Unannounced Care Inspection

Name of Establishment:	**Seapatrick Care Home**
RQIA Number:	**1473**
Date of Inspection:	**9 December 2014**
Inspector's Name:	**Lorraine Wilson**
Inspection ID:	**IN017244**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Seapatrick Care Home
Address:	80 Lurgan Road Seapatrick BANBRIDGE BT32 4LY
Telephone Number:	028 40 628289
Email Address:	seapatrick@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Health Care Mr Jim McCall
Registered Manager:	Edel McCaughley (registration pending)
Person in Charge of the Home at the Time of Inspection:	Hilary Clarke (deputy manager)
Categories of Care:	NH – DE NH – PH (one named person) NH - I
Number of Registered Places:	61
Number of Patients Accommodated on Day of Inspection:	Total- 53 Frail Elderly Unit – 20 Dementia Unit – 33
Scale of Charges (per week):	£581 - £624
Date and Type of Previous Inspection:	13 February 2014 Secondary Unannounced
Date and Time of Inspection:	9 December 2014 11.30am – 17.00 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.
- Discussion with the deputy nurse manager.
- Discussion with the nursing sister and seven staff.
- Discussion with patients individually and to others in groups.
- Consultation with five visiting relatives.
- Review of a sample of policies and procedures pertaining to continence management.
- 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, spoke with five individually and to others in small groups.
Staff	7
Relatives	5
Visiting Professionals	0

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

Issued To	**Number Issued**	**Number Returned**
Patients	0	0
Relatives/Representatives	3	3
Staff	8	3 + 1 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. The requirements made during the previous inspection regarding wound care were followed up during this inspection.

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

Seapatrick Care home is a purpose built nursing home which is situated in Seapatrick, very convenient to Banbridge town and close to a public transport route.

The nursing home is owned and operated by Four Seasons Healthcare and the responsible individual is Mr Jim McCall.
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The current manager Edel McCaughey has submitted an application to RQIA, this application is pending and Ms McCaughey will be referred to throughout the report as manager.

Accommodation for patients is provided in single storey accommodation and there are two units. The nursing unit and dementia units have their own entrance areas.

Within each unit, a number of communal lounges are provided, including a number of television lounges and quiet lounges which are located on corridors throughout the home. One dining room is available in the nursing unit and there are two dining rooms are available in the dementia unit.

The home also provides for catering and laundry services on the ground floor.

A number of communal sanitary facilities are available throughout the home.

A hairdressing facility is provided.

Overall the home is well maintained and there is a secure garden area which can be accessed by patients.

The home is situated in well-maintained grounds and car parking is provided at the front and to the side of the home.

The home is registered to provide care for a maximum of sixty one persons under the following categories of care:

<u>Nursing care</u>

I	old age not falling into any other category to a maximum of 21 patients
PH	one named person under 65 years
DE	dementia care

8.0 Executive Summary

The unannounced care inspection of Seapatrick Care Home was undertaken by Lorraine Wilson, on 9 December 2014 between 11.30 and 17.00 hours

The inspection was facilitated by Hilary Clarke, deputy manager who was available for verbal feedback at the conclusion of the inspection. Claire Doherty, nursing sister of the dementia unit and John Coyle, the peripatetic regional manager were also in attendance for the verbal feedback on conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection on 13 February 2014.

A number of documents were required to be returned to RQIA pre inspection and all the relevant documents were received within the required timescale. Prior to the inspection, these documents were reviewed by the inspector.

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

Throughout the course of the inspection, the inspector met with all patients, speaking with five individually and to others in groups, five visiting relatives and seven staff, also commented on the care and services provided by the nursing home.

Some patients had cognitive impairments and not all were able to provide a view on the care they were receiving. Patients' able to comment about the care were complimentary and no concerns were raised by patients during this inspection.

Five visiting relatives also spoke with the inspector, three relatives confirmed that they were very satisfied with the care and treatment provided to their relative and stated that they found the staff to be attentive and confirmed their relatives care needs were being met. One relative who regularly visited expressed the view that whilst patients were "well looked after", there were insufficient numbers of staff available. The relative described occasions when they visited the general nursing unit and staff were unable to be located. The relative also described occasions when there was a lack of engagement with patients. Refer to additional information11.7.

