Unannounced Primary Inspection

Name of Establishment:	**The Court Care Home**
Establishment ID No:	**1451**
Date of Inspection:	**05 August 2014**
Inspector's Name:	**Bridget Dougan**
Inspection No:	**16915**

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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1.0 General Information

Name of Home:	The Court Care Home
Address:	1A Queens Avenue Ballymoney BT53 6DF
Telephone Number:	028 2766 6866
E mail Address:	thecourt@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Healthcare Ltd Mr James McCall
Registered Manager:	Mrs Louise McIlwrath
Person in Charge of the Home at the time of Inspection:	Ms Fiona Archer, Deputy Manager
Registered Categories of Care and number of places:	Nursing (NH): I and PH - to a maximum of three patients 45
Number of Patients Accommodated on Day of Inspection:	33 patients
Date and time of this inspection:	05 August 2014: 11.30 – 17.30 hours
Date and type of previous inspection:	21 November 2013 Unannounced Secondary

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)

Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/Process

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

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

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

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

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

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

5.0 Consultation Process

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

Patients	**20**
Staff	**8**
Relatives	**2**
Visiting Professionals	**0**

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

Issued To	**Number issued**	**Number returned**
Patients	**6**	**6**
Relatives / Representatives	**1**	**1**
Staff	**8**	**8**

6.0 Inspection Focus

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

The criteria from the following standards are included;

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

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

The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.
The table below sets out the definitions that RQIA has used to categorise the service's performance:

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

7.0 Profile of Service

The Court Care Home is one of a number of homes operated by Four Seasons Health Care Ltd. It is a purpose built, two storey building, set in landscaped grounds in a quiet residential area of Ballymoney. The home is close to the social, commercial and religious facilities of the town.

The home is registered to accommodate a total of 45 patients with a maximum of three persons in the category NH-PH and a maximum of 14 persons in the category NH-DE. The majority of patient accommodation is provided in single bedrooms with four double bedrooms.

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

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (unannounced) to The Court Care Home. The inspection was undertaken by Bridget Dougan on 05 August 2014 from 11.30 hours to 17.30 hours.

The inspector was welcomed into the home by Ms Fiona Archer, Deputy Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to the deputy manager and to Mr John Coyle, Peripatetic Manager at the conclusion of the inspection.

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

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

Questionnaires were issued to patients, staff and one relative during the inspection.

The inspector spent a number of extended periods observing staff and patient interaction. Discussions and questionnaires are unlikely to capture the true experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience.

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

As a result of the previous inspection conducted on 21 November 2013, two requirements and one recommendation were issued. These requirements and recommendation were reviewed during this inspection. The inspector evidenced that the requirements and recommendation had been fully complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

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

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

Inspection Findings:

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

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

The inspector reviewed four patients care records and there was evidence of comprehensive and detailed assessment of patient needs from the date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of the patient's needs was evidenced to inform the care planning process.

Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis and as required.

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

Compliance Level: Compliant

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

The inspector evidenced that wound management in the home was well maintained. There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment. Care plans for the management of risks of pressure ulcers and wound care were maintained to a professional standard. Discussion with staff and review of training records evidenced that not all nurses had received training in the management of wounds/pressure ulcers. A requirement has

been made in this regard. A further requirement has been made for all relevant staff to have training in the prevention of pressure ulcers.

Compliance level: Substantially Compliant

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

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

Robust systems were evidenced with risk assessments and appropriate referrals to GP's, speech and language therapists and or dieticians being made as required. Inspection of staff training records revealed that staff as appropriate required a training update on Dysphagia. A requirement is made in this regard.

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

Compliance level: Substantially Compliant

- **Management of Dehydration – Standard 12**

The inspector examined the management of dehydration during the inspection which evidenced that fluid requirements and intake details for patients were well recorded for those patients assessed at risk of dehydration.

Patients were observed to be able to access fluids with ease throughout the inspection. Staff were observed offering patients additional fluids throughout the inspection. Fresh drinking water/various cordials were available to patients in lounges, dining rooms and bedrooms.

Compliance level: Compliant

Patients / their representatives and staff questionnaires

Some comments received from patients and their representatives:

"This home is very, very good."
"Staff are excellent."
"Enjoyed a trip to Portrush."
"Staff make me feel welcome in the home."

