

Unannounced Care Inspection

Name of Establishment: The Model Care Centre

RQIA Number: 1429

Date of Inspection: 11 November 2014

Inspector's Name: Bridget Dougan

Inspection ID: IN017066

1.0 General Information

Name of Establishment:	The Model Care Centre
Address:	1 Portrush Road Ballymoney BT53 6BX
Telephone Number:	028 2766 4502
Email Address:	the.model@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Health Care Ltd Mr Jim McCall
Registered Manager:	Mrs Bernadette Kelly
Person in Charge of the Home at the Time of Inspection:	Charge Nurse Vasco Alves
Categories of Care:	NH: I NH:LD(E) (1 identified person) RC: I RC:PH
Number of Registered Places:	36
Number of Patients Accommodated on Day of Inspection:	30 patients/residents
Date and Type of Previous Inspection:	07 May 2014 Unannounced Primary Inspection
Date and Time of Inspection:	11 November 2014 11.00 – 16.45 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 nurse in charge
- Discussion with the regional manager
- 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 (by the inspector), during the inspection, to patients / residents, their representatives and staff to seek their views regarding the quality of the service.

Issued To	Number Issued	Number Returned
Patients/Residents	0	0
Relatives/Representatives	0	0
Staff	4	4

6.0 Inspection Focus

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.

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

Standard 19 - Continence Management

Patients receive individual continence management and support.

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

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

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

7.0 Profile of Service

The Model Care Centre is part of Four Seasons Healthcare Ltd which operates a number of homes in Northern Ireland. The Model Care Centre is a two-storey building that has been extensively developed and extended to provide accommodation for those needing nursing care or residential social care. There is a condition of registration in place in respect of three specified bedrooms. The three bedrooms can only accommodate patients/residents without mobility problems, as access to the rooms is via a short flight of stairs.

Accommodation is provided in 28 single bedrooms and four double bedrooms on both floors. Access to the first floor is via a passenger lift and stairs. Day areas, laundry, catering and sanitary facilities are provided.

The home is registered to provide nursing (NH) and residential (RC) care for patients/residents in the following categories:

NH - I: old age not falling into any other category
 RC - I: old age not falling into any other category,
 RC-PH & PH (E): physical disablement above and below 65years of age
 RC-LD: learning disability for one named resident.

The RQIA's certificate of registration was appropriately displayed in the entrance hall of the home.

8.0 Executive Summary

The unannounced secondary inspection of The Model Care Centre was undertaken by Bridget Dougan and Sharon Loane on 11 November 2014 between 11.00 – 16.45 hours. The inspection was facilitated by Mr Vasco Alves, nurse in charge, who was available for verbal feedback at the conclusion of the inspection. Feedback was also provided to Mrs Louisa Rea, regional manager, Four Seasons Healthcare.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous care inspection on 7 May 2013.

Analysis of other documentation including the returned QIP from the previous care inspection confirmed that sufficient information had been provided.

During the course of the inspection, the inspectors met with patients/residents and staff, who commented positively on the care and services provided by the nursing home.

The inspectors reviewed a sample of care records. There was evidence that a continence assessment had been completed for all patients/residents. This assessment formed part of a comprehensive and detailed assessment of patient/residents needs from the date of admission and was found to be updated on a regular basis and as required. The assessment of patient/resident needs was evidenced to inform the care planning process. However there was evidence that one patient/resident had not received topical medication as prescribed. A requirement has been made in this regard.

Repositioning records had been maintained for patients/residents assessed as being at risk of developing a pressure ulcer. A recommendation has been made for a description of the condition of the patients/residents skin to be recorded at each change of position.

The inspectors discussed the importance of a robust communication system between registered nurses and care assistants to ensure that outcomes of care are regularly reviewed and care plans meet the individual's assessed needs and comfort. It is recommended that care assistants are provided with a hand-over report for all patients/residents at the beginning of their shift.

From a review of the available evidence, discussion with relevant staff and observation, the inspectors can confirm that the level of compliance with the standard inspected was substantially compliant.