Throughout the period of this inspection, staff interactions with patients were observed and were found to be positive, caring and respectful. The inspector observed that staff undertook took their duties in an unhurried way and took time with patients.

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.

There is evidence that continence assessments are commenced on admission and continence care plans were in place and these were reviewed and updated on a monthly basis or more often as deemed appropriate.

From a review of the available evidence, discussion with relevant staff and observation, the inspector can confirm that the level of compliance with the standard inspected was moving towards compliance.

To ensure the management of continence care for patients is improved, requirements and recommendations have been made and are recorded in the quality improvement plan. These are in respect of the following areas.

Procedures and guidance documents for continence management should be available for staff and embedded into day to day practice in the home.

Bowel assessments referencing the bristol stool chart should be consistently recorded, for each patient, as well as an effective system to record and monitor bowel function. Prescribed care in respect of catheter management must be provided at all times, for example, the inspector was unable to evidence during inspection that prescribed catheter care had been delivered. Confirmation was provided post inspection of the action taken.

All care and nursing staff require training in continence care, and to meet the needs of patients living in the home, nursing staff require training in female/male catheterisation and the management of stoma appliances.

The quality assurance processes for continence management in Seapatrick could be enhanced by the appointment of a continence link nurse for the home and continence audits being undertaken.

The registered manager was on leave on the day of inspection and the inspection was facilitated by the deputy manager and nursing sister of the dementia unit, both of whom have been working in the home for a number of months. The duty rotas reviewed for the week of inspection indicated that staffing numbers were in accordance with RQIA minimum staffing guidance.

Some nursing staff recently appointed were awaiting their NMC pin number and were working as senior care staff under the supervision of registered nurses. Upon receipt of their registration, the nurses will receive a period of mentorship provided by a designated mentor. Confirmation was provided that recruitment for nursing, care staff and ancillary staff was ongoing, and in the interim agency staff were working in the home.

The inspector also met individually and in private with a number of staff, comments provided were very positive, with the majority of staff commenting on the positive changes which have been made by the nurse manager and the management team. Staff comments indicated that the home could be busy at times, they were very positive regarding the home, the staff team and the care given to patients and no concerns were raised. Refer to section 11.6 of the report.

The home was maintained to a suitable standard of decorative order and hygiene throughout with noted improvements evident.

A number of areas throughout the home had been upgraded during the year and replacement furnishings had been provided. On the day of inspection redecoration work was ongoing in the nursing unit.

The inspector also reviewed and validated the home's progress regarding the four requirements made during the previous care inspection undertaken on 13 February 2014. The findings indicated that three requirements were compliant, one was substantially compliant, and part of the requirement in respect of mandatory training has been stated again.

As a result of this inspection, four requirements and five recommendations were made.

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

The delivery of care to patients was evidenced to be of a satisfactory standard and patients were observed to be treated by staff with dignity and respect.

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

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	15 (2) (a) and (b)	The registered persons shall ensure that the assessment of patients' needs is- (a) Kept under review; and (b) Revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually. Ensure the identified patients', A and B care records are reviewed and updated in keeping with best practice. Ensure that at all times best practice is implemented in regards to wound care in keeping with the homes' policies and procedures. Ensure further auditing is	The inspector can verify that work was ongoing to ensure that the assessments of patients' needs is being reviewed and if necessary revised, for example, confirmation was provided that the deputy manager, nursing sister and nursing staff were reviewing and updating patient care records**.** There is good evidence that wound care is provided in accordance with evidence based practice and confirmation was provided that there was input from specialist tissue viability nursing staff and podiatry staff regarding the management of wounds and leg ulcers. Wound audits are completed monthly with the last completed audit undertaken in November 2014. Confirmation was provided in the returned Quality Improvement plan that a log is kept of all patients' care review meetings which is updated monthly. However, as the log was unable to be located, this information was not validated during this inspection.	Compliant

		implemented to ensure full compliance is maintained in keeping with best practice. Where there are any shortfalls in practice this should be addressed during formal supervision sessions and where appropriate competency and capability assessments of staff should be completed. Records should be maintained.		
2	20 (1) (c) (i)	The registered persons shall ensure that the persons employed by the registered person to work at the nursing home receive, appraisal, mandatory training and other training appropriate to the work they are to perform. Identify a link nurse for tissue viability and provide them with up to date training to guide and provide advice to staff.	Confirmation was provided to the inspector that 70% of staff had completed mandatory training. The deputy manager confirmed that the manager had identified that mandatory training and or updates, were required by a number of staff and prior to this inspection had highlighted to staff the importance of completing mandatory training. Discussion with the manager post inspection, confirmed that training had been provided since the previous inspection, however, a number of staff had since left the home's employment. Confirmation was provided that there were ongoing difficulties with retention of nursing staff and new staff who had recently been appointed, were in the process of receiving training.	Substantially Compliant