Some comments received from staff:

"This is a busy home with dedicated, generous staff who are always putting their residents needs first."
"I feel the residents are well fed and catered for and the standard of care is good."
"Activities are varied and residents enjoy regular bus trips."
"The staff in the home provide a good standard of care. They also have a good relationship with clients."

A number of additional areas were also examined

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

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

Conclusion

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

Patients were observed to be treated with dignity and respect.

The home's general environment was well maintained, however two requirements were made with regard to bedding and the management of equipment.

Other areas for improvement were identified in relation to domestic staffing levels, staff induction and the management of training records.

Therefore, four requirements and one recommendation were made as a result of this inspection. These requirements and recommendation are detailed throughout the report and in the quality improvement plan (QIP).

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

9.0 Follow-up on the requirements and recommendations issued as a result of the previous inspection

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	13 (1) (a)	The registered person shall ensure that the nursing home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. **Reference: Follow up on previous issues**	The inspector observed that a secure enclosed area to the rear of the dementia care unit had been completed. Personal protection equipment (PPE) stations had been re-sited within the unit out of the way of the main corridor and the identified radiator seals had been repaired.	**Compliant**
2	13 (7)	The registered person shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff. The following issues should be addressed: • high level dusting and hovering required in bedrooms • carpets stained in a number of bedrooms, foyer and first floor hallway	The inspector was informed by the deputy manager that since the previous inspection, floor covering had been replaced in a number of patient's bedrooms, dining room and lounge. The inspector examined a random sample of patient's bedrooms, lounges, dining rooms, bathrooms and toilets and can confirm that the home was clean and no mal odours were identified. Following discussion with the domestic staff however, an issue had been identified with regard to staffing levels. Please refer to section 11.8 of this report.	**Compliant**

No	Minimum Standard Ref.	Recommendation	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	12.10	The registered manager must ensure that staff are aware of any matters concerning patients' eating and drinking as detailed in each patient's 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. **Reference: Follow up on previous issues**	The deputy manager informed the inspector that dining arrangements have been reviewed to facilitate increased supervision. The inspector observed the serving of the lunch time meal and can confirm that patients were assisted with dignity and respect throughout the meal. Inspection of a sample of four patients care records evidenced that care plans had been reviewed to reflect patient's nutritional requirements and risk assessments and care plans were reviewed monthly.	**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. Please also refer to section 11.5 of this report.

The inspector was satisfied that any notifications to RQIA regarding safeguarding of vulnerable adults (SOVA) incidents since the previous inspection were being managed in accordance with the regional adult protection policy. Ongoing liaison has been maintained between the local HSC Trust, the registered manager and RQIA.

11.0 Additional Areas Examined

11.1 Documents required to be held in the Nursing Home

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

11.2 Patients under guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection.

The deputy manager advised the inspector that there were no patients subject to a Guardianship Order currently resident at the time of inspection.

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

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

11.4 Quality of interaction schedule (QUIS)

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

The inspector observed the patients' lunch meal which was served in the dining room. The inspector also observed a small number of patients having their lunch meal in the small day room.

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

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

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

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

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

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

Overall the periods of observations were positive.

11.5 Complaints

Prior to the inspection 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 reviewed the complaints records. This review evidenced that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought.

11.6 Patient Finance Questionnaire

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

11.7 NMC declaration

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

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

11.8 Staffing /Staff Comments

The inspector examined duty rotas spanning a three week period which indicated that the nursing and care staffing arrangements were in accordance with the RQIA's recommended minimum staffing guidance for nursing homes for the number of patients currently accommodated.

Discussion with staff and review of domestic staffing levels indicated a shortfall in the numbers of domestic staff on duty. The inspector observed one member of staff allocated to clean the home and one staff member allocated to the laundry on 11 out of the 21 days reviewed. A requirement has been made to review and increase domestic staffing levels to ensure the high standards of hygiene in the home are maintained.

The inspector spoke with eight staff members during the inspection and these staff also completed questionnaires. The following are examples of staff comments during the inspection and from the questionnaires:

"This is a busy home with dedicated, generous staff who are always putting their residents needs first."
"I feel the residents are well fed and catered for and the standard of care is good."
"Activities are varied and residents enjoy regular bus trips."
"The staff in the home provide a good standard of care. They also have a good relationship with clients."

