Unannounced Care Inspection

Name of Establishment:	**Ashgrove**
RQIA Number:	**1462**
Date of Inspection:	**17 December 2014**
Inspector's Name:	**Lorraine Wilson**
Inspection ID:	**17105**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Ashgrove Care Home
Address:	55 Belfast Road Newry BT34 1QA
Telephone Number:	028 30269110
Email Address:	ashgrove.m@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Health Care Mr James McCall
Registered Manager:	Mrs Bijini John
Person in Charge of the Home at the Time of Inspection:	Mrs Bijini John
Categories of Care:	NH-DE
Number of Registered Places:	52
Number of Patients Accommodated on Day of Inspection:	49
Scale of Charges (per week):	£581.00 per week
Date and Type of Previous Inspection:	9 June 2014, secondary unannounced inspection
Date and Time of Inspection:	17 December 2014 10.00 - 17.40 hours
Name of Inspector:	Lorraine Wilson

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- Discussion with the Peripatetic Regional Manager and Support Manager
- Discussion with the Registered Nurse Manager
- Discussion with staff
- Discussion with patients individually and to others in groups
- Consultation with three visiting relatives
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- Review of a sample of care plans
- Review of the 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	Met all patients and spoke with four individually and to others in groups.
Staff	7
Relatives	3
Visiting Professionals	0

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

Issued To	**Number Issued**	**Number Returned**
Patients	0	0
Relatives/Representatives	3	3
Staff	10	5 during inspection + 2 post inspection

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

Ashgrove Care Home is situated close to Newry City and within its own grounds on Newry's Belfast Road.

The nursing home is owned and operated by Four Seasons Healthcare, and Mr Jim Mc Call is the responsible individual for the company.

The current registered manager is Mrs Bijini John.

Single storey accommodation is provided in two units known as Carlingford and Clanryre.

Within each unit a number of communal lounge and dining areas are provided, and a number of communal sanitary facilities are available throughout the home.

Both units are linked to service corridor where catering and laundry services are located.

A designated hairdressing area is available for patients, and a cinema area is located within Clanryre Suite. A sunroom is provided in Carlingford Suite and a secure courtyard area which can be accessed by patients from both units is available. Car parking is available within the grounds of the home.

The home is registered to provide care for a maximum of fifty two patients under the following categories of care:

Nursing care

DE dementia care.

The RQIA certificate of registration was reviewed during this inspection and was displayed appropriately in the foyer area of the home.

8.0 Executive Summary

The unannounced inspection of Ashgrove Care home was undertaken by Lorraine Wilson on 17 December 2014 between 10.00 hours and 17.40 hours. The inspection was facilitated by Mrs Bijini John, registered manager. Both Mrs Bijini John and Mrs Edith Harrison, support manager were available throughout the inspection and received verbal feedback on conclusion of the inspection.

Mr John Coyle, peripatetic regional manager was in attendance mid-afternoon and also received the inspection feedback.

A number of documents were required to be returned to the RQIA pre inspection and all the relevant documents were sent by the registered manager within the required timescale. These were reviewed prior to the inspection.

A complaint in relation to issues pertaining to patient care had been received by RQIA on 8 December 2014**.** RQIA were also informed of safeguarding investigations which are ongoing. Further information in respect of these issues is contained in section 9.1 of the report.

Throughout the inspection period, the inspector met all patients speaking to four patients individually and to others in groups. The patients' who were able communicated positively about the care and treatment they were receiving and no concerns were raised by patients during this inspection.

Three visiting relatives also agreed to speak with the inspector and two relatives completed questionnaires.

During discussion with relatives, whilst positive comments were provided, two relatives expressed the view that the home could be short staffed at times. One relative also advised that they had approached Trust representatives in relation to their concerns. The relative acknowledged some improvement in respect of the issues which had been raised.

Staff interactions with patients were observed throughout the period of inspection and were found to be positive, caring and respectful. Seven staff were consulted and five staff returned completed questionnaires during the inspection and two were submitted to RQIA post inspection. Overall responses provided indicated staff were well supported and received training. Some staff indicated that during the morning period more staff were required as staff did not always have sufficient time to spend with patients. One respondent indicated that increased paperwork also limited the amount of time staff had to spend with patients.

An examination of the duty rotas for the week of inspection evidenced that staffing is in accordance with RQIA's minimum staffing guidance for nursing homes. It is the responsibility of the registered persons to continuously review the home's staffing arrangements to ensure that sufficient numbers of experienced and competent staff are available to meet the needs of patients at all times. In view of the comments made by relatives and staff, a recommendation is made that staffing arrangements are reviewed and RQIA are informed of the outcome.