			The inspector was unable to evidence that all nursing staff had received wound care training and it was also identified during this inspection, that not all nursing staff had received training and had been assessed as competent in male catheterisation. The inspector also met with a staff member who was working in the dementia unit. The staff member had no previous experience but confirmed they had completed e-learning dementia training, but had received no other dementia training. To enhance staff knowledge in dementia care, face to face dementia training should also be provided. The training areas identified during this inspection are required to meet the needs of patients living in the home, therefore the required .training must be provided, and staff assessed as competent with both competence and training records available for inspection at all times. This requirement must be addressed in full, and a discussion was held with the manager post inspection confirming the need for staff training. The deputy manager and nursing sister have been identified as link nurses for tissue viability and confirmation was provided they are due to	

			receive additional training in this regard. **Part of this requirement is stated again for a third time.**	

3	12 (1) (b)	The registered persons shall ensure that all staff identified as being in charge of the home in the absence of the acting manager should be aware that they are in charge in order to carry out their role and function.	The deputy manager was in charge of the home in the absence of the manager and was working supernumerary on the morning of the inspection. The deputy manager chose to remain on duty during the afternoon to facilitate the inspection. Whilst the deputy manager was aware of her role and function, the inspector was unable to view the deputy manager's completed competency and capability assessments. Confirmation was provided by the manager post inspection that this had been completed as part of the deputy manager's induction programme. A requirement is made that a competency and capability assessment is completed by the manager with all nursing staff who are in charge of the home in the manager's absence.	Compliant
4	14 (2) (c)	The registered persons shall ensure that whilst rooms are being redecorated that the appropriate action is taken to prevent accidents. Access to bedrooms should be made secure whilst work is on-going.	On the day of the inspection, redecoration work was ongoing in the lounge of the nursing unit. A general risk assessment completed on 7 July 2014 was in place.	Compliant

9.1 Follow up on any issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

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

Since the previous care inspection, RQIA had received whistleblowing information in respect of staffing arrangements. RQIA asked the management of the company to investigate these allegations and submit a report to RQIA. The requested information was received and assurances were provided to RQIA in respect of the action taken.
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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 four patients' care records evidenced that bladder and bowel continence assessments were undertaken at the time of admission. However, in the records reviewed, some bowel assessment information was incomplete, for example bowel type, referencing the Bristol Stool Chart was not consistently recorded in the assessments reviewed for two patients. A recommendation is made that where patients require continence management and support, bladder and bowel assessments are completed in full on admission. There was evidence that bladder and bowel assessments were reviewed and updated on a monthly basis. Continence care plans were in place and these were reviewed and updated on a monthly basis or more often as deemed appropriate. 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 GPs as appropriate. There was some evidence that patients and or their represenatives had been involved in discussions regarding the agreeing and planning of nursing interventions, however, not all care plans reviewed addressed each patients' assesed need in respect of continence management. A requirement is made. Daily progress notes completed daily by nursing staff recorded statements such as "continence care provided." It was the inspector's professional view that this information was not specific and more detailed nformation should be recorded.	Substantially Compliant

In addition the insector was not assurred, that an effective consistent processes to record and monitor bowel function referencing the bristol stool chart was in place. For example, in the dementia unit, nursing staff were recording the informtion separately from the patient's daily progress notes, and no reference had been made to the bristol stool chart. In the general nursing unit a separate record of patients' bowel function was maintained recording details of the bristol stool type. 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. Discussion with care staff and observation during the inspection evidenced that continence products for patients were stored in each patient's bedroom. Confirmation was provided by staff that adequate stocks of continence products were consistently available.	

