Unannounced Care Inspection

Name of Establishment:	**Kintullagh Care Home**
RQIA Number:	**1426**
Date of Inspection:	**8 January 2015**
Inspector's Name:	**Bridget Dougan**
Inspection ID:	**IN017099**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Kintullagh Care Home
Address:	36 Westbourne Avenue Carniny Road Ballymena BT43 5LW
Telephone Number:	02825654444
Email Address:	manager.kintullagh@kathrynhomes.co.uk
Registered Organisation/ Registered Provider:	Runwood Homes Ltd
Registered Manager:	Mrs Jill O'Neill, acting manager
Person in Charge of the Home at the Time of Inspection:	Mrs Jill O'Neill, acting manager
Categories of Care:	NH-I, NH-PH, NH-LD, RC-I, RC-MP (E), RC-PH(E)
Number of Registered Places:	62
Number of Patients Accommodated on Day of Inspection:	51
Scale of Charges (per week):	£550.00 - Nursing £437.00 - Residential
Date and Type of Previous Inspection:	5 March 2014 / Secondary Unannounced
Date and Time of Inspection:	8 January 2015: 13.30 – 17.30 hours
Name of Inspector:	Bridget Dougan

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: amend as relevant

- Discussion with the acting manager
- Discussion with the director of operations
- Discussion with staff
- Discussion with patients/residents individually and to others in groups
- 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	**20**
Staff	**8**
Relatives	**0**
Visiting Professionals	**0**

Questionnaires were provided 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	**4**	**4**
Relatives/Representatives	**5**	**5**
Staff	**10**	**10**

6.0 Inspection Focus

The inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

STANDARD 19 - CONTINENCE MANAGEMENT

Patients receive individual continence management and support.

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

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

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

7.0 Profile of Service

Kintullagh Care Home is a two storey purpose built facility which occupies a spacious site in a quiet residential area convenient to all the facilities of Ballymena.

Kintullagh was first registered as a Nursing Home on 05 June 1992 and subsequently re-registered to provide both Nursing and Residential accommodation. Following a change of ownership the home was re-registered on 01 September 2006 and following a further change of ownership was re-registered in February 2008.

Accommodation is provided in four double and 51 single bedrooms on both floors, access to the first floor is via a passenger lift and stairs.

Day areas, laundry, catering and sanitary facilities are also provided.

There is car parking facilities at the front of the home, with landscaped gardens to the rear and side.

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

Nursing Care

I	Old age not falling into any other category
PH	Physical disability other than sensory impairment under 65 years
LD	Learning disability

Residential Care

I	Old age not falling into any other category
MP(E)	Mental disorder excluding learning disability or dementia over 65 years

8.0 Executive Summary

The unannounced secondary inspection of Kintullagh Care Home was undertaken by Bridget Dougan on 08 January 2015 between 13.30 – 17.30 hours. The inspection was facilitated by Mrs Jill O'Neill, acting manager who was joined by Mr Emerson Kupfuwa, director of operations for feedback at the conclusion of the inspection. .

During the course of the inspection, the inspector met with patients/residents and staff who commented positively on the care and services provided by the nursing home. One patient/resident expressed some dissatisfaction with the cups/crockery used in the home, while another informed the inspector that the foot plate on her wheel chair had been broken for some time. Questionnaires were completed by patients/residents, relatives and staff and were submitted to RQIA following the inspection. The majority indicated a high level of satisfaction with the services and care provided. Two staff were concerned regarding staffing levels, the privacy afforded to patients/residents and care provided was not always based on need and wishes. The issues raised by patients/resident and staff were discussed with Mr Emerson Kupfuwa, director of operations following the inspection. Mr Kupfuwa agreed to address the issues.

As a result of the previous inspection conducted on 05 March 2014, one requirement and two recommendations were issued. These were reviewed during this inspection and evidence was available to confirm that the requirement and recommendations have been fully complied with.

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

The inspector reviewed a sample of care records. There was evidence that a continence assessment had been completed for all patients/residents. Care plans were in place to meet the individual's assessed needs and comfort and were reviewed regularly. There was evidence that patients/residents and/or their representatives had been involved in the care planning process.

There was evidence that there were adequate stocks of continence products available in the nursing home.

The inspector can confirm that policies and procedures were in place with regard to continence management. However a recommendation has been made that RCN and NICE guidelines on continence care be sourced and made available to staff.

Review of a sample of staff duty rotas for a four week period, discussion with staff and patients/residents indicated that staffing arrangements were in accordance with the RQIA's recommended minimum staffing guidelines for the number of patients/residents accommodated. Accidents/incidents and complaints records were reviewed and found to be maintained appropriately.

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.