Review of a sample of staff duty rosters evidenced that the 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 home's general environment was comfortable and all areas were maintained to a high standard of hygiene. One requirement has been made for a review of the heating system.

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

Additional areas were also examined including:

- care practices
- patients/residents' views
- staffing and staff views
- complaints
- environment

Details regarding these areas are contained in section 11.0 of the report.

The inspectors reviewed and validated the home's progress regarding the four recommendations made at the previous inspection on 7 May 2013 and confirmed compliance outcomes as follows: All four recommendations had been fully complied with.

As a result of this inspection, two requirements and two recommendations have been made.

Details can be found throughout the report and in the quality improvement plan (QIP).

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

The inspectors would also like to thank the 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
		No requirements were made as a result of this inspection.		

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	25.13	<p>The registered manager should ensure that an action plan is developed and follow up action taken to address any areas for improvement in the annual quality report.</p> <p>This report should be prominently displayed in the home and made available to patients/residents and their representatives.</p> <p>Reference: Section 10: Criterion 25.13</p>	Review of the annual quality report evidenced that this recommendation had been addressed.	Compliant
2	11.7	<p>The registered manager should ensure that all care staff complete training on pressure area care.</p> <p>Reference: Section 10: Criterion 11.7</p>	Review of training records and discussion with the nurse in charge evidenced that this recommendation had been addressed	Compliant

3	30.1	<p>The registered manager should ensure that a review is carried out with regard to the deployment of staff, taking into account the layout of the home and the accessibility of facilities.</p> <p>Reference: Section 11.4</p>	<p>The inspectors were informed that staff are allocated on a daily basis and reviewed in accordance with patients/residents needs.</p>	Compliant
4	25.2	<p>The registered manager must ensure that the nurse call system is maintained in good condition and is fit for purpose</p> <p>Reference: Section 11.4</p>	<p>The inspectors discussed this recommendation with the maintenance person who confirmed that this work had been completed since the previous inspection.</p>	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 no notifications to RQIA regarding potential safeguarding of vulnerable adults (SOVA) incidents since the previous inspection.

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: <p>Review of five patients/residents' care records evidenced that bladder and bowel continence assessments were undertaken for all patients/residents. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients/residents' care plans on continence care.</p> <p>There was evidence in care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate.</p> <p>The promotion of continence, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. While skin care plans were in place, the inspectors observed that repositioning charts for three patients/residents did not provide a description of the condition of the patients/residents skin. A recommendation has been made accordingly.</p> <p>The inspectors observed that one patient/resident who had been prescribed a topical cream twice daily had not received this medication since 7/11/14 (four days prior to the inspection). This was discussed with the nurse in charge and upon further investigation it was evidenced that the medication has been out of stock since 8/11/14. A requirement has been made in accordance with Regulation 13 (4) (b) of The Nursing Homes Regulations (Northern Ireland) 2005.</p> <p>The inspectors discussed the importance of a robust communication system between registered nurses and care assistants to ensure that outcomes of care are regularly reviewed and care plans meet the individual's assessed needs and comfort. It is recommended that care assistants are provided with a hand-over report for all patients/residents at the beginning of their shift.</p>	Moving towards compliance

Review of five patient/residents's care records and discussion with patients/residents evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions.

The care plans reviewed generally 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.

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 inspectors can confirm that the following policies and procedures were in place;

- continence management / incontinence management
- stoma care
- catheter care

The inspectors can also confirm that the following guideline documents were in place:

- RCN continence care guidelines
- NICE guidelines on the management of urinary incontinence
- NICE guidelines on the management of faecal incontinence

Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.

Compliant

STANDARD 19 - CONTINENCE MANAGEMENT
Patients receive individual continence management and support

Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	COMPLIANCE LEVEL
Inspection Findings: Not applicable	Not applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	COMPLIANCE LEVEL
Inspection Findings: Discussion with the nurse in charge confirmed that staff were trained and assessed as competent in continence care. Discussion with the staff revealed that identified registered nurses in the home were deemed competent in female and male catheterisation and the management of stoma appliances. The inspectors were 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
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11.0 Additional Areas Examined

11.1 Care Practices

During the inspection staff were noted to treat the patients/residents with dignity and respect.

