Unannounced Care Inspection

Name of Establishment:	**Avila Private Nursing Home**
RQIA Number:	**1464**
Date of Inspection:	**10 March 2015**
Inspector's Name:	**Donna Rogan**
Inspection ID:	**IN017279**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 General Information

Name of Establishment:	Avila Private Nursing Home
Address:	32 Convent Hill Bessbrook Newry BT35 7AW
Telephone Number:	02830838969
Email Address:	avilanh@btconnect.com
Registered Organisation/ Registered Provider:	Kilmorey Care
Registered Manager:	Lucy Holt
Person in Charge of the Home at the Time of Inspection:	Lucy Holt
Categories of Care:	Nursing care: NH-LD NH-LD(E) NH-I NH-PH NH-PH(E)
Number of Registered Places:	39
Number of Patients Accommodated on Day of Inspection:	39
Scale of Charges (per week):	£567.00-£609.00
Date and Type of Previous Inspection:	17 April 2013 Primary Announced
Date and Time of Inspection:	10 March 2015 10.30 – 16.30 hours
Name of Inspector:	Donna Rogan

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 registered nurse manager.
- Discussion with the nurse in charge.
- 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.
- Observation during a tour of the premises.
- Evaluation and feedback.

5.0 Consultation Process

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

Patients/Residents	25
Staff	12
Relatives	2
Visiting Professionals	0

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	2	0
Relatives/Representatives	4	4
Staff	10	7

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.

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

Avila Private Nursing Home was initially registered on 1 November 1989 for thirty six patients and was then further extended and registered in January 2014 to accommodate a maximum of thirty nine patients. The home also provides respite care.

The facility is located on the outskirts of Bessbrook and comprises of thirteen single bedrooms, thirteen double bedrooms, three sitting rooms, a chapel, conservatory, dining room, kitchen, laundry, toilet/washing facilities, staff accommodation and offices.
The gardens and grounds are satisfactory and adequate car parking facilities are available.

Nursing care

NH-I	old age not falling into any other category
NH-PH	physical disability other than sensory impairment under 65
NH-PH(E)	physical disability other than sensory impairment over 65 years
NH-LD	
NH-LD(E)	A maximum of 1 patient shall be accommodated

8.0 Executive Summary

The unannounced care inspection of Avila Nursing Home was undertaken by Donna Rogan on 10 March 2015 between 10:30 and 16:30. The inspection was facilitated by Lucy Holt, registered manager, who was available throughout the inspection and for verbal feedback at the conclusion of the inspection.

As a result of the previous inspection there were two requirements and one recommendation issued. Both the requirements and one recommendation were evidenced to be compliant. Details of the inspection findings can be viewed in the section following this summary.

The focus of this inspection was Standard 19: Continence Management. 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 and as required. The assessment of patients' needs was evidenced to inform the care planning process. The continence assessment and care plan stated the type of continence product to be used and the level support to be given to the patient.

Policies, procedures and guidelines in the promotion of continence and the management of incontinence were available in the home. Discussion with the registered manager confirmed that staff were trained in continence care. A review of the training records evidenced that all registered nurses were trained in the management of catheter care. Care staff spoken with stated they also have received training on continence management and this included product training. There were no requirements or recommendations made in relation to this theme.

9.0 Additional Areas Examined

Care Practices
Complaints
NMC Declaration
Patients Comments
Relatives Comments
Staff Comments
Environment

The overall management of activities were commended on this occasion. The environment was also observed to be tidy and well organised. There were no malodours detected and all areas of the home were observed to be spotlessly clean. The inspector commended the standard of cleanliness to domestic staff on duty on the day of inspection. Four care records were reviewed and all were found to be reflective of the patients' needs. They were updated in a contemporaneous manner. The overall quality of the care records are also commended on this occasion. Details regarding the inspection findings for these areas are available in the main body of the report.

10.0 Conclusion

The inspector can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a good standard and patients were observed to be treated by staff with dignity and respect. Good relationships were evident between staff and patients.

There were no requirements or recommendations made as a result of this inspection.