11.9 Patients' Comments

The inspector spoke with 20 patients individually and with others in groups. Six patients completed questionnaires.

The following are examples of patients' comments made to the inspector and recorded in the returned questionnaires.

"This home is very, very good."
"Staff are excellent."
"Enjoyed a trip to Portrush."

11.10 Relatives' Comments

The inspector spoke with one relative and this relative completed a questionnaire.

The following is an example of the relative's comments:

"Staff make me feel welcome in the home."

11.11 Environment

The inspector undertook an inspection of the home and viewed a number of patients' bedrooms, communal facilities and toilet and bathroom areas. The home was clean, warm and comfortable. The inspector observed that sheets, duvet covers and pillow cases on a number of patients' beds were faded /discoloured. A requirement has been made for a review of bed linen and replacement of bedding as required.

Discussion with staff and review of the laundry area evidenced a number of issues require to be addressed, including the following:

- filter for tumble dryer
- laundry baskets needs replaced
- ironing board cover needs replaced

11.12 Training Records

The inspector was informed by Mr John Coyle, Peripatetic Manager that the majority of mandatory training was provided by means of an e learning package. The

inspector reviewed a computer printout with the names of staff, the dates and type of training completed. This indicated that the majority of staff had completed mandatory training to date. The registered manager must ensure that a record is kept in the home of the names and signatures of those attending the training event; the dates of the training; the name and qualification of the trainer or training agency and the content of the training programme. A recommendation has been made in this regard.

11.13 Agency Nurse Inductions

Discussion with staff and review of a sample of duty rotas evidenced that agency nursing staff were employed in the home and had been block booked to ensure continuity of care. The inspector reviewed the induction records for two agency staff members. However, the inspector was unable to evidence that a further six agency staff had completed an induction. A requirement has been made accordingly.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr John Coyle, Peripatetic 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 • **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**
Prior to admission to the home, the Home Manager or Senior Nurse visits the potential client in their current environment to carry out a pre-admission assessment. This also involves care plans from the referring Care Manager/Social Worker. Where the client comes from their own home, the GP provides an up to date list of medical history and list of medications in advance of the admission.Where the referral is for an emergency admission, the referrer must provide an up to date care plan including Braden, Current mobility status, Nutritional needs including type of diet and a full up to date list of medications. Only when the manager is satisfed that the relevant information is available will a decision be made to admit. In respect of planned admission of clients to the Dementia Unit, the home	Compliant

attempts to facilitate 2 other staff members to visit the client before admission to enable a smoother transfer. On admission the identified nurse completes the inital assessments using a patient centred approach. The nurse communicates with the resident and/or representative, refers to the pre-admission assessment and all other information to assist them as far as possible. In addition to this, the nurse will complete, on admission, Braden, Body Map, MUST, Moving & Handling Risk Assessment, Falls RIsk assessment, Bed Rail/Restraint assessment if required and Initial wound assessment if required. The resident/representative will sign consents for photographs and restraint where required. The Home Manager will audit the file one week after admission to ensure that the relevant documentation is of the required standard. The Regional Manager will also randomly audit these filesThe during her Regulation 29 visit.	

