiving wound care treatment.		
2	16(1)	Nursing care plans should evidence that there has been consultation with the patient or patient's representative as to how the patient's needs in respect of his/her health and welfare are to be met.	The inspection confirmed that patients' and or their representatives were consulted with regard to care plans. This requirement has been addressed.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken – As Confirmed During This Inspection	Inspector's Validation of Compliance
1	5.1	Any documents received from the referring Healthcare Trust should be dated and signed when received.	A review of the care records confirmed that this had not been completed consistently. This recommendation has not been addressed and has been stated for the second time.	Moving towards compliance
2	5.3	It is recommended that where a nursing assessment is made to monitor a patient's daily fluid intake, then the patient's daily (24hour) fluid intake should be recorded in their daily progress record in order to evidence that this area of care is being properly monitored and validated by the registered nurse.	There were a number of patients in bed on the day of inspection and staff advised that this was either due to patient preference or to individual patients being unwell. Staff advised that food and fluid intake recording was carried out for patients, who were unwell. The chart for one patient, who had been nursed in bed all day, could not be located and was unavailable at the end of inspection. A review of the progress notes identified that there were inconsistencies in the recording of fluid intakes. In one week period, there was no intake recorded for 4 days. Fluid targets were not achieved and there was no evidence available to indicate that relevant action had been taken. This recommendation has not been addressed and a requirement has been stated.	Not Compliant

9.1 Follow-up on any Issues/Concerns Raised with RQIA since the Previous Inspection such as Complaints or Safeguarding investigations.

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home. Prior to the inspection, information had been shared with RQIA, with regards to care practices and the management of wounds. These concerns were followed up during this inspection.

On the day of inspection, the inspectors were informed of two ongoing investigations that had not been notified to RQIA. A requirement has been made to address this. The NHSCT safeguarding team are managing the SOVA issues under the regional adult protection policy/procedures.

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:	
A review of care records confirmed that bladder and bowel continence assessments were completed and the assessments identified the type of pad required for day and night use. The assessments were not updated consistently and the outcomes were not consistently incorporated into the patients' care plans. A recommendation has been made to address this. Care plans on constipation did not indicate normal bowel pattern and did not reference the Bristol Stool Chart. A review of progress notes identified that entries regarding bowel movements were made when the bowel movement was type 6 or 7. A recommendation has been made to address this. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Patients were referred to their GPs as appropriate. There were also significant gaps identified in the progress notes, where bowel function had not been recorded. This has been incorporated into a requirement in relation to records keeping. Discussion with staff and observation during the inspection confirmed that there were adequate stocks of continence products available.	Moving towards compliance

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**Compliance Level**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place: • continence management/incontinence management • stoma care • catheter care Continence care guidelines were available to staff. 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 examined	
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 a review of training records confirmed that not all staff were trained in continence care. Competency assessments were not completed. However, continence care was included in the staff induction process and staff spoken with, were knowledgeable regarding continence care. Examples of good practice were provided by staff in regards to the important aspects of continence care. A review of raining records identified that not all registered nurses have completed training in catheterisation/ stoma care. There was one nurse who had been trained in male catheterisation. A review of the regulation 29 report conducted on 4 December 2014, identified that concerns had been raised with regards to a patient who had not being re-catheterised due to staff capability and training. The report stated the home manager had completed an action plan to address this; however, the registered manager confirmed that this had not been completed. The registered manager confirmed that training has been scheduled for the incoming weeks. A recommendation has to ensure that training needs are addressed.	Substantially compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

Care practices were observed throughout the inspection. Staff were observed treating the patients with dignity and respect and responded to patients' requests promptly. Good relationships were evident between patients and staff. Patients were well presented with their clothing suitable for the season. The demeanour of patients indicated that they were relaxed in their surroundings.