The management of continence within the home was of a good standard and one recommendation have been made in respect of the availability of continence guidelines for staff. The inspector's overall assessment of the level of compliance in this area is recorded as 'Substantially Compliant'.

The home's general environment was well maintained and patients/residents were observed to be treated with dignity and respect. A refurbishment programme was underway at the time of the inspection.

Therefore one recommendation has been made following this inspection. This is detailed throughout the report and in the quality improvement plan (QIP).

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

The inspector would also like to thank the patients/residents, 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	20 (1) (a)	The registered person shall, having regard to the size of the nursing home, the statement of purpose and the number and needs of patients – Ensure that at all times suitably qualified, competent and experienced persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients. **Reference: Section 6.2**	Review of a sample of four weeks duty rotas, discussion with the acting manager, staff and patients/residents evidenced that staffing levels were in accordance with RQIA Staffing Guidance for Nursing Homes (2009)	**Compliant**

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	20.2	It is recommended that emergency suction equipment and ambu bag is provided for use on the first floor. **Reference: Section 20.2**	The inspector can confirm that this recommendation has been met.	**Compliant**
2	25.12	It is recommended that progress made on the most recent Quality Improvement Plan is included in all Regulation 29 reports. **Reference: Follow up on previous issues**	The inspector reviewed a sample of Regulation 29 reports and can confirm that this recommendation has been met.	**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 there is considered to be a breach of regulation as stated in the Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

There have been six notifications to RQIA regarding potential safeguarding of vulnerable adults (SOVA) incidents since the previous inspection. The incidents were being managed in accordance with the regional adult protection policy by the safeguarding team within the Northern HSC Trust.

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. Continence care plans were in place for all patients/residents and included the type of continence products to be used. There was evidence in four patients/residents care records that 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 patients/residents' 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/residents 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 • catheter care • stoma care. The inspector recommends that the following guidance documents are sourced and made available to staff: • 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.	Substantially 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	
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 acting manager and review of training records confirmed that all relevant staff were trained and assessed as competent in continence care. Registered nurses received training in male and female catheterisation and had been deemed competent in this area. The inspector was informed that regular audits of the management of incontinence were included in care plan audits and the findings acted upon to enhance standards of care.	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

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/residents requests promptly. The demeanour of patients/residents indicated that they were relaxed in their surroundings.

11.2 Patients/Residents Comments

During the inspection the inspector spoke with 20 patients/residents individually and with the majority of others in smaller groups. Four patients/residents completed questionnaires.

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. One patient/resident expressed some dissatisfaction regarding the cups and cutlery used at meal times, while another patient/ resident informed the inspector that the foot plate on her wheelchair had been broken for some time and it was difficult for her to hold her feet up while being transported in her wheelchair. These issues were discussed with the acting manager and the director of operations at the conclusion of the inspection and assurances were given that they would be addressed. The inspector did not observe any poor moving and handling practice at the time of this inspection.

Some comments received from patients/residents:

- “I’m very fond of in here and I have been here 12 years.”
- “staff are well trained.”
- “I’m happy with the meals.”
- “the quality of care I receive is good”

Five relatives completed questionnaires which were submitted to RQIA following the inspection. The responses received in the returned questionnaires indicated a high level of satisfaction with the services and care provided.

Some comments received from relatives were as follows:

“anything we are concerned about we get to express at the meetings”
“the home is a happy and welcoming place”
“staff ask me about my relatives needs and wishes”
“staff are pleasant and the care is very good”

11.3 Staffing/Staff Comments

Review of a sample of staff duty rotas for four weeks (weeks commencing 7th, 14th, 21st and 28th December 2014) evidenced that the registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients/residents currently in the home.

The inspector met with eight staff during the inspection and ten staff completed questionnaires which were submitted to RQIA following the inspection. Staff informed the inspector that they were provided with a variety of relevant training including mandatory training since the previous inspection. All staff who met with the inspector were very satisfied with the level of care provided to patients/residents. Staff responses in the returned questionnaires indicated that, while the majority of staff were very satisfied with the level of care provided, two members of staff were dissatisfied with staffing levels and one member of staff expressed dissatisfaction with regard to the privacy afforded to patients/residents and care provided was not always based on need and wishes. These issues were discussed with Mr Emerson Kupfuwa, Director of Operations, Runwood Homes following the inspection. Mr Kupfuwa agreed to address the issues identified.

The following are examples of staff comments during the inspection and in questionnaires:

- "staff work well as a team."
- "I would like to have more time to listen and talk to patients."
- "staff have good team building skills and go the extra mile for residents.

11.4 Complaints

Review of the complaints record on the day of inspection confirmed that the complaints were fully investigated and copies of these investigations were held in the home.

11.5 Incidents/Accidents Records

The inspector reviewed a number of randomly selected accident/incident records which were found to be well maintained. Accidents are reviewed on a monthly basis to establish trends.