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 Complaints

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

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

11.3 Patients/Residents Views

During the inspection the inspectors spoke to twenty patients/residents individually and to others in groups. These patients/residents expressed high levels of satisfaction with the standard of care, facilities and services provided in the home. One patient commented that the temperature in their bedroom was cool at times. This was discussed with the nurse in charge and the regional manager who has agreed to address the issue raised. A number of patients were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients'/residents' comments were as follows:

- "everything is very good"
- "the nurses are brilliant"
- "food is good and there's plenty of it"
- "I would like the heating in my room looked at as it can be cold at times"

11.4 Staffing /Staff Comments

Review of a sample of staff duty rosters for a three week period spanning the week of the inspection and the previous two weeks 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. During the inspection the inspectors spoke with eight staff members. The inspectors were able to speak to a number of these staff individually and in private. Four 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 or satisfied that patients/residents were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

Examples of staff comments were as follows:

“Staff work well together”

“there is plenty of training”

“I really like working here”

“I am completing my NVQ level 3”

11.5 Environment

The inspectors undertook an inspection of the premises and viewed the majority of the patients/residents' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a high standard of hygiene. One patient commented with regard to the heating in their bedroom. The inspectors observed that the temperature in the area of the home where this patients bedroom was located was cooler than the other parts of the home. A requirement has been made for a review of the heating system in the home.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr Vasco Alves, charge nurse and Mrs Louisa Rea, regional manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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

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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission. Criterion 8.1 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 : Regulations 12(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
Prior to admission to the home, the Home Manager or a designated representative from the home carries out a pre admission assessment. Information gathered from the resident/representative (where possible), the care records and information from the Care Management Team informs this assessment. Risk assessments such as the Braden Tool are carried out, if possible, at this stage. Following a review of all information a decision is made in relation to the home's ability to meet the needs of the resident. If the admission is an emergency and a pre admission is not possible in the resident's current location then - a pre admission assessment is completed over the telephone with written comprehensive, multidisciplinary information regarding the resident being faxed or left into the home. Only when the	Substantially compliant

Manager is satisfied that the home can meet the residents needs will the admission take place.

On admission to the home an identified nurse completes initial assessments using a patient centred approach. The nurse communicates with the resident and/or representative, refers to the pre admission assessment and to information received from the care management team to assist her/him in this process.

There are two documents completed within twelve hours of admission - an Admission Assessment which includes photography consent, record of personal effects and a record of 'My Preferences' and a Needs Assessment which includes 16 areas of need - the additional comments section within each of the 16 sections includes additional necessary information that is required to formulate a person centred plan of care for the Resident.

In addition to these two documents, the nurse completes risk assessments immediately on admission. These include a skin assessment using the Braden Tool, a body map, an initial wound assessment (if required), a moving and handling assessment, a falls risk assessment, bed rail assessment, a pain assessment and nutritional assessments including the MUST tool, FSHC nutritional and oral assessment. Other risk assessments that are completed within seven days of admission are a continence assessment and a bowel assessment, Following discussion with the resident/representative, and using the nurse's clinical judgement, a plan of care is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations. This can be evidenced in the care plan and consent forms.

The Home Manager and Regional Manager will complete audits on a regular basis to quality assure this process

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.	
<p>Criterion 5.3</p> <ul style="list-style-type: none"> 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. <p>Criterion 11.2</p> <ul style="list-style-type: none"> There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability. <p>Criterion 11.3</p> <ul style="list-style-type: none"> 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. <p>Criterion 11.8</p> <ul style="list-style-type: none"> 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. <p>Criterion 8.3</p> <ul style="list-style-type: none"> 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. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1); 14(1); 15 and 16</p>	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
The named nurse completes a comprehensive and holistic assessment of the resident's care needs using the assessment tools as cited in section A, within 7 days of admission. The named nurse devises care plans to meet identified needs in consultation with the resident/representative. The care plans demonstrate the promotion of maximum independence and focuses on what the resident can do for themselves as well as what assistance is	Substantially compliant

required. Any recommendations made by other members of the multidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable.