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**
The named nurse will complete a comprehensive and holistic assessment of the residents care needs using the assessment tools as previously mentioned. The care plan will demonstrate what the individual's capabilites are and how to maximise independence. Recommendations by other members of the Multi Disciplinary Team will be taken in to account and incorporated in to the care plan. Registered Nurses in the home are fully aware of the referral processes. They refer to the WOund Link Nurse in the home for preliminary advice and refer to the Trust TVN at the earliest opportunity.The Podiatrist is also sent a referral if required. The Home Manager completes a Wound Analysis each month and forwards to the Regional Manager. THe Regional Manager will also randomly select wounds and supporting documentation as a theme to her Regulation 29 visits to further quality assure the care plans and assessments. Where a resident is at risk of developing pressure sores, a PMAP or Pressure Management Action Plan is commenced and this assists in devising the care plan. The equipment is reviewed and additional equipment purchased where necessary. Where the admission is emergency and the home does not have a suitable pressure relieving mattress, the admission would only go ahead if the Trust provided a mattress in the interim until the new mattress is in place. The Registered Nurse refers a resident to the dietician based on the MUST score and their own clinical judgement. All dietician forms are held in the care file. These are faxed to the Dietician but telephone advice can be sought in the interim. The care plan will be further devised on consultation with the professional advice. The Regional Manager will randomly selece Nutrition as part of her Regulation 29 audit and will view residents at high risk/with recent weight loss.	Compliant
Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
THe care files are reviewed monthly or as condition changes. The plan of care would dictate the frequency of the reviews required. The resident is assessed daily and reported on the progress charts and care plan evaluation forms. Changes are reported on a 24 hour shift report and left for the Home Manager. The Home Manager and Regional Mnager will audit Care Plans. The named person in the Trust will also be notified of any changes and will review the care plans during review or more frequently if there are significant changes	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
The Home refers to up to date guidelines as defined by the professional bodies and national standards setting organisations. Guidelines from NICE, GAIN, RCN,NIPEC, HSPPS, PHA and RQIA are available to all staff to refer to. The pressure ulcer grading tool is the EPUAP. If a pressure ulcer is identified then an intial wound assessment is completed with a plan of care which includes the grade of the ulcer, dressing regime, frequency of repositioning, mattress type etc. AN ongoing wound assessment is completed at each dressing change. The wound is photographed if consent has been given. Ongoing measurements are made and progress commented on. There are up to date guidelines available for all staff in respect of Nutrition. There is extensive information on Four Seasons Intranet on Nutrition. Where necessary, additional training would be sourced e.g in the event of the home	Compliant

having a resident with a PEG Percutaneous Endoscopic Gastrostomy.	
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 kept of all nursing interventions activites and procedures that are carried out in relation to each resident. These records are contemporaneous and are in accordance with the NMC guidelines. All care delivered includes and evaluation. Nurses have access to NMC guidelines and Nurses are given additional training in Care Planning and Person Centred Care. Records of the meals provided are recorded at each mealtime on a daily menu choice form. THe Catering Manager retains records of food served and keeps upto date information on specialist dietary needs. Residents who are assessed as being at risk of malnutrition dehydration or excessive eating have their food and fluids recorded in detail using the Four SEasons documentation. The fluid charts are totalled and the nurse comments /makes actions as required. Referrals will be made as necessary.	Substantially compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The care provided is reflected in the daily statements made by the nurses. There will be a minimum of one entry during the day and one at night. The care plan is updated/re-written where necessary i.e if condition changes or if a visiting professional makes recommendations.The Residents/Representatives will read and sign the care plans to indicate their participation and agreement	Substantially compliant
Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their**	

representatives, are kept informed of progress toward agreed goals. **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care Management reviews are generally held within 6-8 weeks post admission and then annually thereafter. Emergency reviews will be arranged where the staff have identified persistent issues and difficulties. Where a resident/representative expresses dissatisfaction with the home then a review is generally called so that all parties can discuss concerns and devise action plan to rectify any issues. The Trust are responsible for arranging these reviews however where they are not held in a timely manner then the Home Manager arranges Home Reviews until the Trust review can take place. At the time of this assessment all annual reviews have been completed. The Home receives the written report of the review from the Named Person in the Trust.	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 compliance**

section	level
On admission the residents needs and choices are established and documented in the care plan. The Catering staff are given written notification of each new admission and regular updates on existing residents when changes occur. The Catering staff meet regularly with the residents and records are kept of organised meetings. Relatives are kept informed at Relative Meetings of any proposed changes. Dietetic and Speech and Language instructions are kept in the residnets files and incorporated in to the care plan. THe Catering Staff meet regularly with the Home Manager and the Regional Manager observes meals during her Regulation 29 visits. The Catering Staff have support from the Four Seasons Catering Managers to devise variations in menus and they also completed food questionnaires with the Residents. Residents are offered a choice of two meals and dessert at each meal time however where a resident refuses then an alternative is made available	Compliant