This inspection focused on the level of compliance with standard 19 of the Nursing Home Minimum Standards (2005) concerning continence care and further detail can be found in section 10.0 of the report.

Three patients' care records were examined. There was evidence that a continence assessment had mostly been completed as part of a comprehensive assessment of patients' needs. It was evidenced that not all patients had completed bowel assessments referencing the Bristol stool chart.

The risk assessments were updated on at least monthly or as required to reflect changing needs and were evidenced to inform the care planning process. Improvements are needed to ensure that robust and consistent systems are in place to monitor bowel function via the daily progress records and person centered statements are recorded in respect of individual continence management.

A number of relevant policies and guidance documents were available for staff on continence management.

Discussion with the registered manager and staff as well as a review of the training records presented confirmed that a number of staff had received training on skincare for the incontinent individual and patient experience in respect of continence care. Confirmation was also provided that training was due to be provided on bowel management.

However, not all staff were trained and assessed as competent in continence care. Currently there is no continence link nurse for the home and there is no evidence that continence management audits are undertaken to enhance the standards of care.

From a review of the available evidence, discussion with relevant staff and observation, the inspector can confirm that the level of compliance with the continence standard inspected was substantially compliant. Four recommendations have been made in respect of this specific standard.

Patients' bedrooms, bathroom, shower and toilet facilities and communal areas in both units, were inspected during a tour of the home. Sluice areas, treatment rooms and laundry facilities were also examined. The inspector evidenced that insufficient progress had been made in addressing requirements pertaining to infection prevention and control and the cleanliness of the home including the management of odours. These specific issues were raised during previous care inspections of the home, and have an impact on patient dignity as well as posing potential risks to patient health and welfare. Details of the inspection findings are included in section 9 and Additional Areas Examined 11.7 of the main report.

The inspector reviewed the progress made in addressing requirements and recommendations which were made at the last care inspection undertaken on 09 June 2014.

Of the five requirements made, two were compliant, two were moving towards compliance and one was not compliant.

Of the three recommendations made, two were compliant, and one which was substantially compliant will not be restated.

On conclusion of the inspection an urgent actions letter was also issued to the registered manager to ensure immediate action was taken in respect of some concerns highlighted.

Conclusion

The delivery of care to patients was generally evidenced to be of a satisfactory standard and during periods of observation, patients were treated by staff with dignity and respect.

Issues identified were in relation to the management of restraint for one identified patient, the personal care needs of one patient and the delivery of timely treatment for another patient.

Overall care records were maintained to a satisfactory standard. One patient was receiving antibiotic treatment for an infection; however the care plan had not been updated to reflect this diagnosis or the care and treatment for this infection.

Recommendations have also been made to improve the management of continence care in the home.

The identified issues were discussed with the management team during the inspection feedback.

Deficits continue to be identified in respect of infection control practices and the management of cleanliness in identified areas throughout the home. The Regulation and Quality Improvement Authority (RQIA) have concerns that the quality of care and service within Ashgrove Care Home falls below the minimum standard expected in these specific areas.

The inspection findings were reported to a senior inspector post inspection and discussed with the head of nursing, following which a decision was taken to hold a serious concerns meeting. The inspection findings were communicated in correspondence to the registered provider and a serious concerns meeting was held at RQIA on 9 January 2015.

The company submitted an action plan to address the identified deficits.

Enforcement action was considered in discussion with the Head of Nursing, Pharmacy and Independent healthcare regulation. It was concluded that enforcement action was not appropriate at present.

Following discussion at the serious concerns meeting, RQIA decided to give the management a period of time to address the issues identified on the action plan. A follow up monitoring inspection will be undertaken within a specified time period to monitor the progress made.

Four requirements were made as a result of this inspection. This includes two restated requirements which were assessed as moving towards compliance and have been stated for a final time.

A requirement which had been carried forward has been brought forward again, and will be reported on upon conclusion of the ongoing safeguarding investigations.

Four recommendations were also made.

Details can be found in the main body of the report and attached quality improvement plan (QIP)

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

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
C/F	13(1)(a)	The registered persons must ensure that upon conclusion of safeguarding of vulnerable adult investigations, RQIA are informed of the outcome, and of any action taken. • The registered manager agreed to inform RQIA of the outcomes and of any recommendations which are made to the home upon conclusion of on-going investigations.	The registered manager provided the inspector with an update in relation to safeguarding investigations some of which are ongoing with external agencies. It was agreed that the registered manager would contact the operations director from FSHC to ensure RQIA are provided with formal response of the outcome of the safeguarding investigations and any recommendations which have been implemented by the company in response. This requirement is carried forward again until the investigations are concluded.	Carried forward