11.6 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients/residents' bedrooms, bathroom, shower and toilet facilities and communal areas. A refurbishment programme was underway on the first floor at the time of the inspection. The home was comfortable 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 Mrs Jill O'Neill, acting manager and Mr Emerson Kupfuwa, Director of Operations, 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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The Regulation and Quality Improvement Authority
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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**
A care management care plan is received, read and signed for on admission to the home where possible. This plan, together with information gained at the pre assessment, which is completed by the home manager or deputy home manager, supports the initial assessment which is completed by the nurse at the time of the patients admission to the home. Where possible braden risk assessment for predicting pressure sore risk and pain and continence assessments are carried out as part of the pre admission assessment. All available nursing and medical records are reviewed during the	Compliant

pre admission process. Roper,Logan and Tierney is the chosen model implemented within the home. Body map, Braden score and other risk assessments are completed within 24hrs of admission to the home. A holistic assessment ising the Roper, Logan and Tierney model is completed within 24hrs of admission to the home. This assessment is an ongoing process and assessments and care plans are reviewed monthly unless the need of patient changes and reassessment is required sooner. Nutrition(MUST scoring) and weight, braden score, body mapping, continence needs, Abbey pain tool, falls risk assessment, moving and handling and other runwood assessment tools must be completed within 11 days of admission.	

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**
All patients are allocated a named nurse and key worker on admission to the home. This is noted in their care file and in unit notice board. Individualised care plans are discussed,planned and agreed with the patient where possible,the relative and named	Compliant

worker incorporating recommendations from other health care providers.
Care plans are structured to promote independence and rehabilitation as far as the patient is able and advise and support is obtained from the OT/Physio.

There are processes in place for the direct referral of residents to the tissue viabiltiy link nurse and to both the Trust podiatry team and 'fitter feet' (who provide a private podiatry service within the home). Staff are able to recognise the need for referral, are aware of trigger points for referral and contact details are available to all registered nurses. There are good lines of communication in place with the tissue viabiltiy nurse and podiatry teams all of whom provide support, guidance and training as required.

Where a patient is deemed to be at risk of developing pressure ulcers, were there are changes to the resident's skin integrity or if the resident has become at risk due to deterioration in health, the current risk assessment will be evaluated and updated and an individualised care plan will be compiled to include pressure releaving equipment, skin care, repositioning and frequency and suitable diet (including nutritional and fluid monitoring). The care plan will include input from relevant health care professionals.Pain assessment and the relevant analgesia is paramount and this is monitored, reviewed and evaluated and advise sourced if pain persists.

Weight loss is audited weekly by the home manager. Any residents who have lost > 2kg in one week are included in a report, with patient specific actions and outcomes. This report is shared with Head Office.

Patients with a MUST score of 2 or more, a 10% weight loss in 6 months or a 5% weight loss in 3 months are referred to the dietician. BMI, a gradual decline in wellbeing and both past and current medical history is also taken into consideration.
Specific dietician referral froms are posted to the dietician team and in the interim period, prior to assessment via the dietician, staff review a resident's food intake and follow the 'food first' guidelines as per the Nutritional guidelines and menu checklist and the 'Promoting food nutrition strategy' (DHSSPS 2010).
Staff are encouraged to incorporate the multidisciplinary approach in relation to nutritional care and will liaise with a patients Geneal Practitioner as required. The dietician will consider both GP and SALT input when compiling an individualised treatment plan

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**
The care plan evaluated and updated daily on each 12hr shift, or more frequently as a patients needs require. Documentation is done in daily progress notes.	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**
Where possible all nursing interventions are supported by evidenced based policies, procedures and assessment tools Pressure ulcers are classified using the European Pressure Ulcer Advisory Panel tool (EPUAP 2009) and an appropriate risk assessment and care plan will be compiled by the named nurse. Staff are familiar with when to seek the input of the tissue viability nurse or podiatry team and staff are also aware that all grade 2 or above pressure sores should be recorded and reported to both the Trust and the RQIA (via the regulation 30, statutory notification of events procedure). All pressure sores are analysed and reported on a weekly basis by the home manager as part of her weekly operations report. This information is shared with Runwood head office. Staff are familiar with the Malnutrition Universal Screening Tool and Promoting Good Nutrition - Guidance and Resources to support the use of MUST (DHSSPS 2012) and utilise these guidelines to compile individualised care plans.	Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing records are maintanined for all interventions that are carried out in relation to each patient. Care plans are completed following NMC guidelines, recorded clearly and contemporaneous with designation, signature and printed name of staff including date and time of entry. The importance of proving documentary evidence regarding care delivered and outcomes in accordance with NMC guidelines is reinforced to staff . Nursing staff are advised that written records should be documented at the time of the evnt or as soon as possible afterwards. A four week rota for menus is in place and the daily menu is printed, with coloured images of the meals, and displayed in each table in dining rooms. The menu is also available for viewing at both entrances to the home to allow relatives and visitors to see what is being served.	Compliant

A patients weight will influence the individual recording for each. This enables an analysis of both weight gain and weight loss and triggers the referral process to othe professionals. High risk patients have daily nutritional charting supported by fluid balance charts as needed.	

