Unannounced Care Inspection

Name of Establishment:	**Whiteabbey**
RQIA Number:	**1452**
Date of Inspection:	**09 March 2015**
Inspector's Name:	**Aveen Donnelly**
Inspection ID:	**17117**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Whiteabbey
Address:	104-106 Doagh Road Newtownabbey BT37 9QP
Telephone Number:	0289085 3021
Email Address:	whiteabbey@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Health Care
Registered Manager:	Aleyamma George
Person in Charge of the Home at the Time of Inspection:	Arni Operario
Categories of Care:	RC-I, NH-I, NH-PH, NH-PH(E)
Number of Registered Places:	59
Number of Patients Accommodated on Day of Inspection:	43
Scale of Charges (per week):	£581 - £592
Date and Type of Previous Inspection:	09 January 2014 Unannounced Secondary Care Inspection
Date and Time of Inspection:	09 March 2015 09:00 - 14:15
Name of Inspector:	Aveen Donnelly

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

4.0 Methods/Process

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

- discussion with the registered nurse manager
- discussion with staff
- discussion with patients individually and to others in groups
- 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	15
Staff	3
Relatives	0
Visiting Professionals	0

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

Issued To	Number Issued	Number Returned
Patients/Residents	6	6
Relatives/Representatives	6	2
Staff	10	8

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

Whiteabbey Care Home is a purpose built, two storey facility situated on the Doagh Road, Newtownabbey, within easy reach of shops and other amenities, public transport and the M2/M5 motorway. The Abbey Centre shopping centre is approximately one mile away.

Accommodation is provided on both floors in 44 single and two double bedrooms. There is a passenger lift for access to the first floor.

Communal lounges, dining areas and sanitary facilities are provided on both floors. Spacious car parking facilities are provided at the front and side of the home, with landscaped gardens enclosed by a wooden perimeter fence.

Respite care can be provided if a bed is available. The home is registered to provide care for persons under the following categories:

Nursing Care

I	Old age not falling into any other category
PH	Physical disability other than sensory impairment – under 65 years
PH (E)	Physical disability other than sensory impairment – over 65 years

Residential Care

RC-I	Old age not falling into any other category

There is a condition of registration for two identified individuals in the category RC-I. The home is also approved to provide care on a day basis only to one person.

8.0 Executive Summary

This summary provides an overview of the services examined during an unannounced care inspection. The inspection was undertaken by Aveen Donnelly on 09 March 2015 from 09:00 to 14:15. The inspector was welcomed into the home by Arni Operario, deputy manager, who was available throughout the inspection. Ms Aleyamma George, registered manager, joined the inspection later and received verbal feedback at the conclusion of the inspection.

The focus of the inspection was in relation to DHSSPS Nursing Homes Minimum Standard 19 – Continence Management. Inspection also sought to assess progress with the issues raised, during and since the previous care inspection.

As a result of the previous care inspection conducted on 09 January 2014, one requirement and three recommendations were made. These were reviewed during this inspection. One requirement and two recommendations have been complied with. One recommendation regarding the regular checking of emergency equipment has not been fully addressed and is stated for the second time. Details of the findings regarding the previous recommendations can be viewed in the section immediately following this summary.

With regards to Standard 19: continence management care practices were deemed to be substantially compliant. However, there were areas identified for improvement. A sample of five care records was reviewed. There was evidence that a continence assessment had been completed for all patients. This assessment formed part of a comprehensive and detailed assessment of patient needs from the date of admission and was found to be updated on a regular basis. The assessment of patient needs was evidenced to inform the care planning process.

Discussion with the registered manager confirmed that staff were trained and assessed as competent in continence care. Training had been provided in urinary catheterisation and staff competency had been assessed by the local Healthcare Trust liaison nurse. Policies, procedures and guidelines in the promotion of continence and the management of incontinence were available in the home.

A recommendation has been made that a continence link nurse is appointed, to undertake regular audits of the management of incontinence to enhance already good standards of care.

The general environment was inspected. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was clean and comfortably heated throughout. There was a smoking room that had been used to store equipment which was identified as being owned by the local healthcare trust which was no longer required. A recommendation has been made to ensure this issue is addressed.

Staffing arrangements were reviewed and were found to be in accordance with minimum standards. Consultation with patients and comments from staff interviewed and in completed returned questionnaires indicated a general satisfaction with care in the home. There were no issues raised regarding care by patients with the inspector on the day of the inspection. However, some staff provided examples of not having time to spend talking to patients in the returned questionnaires. This was discussed with the manager.

As a result of this inspection, three recommendations have been made, one of which has been stated for the second time. These are detailed throughout the report and in the quality improvement plan (QIP).