Registered nurses in the home are fully aware of the process of referral to a TVN when necessary. There are referral forms held in a designated file in the nurse's office, the Tissue Viability Nurse's details are also held in this file - name, address and telephone no. Once the form has been sent it, is then followed up by a telephone call to the TVN where advice can be given prior to their visit. Referrals are also made via this process in relation to residents who have lower limb or foot ulceration to either the TVN or a podiatrist. If necessary, a further referral is made to a vascular surgeon by the G.P, TVN or podiatrist.

Where a resident is assessed as being 'at risk' of developing pressure ulcers, a Pressure Ulcer Management and Treatment plan is commenced. A care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. The care plan will give due consideration to advice received from other multidisciplinary members. The treatment plan is agreed with the resident/representative, Care Management and relevant members of the MDT. The Regional Manager is informed via a monthly report and during the Reg 29 visit.

The Registered Nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Dietician referral forms are held within the home. These forms can be completed by staff in the home and faxed directly to the dietician for referral. The dietician is also available over the telephone for advice until she is able to visit the resident. All advice, treatment or recommendations are recorded on the MDT form with a subsequent care plan being compiled or current care plan being updated to reflect the advice and recommendations. The care plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in the home and other members of the MDT are kept informed of any changes.

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 <ul style="list-style-type: none"> 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
<p>The Needs Assessment, risk assessments and care plans are reviewed and evaluated at a minimum of once a month or more often if there is a change in the resident's condition. The plan of care dictates the frequency of review and re assessment, with the agreed time interval recorded on the plan of care.</p> <p>The resident is assessed on an ongoing daily basis with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the Home Manager's attention.</p> <p>The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.</p>	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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented. Criterion 8.4 <ul style="list-style-type: none"> 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
<p>The home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to.</p> <p>The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading system. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime or if the condition of the pressure ulcer changes.</p> <p>There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', 'PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in relation to nutritional care, diabetic care, care of subcutaneous fluids and care of percutaneous endoscopic</p>	Compliant

gastrostomy (PEG). Copies of above documentation or similar is available for reference by all staff..	
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.	
<p>Criterion 5.6</p> <ul style="list-style-type: none"> 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. <p>Criterion 12.11</p> <ul style="list-style-type: none"> 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. <p>Criterion 12.12</p> <ul style="list-style-type: none"> 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. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25</p>	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
<p>nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are contemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines - Record keeping:Guidance for nurses and midwives.</p> <p>Records of the meals provided for each resident at each mealtime are recorded on a daily menu choice form. The Catering Manager also keeps records of the food served and include any specialist dietary needs.</p>	Substantially compliant

<p>Residents who are assessed as being 'at risk' of malnutrition, dehydration or eating excessively have all their food and fluids recorded in detail on a daily basis using a FSHC food record booklet or fluid record booklet. These charts are recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. The nurse utilises the information contained in these charts in their daily evaluation. Any deficits are identified with appropriate action being taken and with referrals made to the relevant MDT member as necessary. Any changes to the resident's plan of care is discussed with them and/or their representative.</p> <p>Care records are audited on a regular basis by the Manager with an action plan compiled to address any deficits or areas for improvement - this is discussed during supervision sessions with each nurse as necessary.</p>	
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 <ul style="list-style-type: none"> 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. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16</p>	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
<p>e outcome of care delivered is monitored and recorded on a daily basis on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan of care or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their representatives are involved in the evaluation process.</p>	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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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
<p>Care Management Reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the resident's file.</p> <p>Any recommendations made are actioned by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals</p>	Substantially compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
<p>Criterion 12.1</p> <ul style="list-style-type: none"> 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 dietitians and other professionals and disciplines. <p>Criterion 12.3</p> <ul style="list-style-type: none"> 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. <p>Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)</p>	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
<p>The home follows FSHC policy and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs on admission and review on an ongoing basis. The care plan reflects type of diet, any special dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if necessary.</p> <p>The home has a 4 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives - residents meetings, one to one meetings and food questionnaires. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied.</p> <p>Copies of instructions and recommendations from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs.</p>	Compliant

Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything from the daily menu an alternative meal of their choice is provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room, with the 4 week menu displayed in a menu display folder and on the wall outside the kitchen.