Two unsupervised lounges were observed. Information shared with RQIA prior to the inspection, raised concerns that patients were sitting in wheelchairs for long periods. The inspectors substantiated this element of the complaint. The majority of patients were seated in wheelchairs in two separate lounges during the hours 10.00 – 14.00. Eight out of 11 patients seated in wheelchairs, had their seat belts fastened. During the serving of the mid-day meal,15 out of 18 patients were observed to be sitting in wheelchairs. A requirement has been made to address the provision of supervision and the management of seating arrangements. A review of the Regulation 29 visit reports did not identify issues relating to restraint or seating arrangements. A recommendation has also been made to address this.

Discussion with the registered manager confirmed that training on restrictive practices had been included in SOVA training. A requirement has been made to ensure that registered nurses have undertaken training in restraint/restrictive practice and that this is fully embedded into practice. A requirement has also been made to ensure that there is an effective system in place to audit restrictive practices.

One patient was observed displaying anxious behaviour which had resulted in the lap belt becoming positioned over their shoulder. The belt was examined and was very loose. The registered nurse advised the inspectors that due to the patient's restlessness, a wheelchair is used to enable staff to take the patient along with them. A review of the care records did not identify behavioural issues, the use of the lap belt and wheelchair. A requirement has been made in relation to the use of restraints. Discussions with the registered manager confirmed that the identified patient would be reassessed to ensure that she is placed in the appropriate category of care.

A patient receiving oxygen therapy was observed to have removed the nasal speculum on two separate occasions. This was immediately rectified when prompted by the inspectors. This issue has been incorporated into the requirement about seating provision and supervision referred to above.

Inspection revealed evidence of the communal use of toiletries. There was evidence that prescribed creams and thickening agents were being used for patients, other than for whom they were prescribed. The prescription labels had been removed from some containers and some were observed in different bedrooms. A requirement has been made to address this.

Clinical waste bins were identified in the ensuite toilet area in shared rooms. The registered nurse stated that this practice was to manage infectious waste, such as MRSA. The patients' wardrobes were cluttered. This was discussed with the registered manager who agreed to address this.

11.2 Care Records

Four care records were reviewed and identified that there were inconsistencies in the completion of repositioning records. The recommended repositioning frequency on the repositioning records was different from the frequency identified in the care plans and the progress notes. The repositioning records acknowledged comments on skin condition.. However, there were gaps in recording up to 7.5 hours. This was noted to occur most frequently between 18:00 and 23:00. A requirement has been made to address this.

A review of two care records identified that there were inconsistencies in the completion of wound assessment and care plans. One wound assessment examined had not been completed in 27 days. A wound care plan was not updated when the treatment regime had changed. Information shared with RQIA prior to the inspection shared concerns that wound dressings were not being changed. This element of the complaint was substantiated. A review of the progress notes identified 7 - 12 day gaps in changing wound dressings. A requirement in relation to record keeping and a recommendation in relation to wounds management has been made. A review of the pressure ulcer audit confirmed that they were consistently conducted. However, the audits did not identify the effectiveness of the treatment, assessments, care plans, repositioning records and compliance under regulation 30. The issues were discussed with the registered manager who confirmed that stage two wounds had not been notified to RQIA. This matter has been incorporated into a requirement made regarding regulation 30 (see section 9.1)

11.3 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. Prior to the inspection, information was shared with RQIA, in relation to care practices and wound management. These elements were examined during the course of this care inspection.

A review of the complaints records did not identify that complaints were dealt with in accordance with legislative requirements. The management of six complaints received in the preceding six months were reviewed. Three of these complaints related to delays in patients' toileting needs being met and one related to toileting practice. The complaints outcome had not been consistently documented. A recommendation has been made to address this issue.