1.	18(2)(j)	The registered person shall having regard to the size of the nursing home and the number and needs of patients– • ensure processes to keep the nursing home free from offensive odours are effective. This issue is raised for a third and final time. Failure to address this matter will result in enhanced enforcement action being taken.	This inspection continued to identify a number of identified bedroom, bathroom, shower room, toilet and sluice areas where odours continue to be evident. The inspector was concerned that the home was not clean. A serious concerns meeting was held and this requirement was subsumed into regulation 27(2) (d). Enforcement action was considered in discussion with the Head of Nursing, Pharmacy and Independent healthcare regulation, It was concluded that enforcement action was not appropriate at present. A follow up monitoring inspection will be undertaken to assess if the required action has been taken.	Not compliant
2.	20(1)(c)(i)	The registered persons must provide confirmation to RQIA that • one identified registered nurse has completed safeguarding of vulnerable adults training and has been deemed competent by the registered manager.	The registered manager provided confirmation that all registered nurses have completed safeguarding training and have been deemed competent. Records of staff training were available to evidence this requirement.	Compliant

3.	13(7)	The registered persons must ensure that effective processes are in place to address infection control deficits and advise RQIA of the outcome. • In addition confirmation is required of the action taken in addressing the infection control issues identified in the previous report and Additional Areas Examined, 5.1.	The inspector continues to identify deficits in respect of infection prevention and control. Confirmation was provided that the FSHC infection control nurse had visited the home prior to the inspection and undertaken an infection control audit. An action plan to address deficits has been devised, and work has commenced on addressing the issues. Given that this requirement has been stated for a third time, enforcement action was considered in discussion with the Head of Nursing, Pharmacy and Independent healthcare regulation. It was concluded that enforcement action was not appropriate at present. The requirement is assessed as moving towards compliance and has been stated for a third and final time. A follow up monitoring inspection will be undertaken to assess if the required action has been taken.	Moving towards compliance

4.	27(2)(d)	The registered persons must ensure that all parts of the nursing home are kept clean and reasonably decorated.	The inspector continues to identify deficits in respect of cleanliness and the need for upgrading in identified areas of the home. Post inspection, FSHC submitted an environmental checklist confirming the areas where flooring has been replaced, rooms repainted and curtains, bedding, furniture and seating was replaced. Given that this requirement has been stated for a third time, enforcement action was considered in discussion with the Head of Nursing, Pharmacy and Independent healthcare regulation. It was concluded that enforcement action was not appropriate at present. The requirement is assessed as moving towards compliance and has been stated for a third and final time. A follow up monitoring inspection will be undertaken to assess if the required action has been taken within the timescales agreed.	Moving towards compliance

5.	14(2)(c)	The registered person shall ensure as far as reasonably practicable that- unnecessary risks to the health or safety of patients are identified and so far as possible eliminated.	In the main, risks to patients' health and safety were being identified. In relation to one identified patient, the inspector was not assured that robust arrangements were in place for the management of a lap belt. Similar issues had previously been identified. The action plan submitted post inspection has provided confirmation to RQIA that a review has been completed of all patients requiring the use of lap belts to ensure the documentation in use is in keeping with FSHC policy and procedures. Whilst this requirement has now been addressed, management must ensure the use of restrictive practice is kept under continuous review. This will continue to be monitored by RQIA during inspection.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	25.6 32.1	The registered persons must confirm that issues identified by relatives in respect of the arrangements for home laundry and the cleanliness of the premises are effectively addressed and RQIA informed of the action taken when returning the Quality Improvement Plan.	The registered manager provided confirmation that these issues were discussed with care and laundry staff during staff meetings. The returned quality improvement plan confirmed that key workers were assigned to tidy patients' wardrobes on a weekly basis. This recommendation will not be stated again. Refer to requirement 4 above for further information.	Substantially compliant
2.	25.2	The registered manager must provide confirmation to RQIA that newly appointed staff who had submitted registration applications to NISCC have been registered.	The registered manager confirmed that with the exception of recently recruited care staff, the remaining care staff have been registered with NISCC.	Compliant

3.	20.4	The registered person shall ensure that a system is implemented to confirm that all staff trained in first aid has been deemed competent and capable, and written evidence of this process are maintained. • Confirmation should be submitted to RQIA that all staff including recently recruited staff have received first aid training and have been deemed competent by the registered manager.	The registered manager provided confirmation to the inspector that all staff are trained and deemed competent in First Aid. Records of the staff training matrix and training provided were retained 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.

RQIA did receive a complaint through its duty system on the 08 December 2014. In view of the information received the date for this inspection was rescheduled.

RQIA also corresponded with the regional manager of the company requiring an investigation to be undertaken into the identified issues and a report of the investigation to be submitted to RQIA within an agreed timescale.