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 deputy manager and nursing sister were unable to confirm that policies and procedures in relation to continence management / incontinence management were in use , or that RCN continence care guidelines were in use within the home. Four Seasons Healthcare have a policy on the management of catheter care, however, as not all staff were aware of this policy, therefore it has not been effectively been embedded into day to day practice. A recommendation is made. The inspector was provided with reference documentation on catheter care which was available in a reference folder for staff. During the inspection, the management of a patient with a complex medical history and a urinary catheter was reviewed. Deficits were identified in respect of catheter management, for example, the care plan indicated the catheter was due to be changed every 10 weeks, however , there were no records to confirm that a catheter change had taken place within the prescribed timescale and this was concerning. A requirement is made. Nursing staff contacted the patient's general practitioner during the inspection, and an urgent action note was left by the inspector on the day of inspection to ensure immediate action was taken. Post inspection confirmation was provided to the inspector via electronic mail that arrangements were in place to replace the patient's catheter. The management of one patient requiring stoma care was discussed at length with the deputy manager, and there was good evidence of the involvement of the specialist stoma nurse in the patient's care. The inspector also spoke with the patient who confirmed satisfaction with the care and treatment being provided.	Moving towards compliance

Discussion with staff revealed that they had some awareness of the management of continence and incontinence, but as previously stated not all those consulted were aware of the policies, procedures and guidelines for best practice. A recommendation has been made for the following guidelines to be readily available to staff and used on a daily basis: • 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 • RCN continence care guidelines	

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	
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:	
There was no evidence from the training records presented that all staff were trained and assessed as competent in continence care. Some staff consulted during the inspection confirmed they had received training in respect of continence products, which incorporated the importance of good skin care. Confirmation was also provided by the peripatetic manager that further continence management training was scheduled for December 2014. It was agreed that a copy of the continence training programme is submitted to RQIA. A recommendation is made. The deputy manager confirmed that they had been assessed and deemed competent in female/male catheterisation and the management of stoma appliances in their previous place of employment. However, competency in this area had not yet been assessed, since commencing employment in Four Seasons Healthcare. In addition the inspector was unable to verify that all nursing staff in Seapatrick had received training and had been assessed and deemed competent in male/female catheterisation and the management of stoma care. To ensure the needs of the patients' who are currently living in the home are met. A requirement is made that nursing staff receive training in male/female catheterisation and the management of stoma appliances, and are assessed and deemed competent. Records of the training provided as well as the assessments of competency must be maintained and available for inspection. Currently there are no continence link nurses working in the home and this is recommended to ensure there is ongoing review of continence management and education programmes for staff. A recommendation is made. In addition, regular audits of the management of incontinence should be undertaken and the findings acted upon	Moving towards compliance

to enhance standards of care. A recommendation is made.	

Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Moving Towards Compliance**

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.

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.

The inspector spent some time discreetly observing the management of lunch within one of the dining rooms in the dementia unit. The meal was nicely presented and the nursing sister was monitoring that patients' were receiving the assistance they required. Staff were observed sitting with patients and engaging with them in a positive way, for example offering choice of food, encouraging patients to eat and drink.

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.

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 monthly monitoring of the home completed on behalf of Four Seasons Healthcare details complaints which have been received each month. The inspector evidenced that responses were made to the Southern Health and Social Services Trust in respect of issues which had been raised by relatives.

There is evidence that complaints were managed in a timely way and in accordance with legislative requirements.

11.3 Patient Finance Questionnaire

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

11.4 NMC Declaration

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

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

11.5 Patients and Relatives Comments

During the inspection the inspector spoke with all patients, speaking with seven individually and with the majority of others in smaller groups.

Whilst not all patients consulted were able to provide a verbal view of the home, those who could confirmed that they were treated with dignity and respect, staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were satisfied with their treatment in the home.

There were no issues raised by patients during this inspection.

Examples of patients' comments were as follows:

"I find the staff lovely they are so helpful and nice"
"I like the food and feel I am well looked after"
"I can't think of anything they can do better"
"they let me do what I like, there are no rules"

Relatives' Views

During the inspection the inspector spoke to five visiting relatives, three of whom also completed questionnaires. Overall positive comments were provided by all relatives. Three relatives discussed in detail their experiences confirming that they were very satisfied with the care and treatment provided to their relatives. The three relatives described good communication with nursing staff and confirmed they were kept informed in relation to care delivery of their relatives

Two relatives did confirm that whilst the staff were very good and worked very hard, "there was not enough of them", and examples were provided to the inspector by one of the relatives that when patients' were requesting assistance, staff were unable to be located at times.