11.4 Patients' Comments

Patients spoken with and questionnaire responses confirmed the following: patients were treated with dignity and respect; staff were polite and respectful, they could call for help if required, their needs were met in a timely manner; the food was good and plentiful and that they were happy living in the home. There were a number of patients who were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients' comments were as follows:

- "Very good. I am well cared for"
- "Staff are very good"
- "Don't need much help but it is there if I need it"

- “My daughter would not have placed me here if it wasn’t good”
- “Sometimes have to wait but that is understandable as other people need help”
- “Food is good. I get too much”
- “I am provided with total privacy”
- “Family were given permission to personalise my room furniture, notice board, lamps etc. and that’s very important to me as it makes it more homely”
- Food is good but I don’t eat much
- “Everyone very kind and helpful”
- “The staff here are A1”

11.5 Questionnaire Findings/Staff Comments

During the inspection the inspector spoke with 6 staff. The inspectors were able to speak to a number of these staff individually and in private. Six staff completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training and were very satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on their needs and wishes. All staff spoken with regarded care provision in the home to be very satisfactory. Staff spoken with were knowledgeable in continence care and provided examples of good practice in protecting patient privacy and dignity for patients with dementia.

Examples of staff comments were as follows:

- “I am very happy working in the home”
- “The ethos of the home is that we are a family, caring for each other”
- “Patients are treated as I would expect a member of my family to be treated”
- “I would be very happy if any of my family had to live here”
- “The care given is first class. Management is also caring of both staff and clients”
- “The staff are very well trained, kind and careful with the patients”
- “This is a good home we work well as a team.”
- “The patients and residents are well cared for”

There were no relatives spoken with on the day of inspection. However two questionnaires from relatives were submitted to RQIA after the inspection, one of which raised concerns with regards to delays in patients having to wait a long time to have their incontinence needs met. Refer also to inspector’s comments under 11.3 above.

11.6 Environment

The inspectors 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 presented to a high standard of décor and all areas were maintained to a high standard of hygiene.

12.0 Quality Improvement Plan

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

Aveen Donnelly
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

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**
All new admissions are pre-assessed by Nurse Manger, using a validated assessment tool and information from the care manager, transfer notes and the patient's family. Patients' holistic assessment of their needs is completed within 11 days which includes preadmission assessment, initial risk assessments and care management assessments. Risk assessments are completed; these include: Bedrail, Nutrition & MUST, Moving and Handling, Falls, Continence, Body Mapping, Pressure Ulcer, Oral Hygiene, Dependency and Pain.	Compliant

<table>
<tr><th colspan="2">Section B</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>A Named Nurse system is in operation in the home. Each Named Nurse is responsible for planning and evaluating resident care. Each named nurses is responsible for 5-6 identified Patients. The patients' care plans are completed and clearly state the resident's capabilities / needs, with emphasis on ability and what level of care is required. Patients are referred to other health professionals if the need arises, for example dietician, SALT, Physiotherapist,</td><td>Compliant</td></tr>
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TVN, and their advice is documented and acted on. All aspects of care are discussed with the patient and/or relative, care management and documented.	

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<tr><th colspan="2">Section C</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>Re-assessment is ongoing, and risk assessments are reviewed monthly or whenever there is a change to the resident’s condition. Care Plans are discussed with resident and / or relative on admission, and at least three-monthly. Reviews are all recorded, dated and signed.</td><td>Compliant</td></tr>
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<tr><th colspan="2">Section D</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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)</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>Care plans are kept in accordance with DHSSPS, NMC and RQIA Guidelines. These include patient-centred interventions and required evaluations of treatment. A validated Pressure Ulcer Tool is used to screen all patients; those who have skin damage have a care plan in place, which includes ongoing wound assessment, which is updated when dressings are renewed. Advice is sought from TVN and recorded.</td><td>Compliant</td></tr>
</table>

<table>
<tr><th colspan="2">Section E</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>Contemporaneous records are held in individual care plans, which include a daily statement of all nursing interventions, activities and procedures carried out and include outcomes for patients. A record of all patients’ diet and their choice is available for inspection. This is completed in sufficient detail to enable any person inspecting to clarify that each patient’s diet is satisfactory.