An investigation report was submitted from the regional manager as requested post inspection. The investigated outcome indicated that the majority of issues raised were not substantiated and one was not fully substantiated. Confirmation was provided that the investigation had provided learning outcomes for the home and focus areas for improvement.

RQIA are not part of the safeguarding investigation process but have been appropriately notified by the home's management of ongoing investigations in relation to alleged safeguarding of vulnerable adults (SOVA) issues.

In relation to ongoing SOVA issues, updated information was provided by Trust representatives prior to the inspection in respect of one SOVA issue.

During the inspection the registered manager provided confirmation that the outcomes of safeguarding investigations undertaken by external agencies remain outstanding**.** It was agreed with the registered manager that a formal update would be provided by FSHC to RQIA in respect of ongoing investigations. A requirement has been carried forward again until the safeguarding investigations are concluded.

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 three patients' care records evidenced that bladder and bowel continence assessments were undertaken. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. In one of the care records reviewed, the bowel assessment did not incorporate the bowel type referencing the Bristol stool chart. A recommendation is made. There was evidence in the care records that bladder and bowel assessments and continence care plans were reviewed and updated at least monthly or more often as deemed appropriate. The care plans reviewed addressed the patients' assessed needs in regard to continence management. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken as part of the continence admission assessment and patients were referred to their GPs as appropriate. Review of three patient's care records and discussion with three visiting relatives evidenced that they had been involved in discussions regarding the agreeing and planning of nursing interventions. A review of a sample of daily progress notes completed by nursing staff recorded statements such as "incontinence needs attended to," or "assistance by one with elimination needs". It was the inspector's professional view that this information was not patient specific or person centered, therefore improvements in recording were needed. In addition the insector was not assurred, that there was an effective and consistent processes to record and monitor bowel function referencing the bristol stool chart as this information was not recorded in the patients'	Substantially compliant

nursing notes. Records available indicated staff were recording the informtion separately from the patient's daily progress notes, and as well as a lack of consistencty, the record reviewed had not been consistently completed. To enable traceability of bowel function, a consistent record referencing the bristol stool chart should be recorded in each patient's progress record as this is the patient's personal record of care and treatment. A recommendation is made in respect of these issues. This was also discussed with the peripatetetic manager who confirmed that it the expection of FSHC that this information is recorded in the relevant section of the daily progress record for each patient. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
Confirmation was provided by the peripatetic regional manager that admission policies include information on • continence / incontinence management The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence There were no patients requiring catheter care or stoma care on the day of inspection. Discussion with staff revealed that they had an awareness of some of these policies, procedures and guidelines. The inspector discussed the management of continence care with three staff. Staff knowledge was varied. One care assistant advised of specific training they had in understanding the patient experience. The staff member confirmed the training had been very beneficial in increasing understanding as well as providing awareness and insight into some of the difficulties being experienced by patients. Issues such as managing continence were covered during this practical training session. A recently appointed staff member was also taking part in the patient experience training during the inspection.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not applicable.	Not applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector evidenced from training information reviewed, that a number of staff had successfully completed training entitled “skincare for the incontinent individual”. Confirmation was also provided by the registered manager that as part of ongoing improvement for the management of continence care, a bowel management workbook had been implemented by the company, and training for staff on the use of the workbook was due to be arranged. The inspector was unable to evidence that all staff had completed continence care training., or that all nursing staff employed in the home had been assessed and deemed competent in male/female catheterisation and stoma management. A recommendation is made in relation to staff training for continence care. The action plan submitted to RQIA post inspection provided confirmation that all staff working in Ashgrove would receive continence care training to include catheter care by 27 February 2015. Currently there are no continence link nurses working in the home. In addition, as part of the quality assurance process of the home, audits on continence management should be undertaken and the findings acted upon to enhance standards of care. A recommendation is made.	Moving towards compliance

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

11.0 Additional Areas Examined

11.1 Care Practices

During the inspection staff were noted to treat the patients with dignity and respect. Good relationships were evident between patients and staff. The demeanour of patients indicated that they were relaxed in their surroundings. Staff were observed responding to patients' requests promptly, and two moving and handling practices observed during this inspection were undertaken in accordance with best practice.

Overall patients were well presented with their clothing suitable for the season. The personal care arrangements for one identified patient required improvement to ensure the patient was appropriately shaved and nail care was clean and well maintained. The findings were highlighted to the registered manager. A requirement is made in accordance with regulation 13(1) (b).

The action plan submitted post inspection has confirmed that care staff will complete a daily personal care form to evidence the personal care delivery of each patient. The completion of this record will be monitored by registered nursing staff within each unit.