Section I

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

Criterion 8.6

- Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.

Criterion 12.5

- Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.

Criterion 12.10

- Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:
 - risks when patients are eating and drinking are managed
 - required assistance is provided
 - necessary aids and equipment are available for use.

Criterion 11.7

- Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section

Section compliance level

he home follows FSHC policy and procedures in relation to nutrition and follows best practice guidelines as cited in

Compliant

section D. Registered nurses fully assess each resident's dietary needs on admission and review on an ongoing basis. The care plan reflects type of diet, any special dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if necessary.

The home has a 4 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives - residents meetings, one to one meetings and food questionnaires. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied.

Copies of instructions and recommendations from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs.

Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything from the daily menu an alternative meal of their choice is provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room, with the 4 week menu displayed in a menu display folder and on the wall outside the kitchen

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 of 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.
<ul style="list-style-type: none"> • 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 where 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 	<p>Examples include: Brief verbal explanations and encouragement, but only that which is necessary to carry out the task</p> <p>No general conversation</p>

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	Negative (NS) – communication which is disregarding of the residents’ dignity and respect.
<p>Examples include:</p> <ul style="list-style-type: none"> • 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 	<p>Examples include:</p> <ul style="list-style-type: none"> • 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 Model Care Centre
11 November 2014

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

The specific actions set out in the Quality Improvement Plan were discussed Mr Vasco Alves, charge nurse and Mrs Louisa Rea, regional 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	13 (4) (b)	<p>The registered manager must ensure that medicine which is prescribed is administered as prescribed to the patient for whom it is prescribed.</p> <p>Reference: Criterion 19.1</p>	One	F20 notice served on the day in relation to 1 specific resident. Medication sourced and collected from local chemist. Administration of same re-commenced immediately on receipt of medication. Nursing staff advised of requirement and reminded of responsibilities regarding immediate replacement of any prescribed medication	From the date of this inspection
2	27 (2) (p)	<p>The registered person shall ensure that the heating system in all parts of the home is suitable for the purpose for which it is to be used.</p> <p>Reference: Section 11.5</p>	One	Regular temperature checks maintained in all areas of the building. Risk assessment and management strategies formulated if room temperatures fall below recommended levels. (Portable heaters available if required) Heating regulated as necessary by maintenance man.	Within two weeks from date of this inspection.

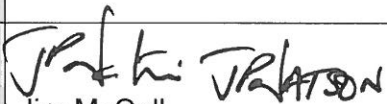
Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	19.1	<p>It is recommended that where a patient/resident has been assessed as being at risk of developing pressure ulcers, a record is maintained of the condition of their skin at each change of position.</p> <p>Reference: Criterion 19.1</p>	One	All staff advised of outcome of inspection...the condition of the patients skin is recorded daily on progress notes where a potential problem has been identified. Care staff are now recording condition of skin for residents who have been identified as at risk following delivery of continence / personal care .	From the date of this inspection
2	5.3	<p>The registered manager should review the communication system between registered nurses and care assistants to ensure that outcomes of care are regularly reviewed and care plans meet the individual's assessed needs and comfort.</p> <p>It is recommended that care assistants are provided with a hand-over report for all patients/residents at the beginning of their shift.</p> <p>Reference: Criterion 19.1</p>	One	<p>RN who is scheduled to work AM shift now meets with care staff on each floor immediately after handover to cascade any relevant information.</p> <p>A daily handover record is also in place for completion by care staff. This includes relevant information on each individual resident, eg level of mobility, assistance of 1/2 staff, type of hoist and sling prescribed for use, dietary needs. This is regularly reviewed and updated by home manager or charge nurse. The home manager is</p>	From the date of this inspection

				frequently on-site to speak to staff prior to the commencement of shift and will advise on any outstanding or specific issues relating to individual residents.	
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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	Bernadette Kelly
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	 Jim McCall DIRECTOR OF OPERATIONS 27/1/15.

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable			
Further information requested from provider			

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Bridget Dougan	28 January 2015
Further information requested from provider			