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

9.0 Follow-up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	16 (1) (b)	The registered manager must ensure that risk assessments and care plans have been reviewed in a timely manner.	A review of five care records identified that risk assessments and care plans had been reviewed in a timely manner.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	20.1	The registered manager must ensure that patients DNR decisions are recorded in keeping with good practice guidelines and there should be evidence of effective communication of DNR decisions between staff involved in the patients care	A review of two care records identified that Do Not Resuscitate (DNR) decisions had been recorded on consent forms and in the care plans. Staff spoken with confirmed that patients' DNR status is communicated in the daily handover report.	Compliant
2	20.2	It is recommended that, in addition to the emergency equipment already provided, the following equipment is readily available and records maintained of regular checks: • Emergency patient airways - (both floors) • Emergency 'ambu' bag (both floors) • Suction equipment (ground floor)	Emergency patient airways, 'ambu' bags and suction equipment had been provided on both floors of the home. Records of regular checks were available. A review of these records revealed that checks were not entered consistently. This was discussed with the registered manager at the conclusion of the inspection. Assurances were provided that the system of conducting regular checks would be reviewed. This recommendation has not been fully addressed and is stated for the second time.	Substantially compliant

3	20.3	Guidance documents such as Nursing Midwifery Council (NMC) guidance and the Resuscitation Guidelines 2010 from the Resuscitation Council UK were not available for reference in the home.	The NMC guidance and the Resuscitation Guidelines from the Resuscitation Council were available for reference in the home.	Compliant

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

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

Since the previous inspection in January 2014, RQIA have been notified by the registered manager of incidents in accordance with Regulation 30 of the Nursing Homes Regulations (NI) 2005.

Discussion with the registered manager evidenced that she was aware of the protocol and requirements for managing potential or alleged safeguarding of vulnerable adults (SOVA) issues.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of five patients' care records evidenced that bladder and bowel continence assessments were undertaken and care plans evaluated on a monthly basis or more often as deemed appropriate. The care plans reviewed addressed the patients assessed needs in regards to continence management. Urinalysis was undertaken and patients were referred to their GPs as appropriate. A review of the care records and discussion with patients evidenced that either they or their representatives had been involved in discussions to agree and plan nursing interventions. The care records evidenced that appropriate referrals to continence professional or General Practitioner, as deemed appropriate, had been made. Discussion with staff and observation evidenced that there were adequate stocks of continence products available. It is recommended that regular audits of the management of incontinence are conducted and reflected in care plan updates, as deemed appropriate, to enhance standards of care.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
Policies, procedures and guidelines in the promotion of continence and the management of incontinence were available in the home. The inspector can confirm that the following policies and procedures were in place: • continence management/incontinence management • stoma care • catheter care The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines • RCN catheter care • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence • British Geriatrics Society Continence Care in Residential and Nursing Homes Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not examined.	N/A
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the manager revealed that all the registered nurses in the home were deemed competent in urinary catheterisation and the management of stoma appliances. Continence care was included in the induction programme of all staff. There was no continence link nurse working in the home. This was discussed with the registered manager who confirmed that there were plans in place to appoint a continence link nurse. This has been incorporated into one recommendation on the auditing of incontinence management.	Substantially compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

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

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

11.3 Patient Finance Questionnaire

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

11.4 NMC Declaration

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

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

11.5 Patients' and Relatives' Comments

During the inspection the inspector spoke with 15 patients individually. Patients spoken with and the questionnaire responses confirmed that patients felt they were treated with dignity and respect, staff were polite and respectful, they could call for help if required, their needs were met in a timely manner, food was good and plentiful and that they were happy living in the home. 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' comments were as follows:

- "It's very good here."
- "Food is very good."
- "The home is spotless."
- "I have never been as happy and it is a great place."

There were no issues raised with the inspector on the day of inspection. However, two questionnaires from relatives submitted to RQIA after the inspection, raised concerns with regards to patients having to wait a long time to have their incontinence needs met. These concerns were discussed with the registered manager following the inspection. Assurances were provided that response times will be audited and concerns raised will be discussed at the upcoming relatives meeting. The inspector is satisfied with these actions.

11.6 Questionnaire Findings/Staff Comments

During the inspection, the inspector spoke with three staff individually and eight staff completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes. All staff spoken with regarded care provision in the home to be very satisfactory. Staff spoken with were knowledgeable in the management of continence care and provided examples of good practice in protecting patient privacy and dignity for patients. However, four staff were concerned that they did not have the time to spend talking with patients. These concerns were discussed with the registered manager following the inspection. Assurances were provided that dependency levels would be regularly monitored and that staffing arrangements would be reviewed accordingly. The registered manager also provided assurances that these concerns would be further discussed at an upcoming staff meeting.