The inspector was not assured that issues pertaining to restraint were managed appropriately for one identified patient. The patient was observed seated in a chair which had a lap belt attached. This was not in use during the period of observation. Discussion with care staff and a review of the patient's contemporaneous care records indicated occasions when the lap belt had been in use. The care records examined did not include any consent information by the patient or discussion with their representative regarding the use of restraint to maintain patient safety. This was brought to the attention of nursing staff and the registered manager. Confirmation was provided to the inspector that a telephone discussion had been held with the patient's representative, and a best interest decision had been recorded during the inspection.

The registered manager must ensure that at all times the use of restrictive practice is in accordance with best practice guidelines. The action plan submitted post inspection has provided confirmation to RQIA that a review has been completed of all patients requiring the use of lap belts to ensure the documentation in use is in keeping with FSHC policy and procedures.

A similar issue had also been identified during the previous care inspection. It was concerning that similar practices were continuing to recur. Whilst the requirement in respect of restrictive practice has now been addressed, management must ensure the use of restrictive practice is kept under continuous review. This will continue to be monitored by RQIA during inspection.

Where restraint is provided over and above nursing interventions which have been agreed by the patient, their representatives and the multidisciplinary team, a report should be submitted to RQIA as soon as is practicable to comply with regulation.

The inspector observed one patient with an inflamed eye with the inflammation spreading to the patient's cheek area. The care records reviewed did not provide any information in respect of the inflammation or of the care and treatment being provided. The support manager also examined the patient and provided confirmation to the inspector that medical intervention would be sought. The health and welfare needs of patients must be promptly identified and addressed in a timely way. A requirement is made in accordance with regulation 13(1) (b).

The care records of another patient who was receiving treatment for a diagnosed infection had not been updated to reflect the planned treatment and care for the current infection. A requirement is made in accordance with regulation 16(1) (2).

11.2 Complaints

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

As indicated in 9.1of this report, RQIA received a complaint in respect of issues pertaining to patient care and staff communication. Upon receipt of the complaint RQIA corresponded with the regional manager for the home requesting an investigation to be completed in respect of the issues raised. This investigation was ongoing on the day of inspection and an investigation report has since been submitted to RQIA.

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. There was evidence that some complaints had been raised with trust representatives and responses were provided to the trust in respect of these issues.

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' Views

The inspector met all patients and spoke to four individually and to others in groups. A number of patients were unable to express their views verbally. Those who were able expressed satisfaction with the standard of care, facilities and services provided in the home, and there were no issues raised with the inspector.

Examples of patients' comments were as follows:

"The staff are pleasant and look after us well"
"I enjoy the food, it is usually good."
"I would prefer to be at home, but who wouldn't"
"It is warm and comfortable here"

Three visiting relatives also spoke with the inspector described their experience when visiting the home. Two relatives also completed questionnaires.

The three relatives visited the home regularly and confirmed they were generally satisfied with the care provided to their relatives.

One relative confirmed their relative "never gets an infection" and expressed the view that "staff are quick to act." The relative confirmed that they often visited the home during mealtimes and described the meals as "beautiful" The relative stated "the home was understaffed at times". The relative advised that any concerns which had been raised were addressed quickly.

The relative completed a questionnaire and confirmed "they were very satisfied with the care."

Another relative who spoke with the inspector also discussed their experience. The relative provided some positive comments but also confirmed that they had raised concerns with the management of the home and with representatives from the commissioning trust.

Examples of the concerns identified included lack of staff, lack of activity provision and cleanliness of the home. The relative verbally expressed the view that "whilst some improvements have been made, more are required".

The third relative consulted confirmed overall satisfaction with the care and treatment provided to their relative and provided positive comments to the inspector.

In responses to a series of questions included in the questionnaires, the respondents confirmed that staff always or often gave the best care; though both respondents indicated there is not always sufficient time for staff to give care and treatment to patients.

The responses indicated that staff made the care better always or often, though one respondent indicated that consultation with staff occurred sometimes. Both were fully satisfied that they were involved and included in the care provided to their relative.

11.6 Management, Governance and Staffing Arrangements

The peripatetic manager had completed the monthly regulation 29 report on 15 December 2014 on behalf of the responsible individual of FSHC. Confirmation was provided that environmental issues had been highlighted during this visit.

Confirmation was provided that night time monitoring visits had recently been undertaken by two managers from FSHC to review care practices. The inspector was informed whilst overall findings were positive, identified staff have received face to face retraining and reassessment of competency in respect of a care practice.

The home has a full time registered manager who has worked in the home for a number of years. A support manager who is providing management support to the registered manager was also in the home on the day of inspection.