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

11.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	21 (5) (b)	Ensure competency and capability assessments completed for all nurses taking charge of the home includes the action to be taken in the event of an allegation of abuse. Ref 16.3	The inspector reviewed two competency and capability assessments completed for two nurses taking charge of the home. The competency and capability assessments included the action to be taken in the event of there being an allegation of abuse made.	Compliant
2	12 (1) (b)	Ensure the wound care/pressure ulcer policy is updated to reference the NICE guidelines in keeping with best practice.	A review of the wound care/pressure ulcer policy evidenced that it has been updated to reference the NICE guidelines in keeping with best practice.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	25.12 25.13	Ensure information is placed on the patient/relatives' notice board informed patients and their representatives that copies of the Regulation 29 unannounced visit reports and annual quality review reports were available on request.	There was a notice displayed in the patient/relatives information board that copies of the Regulation 29 unannounced visits reports and the annual quality review reports were available on request.	Compliant

11.1 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 of 17 April 2013, RQIA have not been notified by the home or SHSCT of ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues.

12.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**Compliance Level**
Inspection Findings:	
Review of four patients' care records evidenced that bladder and bowel continence assessments were undertaken. The outcome of the assessments, including the type of continence products to be used, was incorporated into all four patients' care plans on continence care. There was evidence in four patients' care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. Care records evidenced that the 'Bristol Stool Chart' was referenced in patients' records and the monthly evaluation of the care plan. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their General Practitioners as appropriate. Review of four patients' care records evidenced that patients or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Compliant

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

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**Compliance Level**
Inspection Findings:	
Not applicable	Not applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**Compliance Level**
Inspection Findings:	
Discussion with the registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the registered manager revealed that all registered nurses in the home had received recent training and were deemed competent in female and male catheterisation and the management of stoma appliances. A review of two members of staffs' induction programmes evidenced that continence care was included in the programme for all grades of care staff.	Compliant

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

13.0 Additional Areas Examined

13.1 Care Practices

During the inspection staff were noted to treat the patients with dignity and respect. Good relationships were evident between patients and staff.

Patients were well presented with their clothing suitable for the season. Staff were observed to respond to patients' requests promptly. The demeanour of patients indicated that they were relaxed in their surroundings.

There were individual activities on-going in the home on the day of inspection. Activities were observed to be individualised and well organised, records are maintained. The inspector commends the standard of activities observed on this occasion.

13.2 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.

13.3 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.

13.4 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.

13.5 Patients and Relatives Comments

During the inspection the inspector spoke with 25 patients individually and with others in groups. Patients whom the inspector could communicate indicated that they were satisfied with the standard of care, facilities and services provided in the home. These patients also indicated by positive gestures that they were happy living in the home. The inspector also met with two relatives during the inspection. Examples of patients' and relatives' comments were as follows:

"This place is marvellous"
"It couldn't be better"
"Staff are great we are kept well informed"

"I'm very happy here"
"Staff are attentive and they listen to me"
"When I buzz for assistance, staff usually answers promptly"
"I've no complaints"
"Food is really good, it's homemade and we get a choice every day"
"The staff couldn't be any kinder"

There were two patient questionnaires issued. None of the questionnaires were returned in time for comments to be included in the report. There were four relatives questionnaires issued. All four were returned in time for comments to be included in the report. Comments returned in the questionnaires were as follows;

"The home is everything I want for my mum. Staff are excellent"
"My mum is so content, from she came into Avila"
"Staff are so welcoming"
"Staff are pleasant and dignified"

There were no issues raised by patients or relatives during this inspection.

13.6 Staff views

During the inspection the inspector spoke with approximately twelve staff. Staff spoken with expressed satisfaction with the level of care in the home. All stated that the staffing arrangements were sufficient in numbers to meet the needs of the patients. Staff spoken with informed the inspector that they had regular staff meetings and were confident in raising issues if required and that they could approach management and have them resolved. There were ten questionnaires issued to staff. Seven were returned in time to include comments in the report.

Examples of comments made to the inspector and in the returned questionnaires included the following;

"We work hard to make sure the residents get all they need"
"I like working here"
"We attend training at least every year"
"We are all a happy bunch"
"The manager is great, we are listened to"
"We attend regular staff meetings"
"The standard of care provided in the home is very high"
"Care staff encourage residents to be independent and to join in with everything"
"Patients' needs are always met and any concerns dealt with promptly"

There were no issues raised by staff to the inspector during the inspection.

13.7 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. There were no malodours in the home. The inspector commended the standard of cleanliness to domestic staff on duty on the day of inspection.

14.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Lucy Holt, as part of the inspection process.