Patients’ refusal to eat meals is documented in nutrition charts and daily notes. Care plans are updated and food and fluid charts recorded. If it continues, referrals are made to GP, Dietician and SALT. Records are also kept of any patient who is eating excessively</td><td>Compliant</td></tr>
</table>

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care delivered is monitored and recorded in a daily statement in patient's care plan. All care plans are reviewed at least monthly and three-monthly with relatives. Multidisciplinary reviews are held annually.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care reviews are carried out initially at eight weeks, and then yearly, where patients are encouraged to participate and to contribute to all aspects of their care. Care reviews are also arranged in response to changing needs, expressions of dissatisfaction with care, at the request of Nurse Manager, patient or relative. The named nurse will prepare for the review and attend meeting if possible. On completion of review, care management make copies available to the patient's representative and The Cottage, which are retained in care plan. Changes to patient's care or wellbeing, requiring action following review, are documented in the care plan and patient and representative notified.	Compliant

<table>
<tr><th colspan="2">Section H</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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)</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>Patients are provided with a nutritious and varied diet which meets their needs and preferences, as well as relating to current Nutritional Guidelines. All likes/dislikes are recorded on admission and displayed in the kitchen. All staff are made aware of patients with specific dietary requirements, such as modified, fortified or diabetic diets, and needs are catered for. A nutritional assessment and MUST are carried out on all patients. All patients are offered a choice of meal at breakfast, lunch and dinner, two choices at lunch and three at dinner, and alternative is offered if patient does not like any of these options.</td><td>Compliant</td></tr>
</table>

<table>
<tr><th colspan="2">Section I</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>All staff are encouraged to attend study days on nutrition and swallowing difficulties. When a patient is reviewed by SALT, instructions are adhered to and made available to all staff. Hot and cold drinks are offered between meals, and fresh drinking water and juice is always available. Jugs of water / cordial are provided to patients in bedrooms, and water machine is also available. Matters concerning patients eating or drinking is detailed in each care plan, and relayed to kitchen and nursing staff. All nursing staff on duty are available at lunch and dinner time to facilitate with assistance. Each morning, a member of staff remains in the dining room to assist with patients who require support. Protective clothing, aids such as cutlery, non-slip mats, plate guards and cups are available where necessary. Staff have had first aid training, the management of risks and appropriate action to be taken in the event of a resident</td><td>Compliant</td></tr>
</table>

choking.	

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 necessary to carry out the task No general conversation

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

References

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

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

Quality Improvement Plan

Secondary Unannounced Care Inspection

The Cottage

4 February 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the 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	15 (2) (a)&(b)	The registered person must ensure that where a nursing assessment is made to monitor a patient's daily fluid intake, then the patient's daily (24hour) fluid intake should be recorded in their daily progress record in order to evidence that this area of care is being properly monitored and validated by the registered nurse. **Ref 9.0 Follow up on previous issue**	One	The total fluid intake is recorded in the daily progress notes for any resident that requires daily monitoring of their fluid intake. A weekly evaluation of fluid intake is additionally recorded to ensure residents fluid targets are met.	18 April 2015
2	30 (1)(d)(g)	The registered persons must ensure that statutory notifications to RQIA are forwarded for any allegation of misconduct by any person who works in the home. Pressure sores of stage 2 or above must also be notified to RQIA. **Ref 9.1 and 11.2**	One	Statutory notifications are completed and submitted to the RQIA for all adverse events including any alleged misconduct. Grade two pressure ulcers will be reported.	18 April 2015
3	19(1)(a) Schedule 3 (3)(K)	The registered person must ensure that record keeping is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance including: • wound observation charts must be	One	Record keeping is maintained appropriately in accordance with legislative requirements with specific reference to the completion of repositioning charts, wound observation charts, bowel function and	18 April 2015

		completed at the time wounds are being dressed • repositioning records must be fully completed • dressing changes and observations of wound healing must be recorded in the progress notes • Care plans must be updated to reflect changes in wound treatment • Bowel function must be recorded contemporaneously in patients' care records. **Ref 10.0 and 11.2**		related care plans and progress notes. The completion of the above documents is monitored regularly by the Registered Manager.	
4	13 (1)(a)(b)	The registered person must ensure that at all times there is proper provision for seating arrangements in the home and the supervision of patients. Particular attention must focus on: • seating arrangements for patients during mealtimes • supervision of patients receiving oxygen therapy. **Ref 11.1**	One	Arrangements are in place to ensure that appropriate seating is used at all times. Residents in receipt of oxygen therapy are appropriately supervised by staff.	18 April 2015