A deputy manager and a nursing sister are also part of the management team

An examination of the duty rotas for the week of inspection evidenced that staffing is in accordance with RQIA's minimum staffing guidance for nursing homes. Confirmation was provided that a designated person had recently been appointed to undertake activity provision.

It is the responsibility of the registered persons to continuously review the home's staffing arrangements to ensure that sufficient numbers of experienced and competent staff are available to meet the needs of patients at all times. In view of the comments made by relatives and staff, the staffing arrangements should be reviewed and RQIA informed of the outcome. A recommendation is made.

The registered manager confirmed that a registered mental health (RMN) nurse had recently been appointed. The nurse's main role and function is to promote and improve practice and innovation in dementia care throughout the home. This is an encouraging appointment.

The inspector spoke with seven staff individually, including the deputy manager, nursing staff and care staff, and all communicated appropriately. One care staff member whose first language was not English experienced some difficulty in explaining their knowledge of continence care. This was discussed with the registered manager. A recommendation is made.

Five staff also returned completed questionnaires during the inspection and two questionnaires were submitted to RQIA post inspection.

Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

Examples of staff comments were as follows;

"More staff in morning time"
"More time to sit with residents one to one"
"Here at Ashgrove, we value each resident's rights, beliefs, preference and life history.
"We offer individualised care in a friendly environment, and comfort and reassurance in times of distress"
"I think it is lovely how the staff look after and care for the residents"
"The increasing burden of paperwork is reducing the time given to deliver care to patients"

11.7 Environment

The inspector was informed that, a programme of redecoration and upgrading has been implemented since the previous care inspection undertaken in June 2014. Further work was also scheduled.

Confirmation provided to RQIA post inspection confirmed environmental upgrading included the replacement of flooring, repainting of a number of bedrooms, replacement of curtains, bedding, furniture and seating in identified areas and a full refurbishment of the home's kitchen.

The inspector undertook an inspection of the premises and viewed the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas. Sluice and laundry areas were also examined.

However, the inspector was unable to evidence compliance in respect of requirements made previously regarding infection prevention and control, the cleanliness of the premises and the management of odours.

The following issues which do not meet with best practice in terms of infection prevention and control were evidenced:

- cream prescribed for a male patient was observed in a female patient's bedroom;
- two mattresses were observed stored in one shower room in Carlingford Suite;
- hoisting slings were observed stacked on top of each other posing infection risks to patients;
- the laundry area was in need of upgrading to ensure effective infection prevention and control practices are promoted, for example, walls and tile areas were not visibly clean and the sink unit including the draining area was not clean;
- the casing for the sink in one patient's bedroom was worn and in need of replacement; and
- menu holders observed in one dining room were in need of cleaning.

The following issues which do not meet with best practice in terms of cleanliness, redecoration and the management of odours were evidenced:

- a number of walls throughout the premises were in a poor state of repair, in some visible damage was also noted. These areas cannot be effectively cleaned;
- a number of doors, architraves and skirting boards throughout the premises were in poor state of repair and exposed wood was evident. These areas cannot be effectively cleaned;
- one bath was dirty and in need of cleaning;
- one vacant room was in need of painting before being allocated to a new patient;
- one identified patient's chair was in need of cleaning;
- the laundry ceiling was in need of painting;
- the designated smoke room was cluttered and untidy and was being used to store items including paint; and
- malodours were evident in a number of bedrooms, bathroom/shower rooms and toilet areas in both units of the home. In one unit there was a malodour in one sluice.
- the inspector was concerned that identified areas were not clean

An urgent action note was issued to the registered manager on conclusion of the inspection detailing the immediate action required in respect of the issues identified.

In addition a serious concerns meeting was held with Four Seasons Healthcare representatives post inspection to discuss the above concerns. During the meeting FSHC representatives presented an action plan detailing how the issues are to be addressed.

Enforcement action was considered in discussion with the Head of Nursing, Pharmacy and Independent healthcare regulation. It was concluded that enforcement action was not appropriate at present.

RQIA have agreed to give the registered persons a period of time to fully implement the required actions. Two requirements which had been assessed as moving towards compliance have been stated for a final time.