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**
Daily progress notes are recorded for each patient by nursing staff. Care plans are reviewed at least monthly and more frequently as required. Reviews are done by nursing staff with relatives at regular basis, 3monthly, 6 monthly and yearly. Formal care reviews are done yearly by named worker. All reviews include both the patient and relatives where possible.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Representatives are invited to attend care reviews with input sought from key worker, and where appropriate patient would be invited to contribute to this meeting. The results of the care plan discussion would be agreed and a copy of the care review notes will be sent from the care manager to the home. These notes would be filed within the patients care file and a copy is also kept on file in managers office. Manager will sign on receipt of review notes into the home and highlight on notes if any action has been required.	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**
A resource folder with nutritional guidance documents is available and accessible to all staff members. Relevant information is shared with kitchen staff. Menu plans are agreed with input from the catering staff, nursing staff and residents (via residents meetings) and where necessary from residents' families. Likes ,dislikes and medical requirements are discussed and recorded initially at pre-admission assessment and care plans are updated when needs change. Where advice has been sought or referrals have been made to other members of the multidisciplinary team, information and advice given and / or prescribed is shared with all relevant staff and care plans updated. All patients are given two choices at each meal, this includes residents on therapeutic or special diets. Where choices offered are not the meal of choice for a resident this is discussed with the catering team and an alternative offered. Menus (both pictures and words) are displayed in each dining room and staff assist residents in completing the menu request form which is then relayed to the catering team with any special requests noted.	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**
All staff members have training on dysphagia which is updated annually as part of mandatory training. Speech and Language Therapy (SALT) instructions are reflected in the residents' care plans and are recorded at the top of the food/fluid record. Meals are provided at conventional times, in accordance with patient/resident preferences. Fresh drinking water is available at all times.	Substantially compliant

Staff are aware of individual care plans regarding eating and drinking and provide assistance where necessary. Specialist equipment is available for residents, whose independence could be promoted by using particular aids. Training has been offered to registered nurses in wound assessment and wound care management, including learnings on choices of wound care products and dressings. This training has been provided as part of the 'transforming your care' initiative. Wounds of stage two or above are reported on a statutory notification of events form and this information is shared with is the care manager and the Tissue Viability Nurse. Separate direct referral is made, according to the Tissue Viability Nurses Referral Procedures, however, telephone advice is also sought, where guidance is needed. Wound charting is carried out daily and body mapping evidence documented accordingly. All nursing interventions, activities and procedures are supported by research evidence that is held in a 'Wounds' folder in the Administrator's Office. This includes the following documents: CREST Guidelines (1998) Guidelines on the general principles of caring for patients with wounds European Pressure Ulcer Advisory Panel (EPUAP) (2009) Pressure Ulcer Prevention: Quick Reference Guide European Pressure Ulcer Advisory Panel (EPUAP) (2009) Pressure Ulcer Treatment: Quick Reference Guide National Institute for Health and Clinical Excellence (2005) Pressure Ulcers – Prevention and Treatment National Institute for Health and Clinical Excellence (2005) Clinical Practice Guidelines: The Use of Pressure Relieving Devices (beds, mattresses and overlays) for the Prevention of Pressure Ulcers in Primary and Secondary Care National Institute for Health and Clinical Excellence (2005) Pressure Ulcers – The Management of Pressure Ulcers in Primary and Secondary Care Nursing and Midwifery Council (2009) Record Keeping Guidance for Nurses and Midvives SIGN Guidelines (2010) Management of chronic venous leg ulcers	

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

Secondary Unannounced Care Inspection

Kintullagh Care Home

8 January 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 Mrs Jill O'Neill, acting manager and Mr Emerson Kupfuwa, Director of Operations, 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.

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	19.2	The inspector recommends that the following guidance documents are sourced and made available to staff: • RCN continence care guidelines • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence. **Reference: Section 10, Criterion 19.2**	One	Items downloaded and made available to staff by Acting manager Jill O'Neill ,as of 19.03.15, as follows: RCN "Improving Continence care for Patients" 2006 NICE pathway 2014 for "Faecal incontinence overveiw" NICE quality standard 77 2015 "Urinary Incontinence in Women"	Within one week from date of this inspection

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Jill O'Neill
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Logan Logeswaran

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	B. Dougan	17/04/15
Further information requested from provider			