Section I

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

Criterion 8.6

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

Criterion 12.5

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

Criterion 12.10

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

Criterion 11.7

- **Where a patient requires wound care, nurses have expertise and skills in wound management that includes**

the ability to carry out a wound assessment and apply wound care products and dressings. **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Staff have received training in Dyspagia and further training is scheduled for the 1st May 2014. The Catering Team met with the Four Seasons Catering Manager in MArch 2014 and had training in thickening foods and pureed diets etc. All recommendations are incorporated in to the care plan. The Catering Staff retain an up to date list provided by the Nursing staff. The Care Staff have "Easy Guides" made out indicating type of diet/fluid/personal preferences for each resident and are located in the "supplementary chart file". Staff are given training on how to deal with the choking resident through their Basic Life Support practical training and also have to completed e learning in first aid.Each unit has a suction machine and Registered Nurses are present at each mealtime. Meals are served as follows: Breakfast - 8.30am - 10.30am Morning Tea - 11am Lunch - 12.40pm - 1.30pm Afternoon Tea - 3pm Evening Tea - 4.45pm - 5.30pm Supper - 8.15pm-9pm These are the usual times in the home but a resident can request outside of these times or if going out to an appointment or late back in from appointment. They are encouraged to use the dining room but can eat in their own bedroom if preferred. Drinks are available 24 hours per day and are refreshed as required. Resident have equipment provided as required in order to maintain independence and dignity. Registered Nurses have completed the Pressure Area care module on e-learning. THe home has a Wound Care Link Nurse who is presently completing supervisions and competencies on the other nurses to ensure a consistent approach to wound care. Where the dressing is complex then the Tissue Viability Nurse from the Trust would give additional support and guidance and supervision.	Substantially compliant

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

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Primary Inspection

The Court Care Home

05 August 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Mr John Coyle, Peripatetic Manager, either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	20 (1)	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 11.8**	One	The off duty is devised in accordance with Company and Regulatory guidance . The number of Nursing & Care Staff on shift would be consistently over and above the required ratios. Where regular staff are unavailable then agency cover is sought. The home is actively recruiting staff on an ongoing basis. In the event whereby the home has no alternative but to work under the ratio then the RQIA are notified via Regulation 30.	From the date of this inspection
2	20 (1) (c) (i)	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 the persons employed by the registered person to work at the nursing home receive appraisal, mandatory training and other training appropriate to the work they are to perform. All agency staff are required to complete a structured orientation and induction.	One	Staff receive mandatory induction and training specific to their role. Records are retained to demonstrate all training. All agency staff have an orientation and induction completed and these are available for inspection.	From the date of this inspection

		Reference: Section 11.13			
3	27 (2) (c)	The registered person shall, having regard to the number and needs of patients, ensure that equipment provided at the nursing home for use by patients or persons who work at the home is in good working order, properly maintained in accordance with the manufacturer's guidance, and suitable for the purpose for which it is to be used. The following issue require to be addressed: • filter for tumble dryer • laundry baskets needs replaced • ironing board cover needs replaced. **Reference: Section 11.11**	One	All issues identified have been addressed. there is ongoing maintenance and refurbishment in the home. items are purchased as required	Within one week from receipt of this QIP
4	27 (2) (d)	The registered person shall, having regard to the number and needs of patients, ensure that all parts of the home are kept clean and reasonably decorated. The registered person should ensure there is a review of bed linen and replacement of bedding as required. **Reference: Section 11.11**	One	Additional bedding purchased and in the home. This is reviewed as required	Within one month from receipt of this QIP

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	Recommendation	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	28.6	The registered manager must ensure that a record is kept in the home of the names and signatures of those attending the training event; the dates of the training; the name and qualification of the trainer or training agency and the content of the training programme. **Reference: Section 11.12**	One	All training records are retained in the home and available for inspection. These records are viewed monthly by the Regional Manager. The Manager has reviewed the storage of these documents to faciliate ease of access	From receipt of this QIP

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	Louise McIlwrath
Name of Responsible Person / Identified Responsible Person Approving Qip	Jim McCall DIRECTOR OF OPERATIONS 17.9.14

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				Inspector	Date
		Yes	No		
A.	Quality Improvement Plan response assessed by inspector as acceptable	X		B Dougan	19/09/14
B.	Further information requested from provider				