A monitoring inspection will be undertaken by RQIA within a specified timeframe to ensure the required actions have been taken as agreed.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Bijini John, 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:

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

Appendix 1

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

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
Prior to admission to the home, the Home Manager or a designated representative from the home carries out a pre-admission assessment. Relevant information will be gathered from the resident, family care records and multidisciplinary records such as OT, physio etc. In case of emergency admission where an assessment cannot be carried out, then the information will collect over the phone followed by the documents from District Nurse and Social worker. On Admission an identified nurse completes initial assessment after communicating with the resident and representative. The risk assessments will be carried out immediately after admission. This includes Braden Scale, Nutritional Tool, Handling Assessment, Wound Assessment etc.	Compliant

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 Names nurse comprehensive and holistic assessment of resident's needs using an appropriate tool within 7 days of admission. Named nurse meet with resident and relative and a detailed care plan will be developed. The care plan demonstrates maximum independence and focus on person centered care. All recommendations made by multidesciplinary team are included in the care plan. Registered Nurse is fully aware of TVN reference procedures if necessary. The assessment of TVN will be associate with care plan and kept in the file for referals. Reference will be made for other wounds such as leg ulcer or any other complicated wounds. Registered Nurse makes decision about referal for dietian based on the MUST score and clinical judgement. This will be usually done through GP clinic. All advise, treatment and recommendations from Dietian are reflected to care plan and documented in multidesciplinary forms.	Substantially 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**
Risk assessments, need assessments and care plans will be evaluated monthly and when required. The resident is assessed on a daily basis with the changes in progress notes. All changes and developments will be passed over to the next shift through hand over report and 24 hours HM report to Home Manager.	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 take reference from guidelines of NICE, RCN, GAIN, NIPEC, HSSPS, PHA, and RQIA when planning care. The pressure ulcer grading screening tool is developed based on EPUAP grading system. Nurses uses valid tools to grade and assess the pressure ulcer or other type of wound according to NICE guidelines. Staff also refer to FSHC policy and procedure in relation to nutrition, wound, diabetic etc.	Substantially compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Residents all activities, interventions and procedures are recorded and readily available. These records are maintained according to NMC guidelines - Record Keeping: Guidance for Nurses and Midwives. Meals provided to residents are recorded in the meal chart as necessary, the catereing manager keeps records of residents special dietary requirements. Residents who are assessed as "at risk" of malnutrition or dehydration are maintained on a food and fluid chart. Referals made to SALT, Dietian etc when required.	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**
Details of care deliverd are recorded on a daily progress notes with a least a minimum of one entry during day and at night. More entries made as required and when a multidisciplinary recommendation made or residents condition changes.	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**
The Care Management meetings usually takes place 4 to 6 weeks post admission and annually there after. Additional reviews taken place when necessary and on request. The Trust will be responsible for the review arrangements, however Homes reminds if one is overdue. All recommendations are actioned by The Home with care plan reviewed to reflect the changes.	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 procedure in relation to nutrition for the best practice.Registerd Nurse carries out an initial assessment soon after the admission, follows any recommendations made by SALT or dietian. Risk assessment and care plan is evaluated monthly and when residents condition changes. Ashgrove has 3 weeks menu which is reviewed 6 monthly based on season. The menu is complied following consultation with residents and their representatives from resident/relative meeting and food questionaire. The PHA document - "Nutritional and Menu Checklist for Residential and Nursing Home" is used to ensure the menu is nutritious and varied. The recommendations from Dietian and SALT are passed on to the Cook. Residents are always given a choice of food at each meal time. The menu offers the same choice of meal as much as possible for therapeutic and modified diets.	Substantially compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
Registered nurses and most of the care staff have received training on dyshagia Currently no residents receive PEG feed. The SALT and dietian provide advise on how to feed residents who are having difficulties. Nurses refer to up to date guidance such as NICE. All recommendations made by SALT are incorporated with care plan to include type of diet, consistency of fluids, position during feeding, euipment or special cutlery to use and assistance required. The kitchen staff will be informed of all recommendations and special dietary requirment for residents. Meals are provided in the following times: Breakfast 9.00 - onwards Morning Tea - 11am Lunch - 12.45pm Afternoon Tea - 3pm Evening Dinner - 4.45pm Supper - 08.00pm There are variations to the above timing as per residents request. Hot and cold drinks are available all the time. Any matters concerning residents eating or drinking are detailed on individual care plans, such as likes, dislikes, type of diet, consistency of fluid. Meals are served in the presence of a staff member, residents who need supervision are part or full assisted and supervised for the same. Each nurse now has completed an educational e-learning module on pressure area care. The Home has 3 link nurses who had received enhaced training to provide support to other staff. All nurses within the Home have completed a competency assessment on wound care. Competency Assessments have a quality assurance element built into the process.	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 Care Inspection

Ashgrove

17 December 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 Mrs Bijini John, registered manager 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
C/F	13(1)(a)	The registered persons must ensure that upon conclusion of safeguarding of vulnerable adult investigations, RQIA are informed of the outcome, and of any action which has been taken. • The registered manager agreed to Inform RQIA of the outcomes and of any recommendations which are made to the home upon conclusion of on-going investigations. **Ref: Follow up to previous issues**	Two	Still on going .No report received from PSNI	Upon conclusions of the investigations.
1.	13(7)	The registered persons must ensure that effective processes are in place to address infection control deficits. Evidenced based practice in terms of infection prevention and control must be instigated at all times. • cream must only be used for the patient for whom it is prescribed • mattresses should be appropriately stored • hoisting slings should be stored appropriately and in accordance with manufacturer's instructions	Three	Creams are only using for prescribed residents . Identified cream has been removed from the room . Mattressess are stored appropriately in a designated area. An area has been allocated for the storage of hoist and slings. The laundry has been deep cleaned and scheduled for painting by end Feb 2015 .	From date of inspection