Examples of staff comments were as follows:

- “Patients are well catered for.”
- “This has been a nice home to work in.”
- “The patients and residents are well cared for.”
- “Don’t get enough time to speak (to patients).”
- “Patients are dealt with to the highest standard.”.

11.7 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients’ bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a high standard of hygiene. However, there was a smoking room identified which had been used to store equipment which was identified as being owned by the local healthcare trust which was no longer required. The registered manager confirmed that they did not intend to change the purpose of this room. This was discussed with the registered manager following the inspection. Assurances were provided that the smoking room no longer contained the identified furniture. A recommendation has been made to ensure this issue is addressed.

12.0 Quality Improvement Plan

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

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
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Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Prior to admission to the home, the Home Manager or a designated representative from the home carries out a pre admission assessment. Information gleaned 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 regard to the home's ability to meet the needs of the resident. If the admission is an emergency admission and a pre admission is	Substantially compliant

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 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 addidtion to these two documents, the nurse completes risk assessments immedidiately 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.	
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**
A 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 and in consultation with the resident/representative. The care plans demonstrate the promotion of	Substantially compliant

maximum independence and focuses on what the resident can do for themselves as well as what assistance is required. Any recommendations made by other members of the mutidisciplinary 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 designated referral forms . 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 • **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 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. 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. The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.	Substantially compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
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. The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading sysytem. 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. There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition',' PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff	Substantially compliant

to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in relation to nutritional care, diabetic care, care of subcuteanous fluids and care of percutaneous endoscopic gastrostomy (PEG)..	

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, activities and procedures that are carried out in relation to each resident. These records are comtemporaneous 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. 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. Residents who are assessed as being 'at risk' of malnutrition, dehyration or eating excessively have all their food and	Substantially compliant

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. 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.	

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

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
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. The home has a 4 week menu which is reviewed on 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	Substantially compliant

in the kitchen along 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 in 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:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Registered nurses have received training on dysphagia and enteral feeding techiques (PEG) on12/09/13 and 03/04/14.care staff received dysphagia training on29/05/13. Further training on dysphagia and feed,are arranged on 13/08/14. The Speech and Language therapist and dietician also give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document - 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language	Substantially compliant

therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for feeding, equipment to use and assistance required. The kitchen receive a copy of the SALT's recommendations and this is kept on file for reference by the kitchen. Meals are served at the following times:- Breakfast - 9.20am-10.30am Morning tea - 11-15am Lunch - 12.45pm-13:00pm Afternoon tea - 3pm Evening tea - 5.30pm Supper --8 -9pm There are variations to the above if a resident requests to have their meals outside of these times. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. There are foods available outside of these times for those resident's who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedrooms, these are replenished on a regular basis. Any matters concerning a resident's eating and drinking are detailed on each individual care plan - including for eg. likes and dislikes, type of diet, consistency of fluid, any special equipment required and if assistance is required. A diet notification form is completed for each resident with a copy given to the kitchen and one held in the care file. Meals are not served unless a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Each nurse has completed an education e-learning module on pressure area care. The home has a link nurse who has received enhanced training, to provide support and education to other nurses within the home on an ad hoc basis. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the home have a competency assessment completed.	

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	Examples include: Brief verbal explanations and encouragement, but only that necessary to carry out the task No general conversation

individual's care in front of others	

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 Care Inspection

Whiteabbey

9 March 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the registered manager either during or after the inspection visit.

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

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

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

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

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	20.2	It is recommended that, in addition to the emergency equipment already provided, the following equipment is readily available and records maintained of regular checks: • Emergency patient airways - (both floor • Emergency 'ambu' bag (both floors) • Suction equipment (ground floor) **Ref: 9.0**	Two	Emergency patient airways,'Ambu bags' and suction equipments are provided on both floors of the Home. Records of regular checks are available and checks are entered consistently by the Registered Nurse and monitored by home manager .	01 May 2015
2	19.1 & 19.4	Consideration should be given to the appointment of a continence link nurse to undertake regular audits of the management of incontinence. **Ref: 10.0**	One	The Team Leader is the continence link nurse	01 May 2015
3	32.11	The registered manager should ensure that the room designated for smoking is not used for any other purpose. This relates to the storage of Trust owned equipment that is no longer required. **Ref: 11.7**	One	The trust owned equipments that is no longer required are already removed and taken by the Trust.	01 May 2015

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Aleyamma George
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall MANAGING DIRECTOR 28/4/15.

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Aveen Donnelly	01/05/2015
Further information requested from provider			