5	14 (5)&(6)	The registered person must ensure that no patient is subject to restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other patient and there are exceptional circumstances. The registered persons must ensure that there is an effective system in place to review the management of restrictive practice. A record of any evaluation or audit undertaken must be retained and any deficits identified must be fully addressed. **Ref 11.1**	One	Interventions that are viewed as restraint are only used in exceptional circumstances and following consultation and agreement with the family and care manager. An audit has been introduced to review the management of any restrictive practices. Any deficits identified have been fully addressed.	18 April 2015
6	14 (4)	The registered person must ensure that registered nurses have undertaken training in restraint/restrictive practice and that this is fully embedded into practice. **Ref 11.1**	One	Registered Nurses have been updated on the company's policy and procedure on the use of restraint. The RCN Guidelines on “Rights, Risks and Responsibility” have been discussed and shared with staff during supervision sessions.	18 May 2015
7	13 (4)(b)	The registered persons must ensure that prescribed creams and thickening agents are not used for patients for whom they have not been prescribed. **Ref 11.1**	One	All prescribed creams and thickening agents are used only for the residents they are prescribed for. These are monitored on a daily basis	18 April 2015

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.1	Any documents received from the referring Healthcare Trust should be dated and signed when received. **Ref 9.0 Follow up on previous issue**	Two	All documents from the referring Health Care Trust are signed and dated when received. This is regularly monitored by the Registered Manager.	18 April 2015
2	5.6	Bowel function, reflective of the Bristol Stool Chart should be recorded on admission as a baseline measurement and thereafter in the patients' daily progress records. **Ref 10.0**	One	Bristol stool charts have been implemented for all residents which indicate their baseline and regularity. This is then recorded in the daily progress notes following admission.	18 April 2015
3	19.1	Continence assessments should be comprehensive, regularly updated and used to inform the care plans. **Ref 10.0**	One	Continence assessments are comprehensive, regularly updated and used to inform care plans.	18 April 2015
4	19.4	Registered nurses should be provided with training in urinary catheterisation. **Ref 10.0**	One	Two senior nurses have completed training on male catheterisation. Catheterisation training will be arranged for all nurses. Stoma care training has taken place and further training has been arranged.	18 June 2015

5	25.12	The registered person should further develop the template of the Regulation 29 visits to include the monitoring of restraint and seating arrangements for patients. **Ref 11.1**	One	The Regulation 29 visit template has been further developed to include the monitoring of restraint and resident seating arrangements.	18 April 2015
6	11.7	The registered manager should ensure that wound care dressings are applied appropriately and that that wound assessments are carried out and used to inform the care plans. **Ref 11.2**	One	Wound care dressings are applied appropriately and assessments are carried out and used to inform care plans.	18 April 2015
7	17.6, 17.10 & 17.16	The registered manager should establish a process to determine complainant' satisfaction with actions taken. Information should also be provided to complainants with regards to what they can do, if they remain dissatisfied with the outcome that has been provided. **Ref 11.3**	One	A copy of the complaints procedure is included in the Patient's Guide which is issued to Residents and their next of kin. The complaints procedure outlines the action to be taken if dissatisfied with the outcome of a complaint. A copy of the complaints procedure is also displayed on the relatives' notice board. Complainant satisfaction is included as part of the complaints procedure and a record retained of discussions held with complainants.	18 April 2015

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Kathy Holmes
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Therese Conway

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Aveen Donnelly	21/04/2015
Further information requested from provider			