		• the laundry must be upgraded • sink casing's which are worn should be replaced in identified bedrooms • menu holders must be kept clean This requirement has been stated for a final time. **Ref: Follow up to previous issues and Additional Areas Examined 11.7**		The damaged sink replaced with new vanity units . The menu holders has been replaced with new holder.	
2	27(2)(d)	The registered persons must ensure that all parts of the nursing home are kept clean and reasonably decorated. • walls throughout the premises must be maintained to a good state of repair to enable them to be effectively cleaned • doors, architraves and skirting boards must be repaired, repainted and or replaced to enable them to be effectively cleaned; • baths should be cleaned after use • vacant rooms should be repainted before allocation to a new patient; • patient seating should be kept clean and well maintained at all times • the laundry ceiling should be repainted • odour management issues in identified bedrooms and sluice areas must be effectively addressed • the designated patient smoke room should be clean, tidy and available for its stated purpose	Three	Identified bedrooms have been painted and new floor coverings are presently being fitted. Painting is in progress in the corridors, lounges and dining areas as per action plan. This will incoporate the repair of damages walls, architraves and skirting boards. The baths are decontaminated after use and records maintained. All seating has been deep cleaned and a schedule in place for maintaining. Pull cords are covered with plastic wipeable tube. The smoke room has been decluttered and deep cleaned.	From date of inspection

		• the home must be kept clean at all times. This requirement has been stated for a third and final time. **Ref : Follow up to previous issues and Additional Areas Examined 11.7**		Deep cleaning has been completed in all areas in the home . Infection control audits carried out for each units. Domestic hours have been reviewed and increased to include a Housekeeper.	
3	13(1)(b)	The registered person must ensure that the health and welfare needs of patients are effectively addressed: • the personal care needs of an identified patient must be appropriately addressed. • the health and welfare needs of patients must be promptly identified and addressed in a timely way. **Ref: Additional Areas Examined 11.1**	One	Identified patients personal care needs were attended to immediately. The issue with the identified resident has been addressed	From date of inspection
4	16(1)(2)	The registered person must ensure that each patient's plan of care is updated in a timely way to reflect the patient's prescribed care and treatment. **Ref: Additional Areas Examined 11.1**	One	Addressed and on going Restraint log has been updated.	From date of inspection

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	19.1	The registered manager must ensure that a completed bowel assessment referencing the Bristol Stool chart is completed for each patient. **Ref: Section 10, criterion 19.1**	One	This has been addressed and is on going .	31 January 2015
2	19.1	The registered manager must ensure that patient daily progress notes reflect person centered information in respect of continence care, and a consistent record referencing the bristol stool chart is recorded in each patient's progress record to enable effective traceability of bowel function. **Ref: Section 10, criterion 19.1**	One	Discussed with staff and they are recording the bowel function in the daily progress sheet .	31 January 2015
3	19.4	The registered manager must confirm that all nursing and care staff have received continence care training. **Ref: Section 10, criterion 19.4**	One	I can confirm that 90% of staff have received continence & skin Care training. Further dates to be confirmed .	27 February 2015
4	19.4	The registered manager should ensure that a link nurse(s) for continence care is	One	A continence link nurse has been allocated	27 February 2015

		appointed, and audits on continence management are undertaken and the findings acted upon to enhance standards of care. **Ref: Section 10, criterion 19.4**			
5	25.2	The registered manager must review staffing arrangements to ensure patients' individual needs are delivered in a person centred way at all times. The registered manager must ensure that all staff providing care and treatment to patients can communicate effectively, and where necessary effective systems are implemented to support individual staff. RQIA should be informed of the staffing review outcome and of any action taken by management to assist communication for individual staff. **Ref: Additional Areas Examined 11.6**	One	Staffing levels have been reviewed and are in line with minimum staffing guidelines. Domestic service hours have been increased to include hours for a housekeeper. Staff who require further assistance with communicating effectively have been directed to local English classes and support had been provided from FSHC training department on clinical areas.	When returning the Quality Improvement Plan

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	Bijini John
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall JP Watson DIRECTOR OF OPERATIONS 9/2/15

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	J Scarlett	16.2.15
Further information requested from provider			