Where the inspection resulted in no recommendations or requirements being made the provider/manger is asked to sign the appropriate page confirming they are assured about the factual accuracy of the content of the report.

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:

Donna Rogan
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**
All planned admissions to the Home are pre-assessed by either the nurse Manager or a Senior Nurse, using the Roper Tierney Logan model in conjunction with the information received from the Care Management team. When patient's are admitted a Nurse undertakes an activities of living assessment, based on the pre-assessment tool and information gained from the Patient and their representatives, and the care management team. This is undertaken within 11days of admission. The only exceptions are where an emergency/out of hours admission has been arranged. The Roper Tierney Logan	Compliant

tool is used to complete the comprehensive, holistic assessment of patient care needs and includes the Braden and MUST risk assessments.	

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**
Each patient is allocated a named Nurse who developes a care plan with both the Patient and their representatives to promote independence in conjunction with the disciplinary team. Nursing Staff have access to MDT including TVN's by telephone, email and a formal referral system.	Compliant

The Braden Scale assists Nurses to identify those patients at risk of developing pressure ulcers. A care plan is then developed to minimise risk and promote comfort for the patient. Advice may be sought from other health care professionals. All Nursing Staff have access to the referral system for TVN and podiatry input. Dietetic services are engaged when the MUST tool and food records indicate the need for specialist intervention. The nutritional plans developed with the Dietician and patient are adhered to, reported upon and reviewed on a monthly basis or sooner if there are concerns.	

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**
All care given is evaluated daily. This is a reflection of the risk assessment and subsequent care plan, which are reviewed monthly by the named Nurse. This ensures changing needs are identified, and referrals are followed up.	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**
Care is evidence based using NICE guidelines. Advice and guidance is also taken from the MDT members. All Nurses have received Wound Management Training in June 2014 and are familiar with and use the European Pressure Ulcer Grading Tool. Nurses and Catering Staff are familiar with Nutritional Guidelines. It is intended to provide MUST training updates for all Nurses within the next three months.	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**
Timely accurate records are maintained for each patient reflecting the agreed outcomes. Meal choices, meals taken or not and actions planned are recorded. Referrals are made as necessary and follow up action taken and recorded as appropriate.	Compliant

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

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Patients and their representatives are encouraged to participate and contribute to the review process through the formal multidisciplinary review meetings as arranged by the relevant HSC Trusts. These reviews are recorded, agreed and signed, and Care plans further developed to reflect any change identified and goals as agreed. Patients and their representatives are kept informed of progress.	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**
On admission, new patients or their representatives meet with Catering Staff to discuss food preferences, a record of same is kept in Kitchen and patients folder. Menus are planned to provide as nutritious and varied diet as possible; suited to the individuals needs. Advice from Dietician, SALT and other relevant MDT's is followed and documented. Menus are displayed and choice is evident. Cooks are flexible and will cook for the individual should their preference not be on the nemu.	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All Nurses are experienced in managing feeding techniques for those patients who have swallowing difficulties. They are also responsible for the supervision of Care Staff thus ensuring that instructions as drawn up by SALT are understood and adhered to. Meals are provided also throughout the year. Patients birthday's are celebrated with a traditionally decorated cake. Menus reflect that beverages and snacks are available throughout the day. Those patients who wish to have their meals outside the conventional times are catered for. Staffing levels allow adequete supervision and assistance at mealtimes.	Compliant

Risks are assessed and managed as per Care plans and SALT advice and any necessary aids to further reduce risk are provided. Nurses have received Wound Care Management Training in June 2014. This in conjunction with advice from TVN assests them to carry out Wound assessments and choosing the appropriate wound care products and dressings.	

Provider's Overall Assessment Of The Nursing Home's Compliance Level Against Standard 5	Compliance Level
	Compliant

Appendix 2

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

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic care: (BC) – basic physical care e.g. bathing or use 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.

No requirements or recommendations resulted from the announced inspection of **Avila Private Nursing Home** which was undertaken on **10 March 2015** and I agree with the content of the report. Return this QIP to **nursing.team@rqia.org.uk**

Please provide any additional comments or observations you may wish to make below:

NAME OF REGISTERED MANAGER COMPLETING	Lucy Holt
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING	Peggy O Neill

Approved by:	**Date**
Donna Rogan	28 April 2015