One of the two relatives also indicated that staff did not always engage with patients, an example was provided that some staff would come into the lounge and not speak to patients. One staff member was also singled out as an exemplar for their engagement with patients.

Examples of relatives' comments were as follows:

"this is a really good home and you will not find anything wrong here"
"the staff have always responded well to any queries I have raised"
"my relative was recently discharged from hospital and has improved since coming here"
"I visit daily and the staff are busy, they cannot always be found and have no time to spend with patients"
"as a family we are very happy with the care in this home and would recommend it"

11.6 Questionnaire Findings/Staff Comments

During the inspection the inspector spoke with seven staff individually and in private. Three staff returned completed questionnaires on the day of inspection and one questionnaire was received by RQIA post inspection.

In discussion with staff and in two of the returned questionnaires, staff indicated that they had received an induction, two staff also confirmed in questionnaires they had 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.

However, the three staff who completed questionnaires indicated they were dissatisfied with the time they had to listen and talk to patients. In one questionnaire which was submitted to RQIA post inspection it was noted that the staff member indicated that they were dissatisfied that patients were afforded privacy. There was no other comment made by the staff member in this regard.

Examples of staff comments were as follows;

> "the look of the home has changed. It has more a homely feeling so the residents feel more like their own home. New deputy manager in general has made changes. There are no pressure sores in general, so it shows that good care is being given"
> "the present home manager works out problems promptly"
> "I think Seapatrick is very good"
> …"sometimes we haven't any free time for talk with patients and their families"

11.7 Staffing Arrangements

The duty roster for the week of inspection was reviewed and indicated the staffing was in keeping with RQIA recommended minimum staffing guidance.

A manager with designated hours for management duties is in charge of the home on a day to day basis. An application for registration has been received by RQIA and is being processed.

To enhance the management team, a deputy manager and a nursing sister has been appointed since the previous inspection. Staff consulted were aware of the reporting arrangements in place should they have concerns, and staff were positive in their comments about the current management team and the positive changes being made to enhance patient care**.**

In the absence of the manager, the deputy manager was undertaking management duties on the day of inspection, and whilst aware of their role, function and responsibility, the inspector was unable to verify that a competency and capability assessment had been completed by the manager. This was discussed with the manager post inspection and confirmation was provided that this was completed during the deputy manager's induction. In accordance with regulation 20(3), a requirement is made that a competency and a capability assessment must be completed by the manager with any nurse who is given the responsibility of being in charge of the home in the absence of the manager.

Confirmation was provided to the inspector that recruitment for staff of all grades was ongoing and positions had been offered following recent interviews. It was anticipated that following completion of the mandatory recruitment checks, new staff would be appointed.

Discussion with the manager post inspection confirmed that an ongoing challenge is the retention of nursing staff in particular, with some nursing staff relocating to the mainland within a few months of appointment, after completing induction and mandatory training.

11.8 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 decoration and hygiene throughout with positive improvements evidenced.

On the day of inspection upgrading work was ongoing in the general nursing unit with one of the communal lounges being repainted.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Hilary Clarke, deputy 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:

Lorraine Wilson
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. If the patient is being discharged form hospital the ICS team will provide an up to date assessment of the patients needs, if the patient is being admitted from home then the community team will provide the details for assessment. Only when the Manager is satisfied that the home can meet the residents needs will the admission take place.	Compliant

On admission the nurse completes initial assessments. The nurse consults with the resident and/or their representative as well as the pre admission documentation to plan the patients care. The admission assessment should be completed within twelve hours of admission and should include; photography consent, record of personal effects and a record of 'My Preferences'. A needs assessment should also be completed at this time. Each patient will also have a skin assessment, using the Braden Tool, a body map, an initial wound assessment (if required), a moving and handling assessment, a falls risk assessment, bed rail assessment, a pain assessment and nutritional assessments including the MUST tool, FSHC nutritional and oral assessment. Other risk assessments that are completed within seven days of admission are a continence assessment and a bowel assessment, Following discussion with the resident/representative, and using the nurse's clinical judgement, a plan of care is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations. This can be evidenced in the care plan and consent forms. The Home Manager and Regional Manager will complete audits on a regular basis to quality assure this process	

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
A named nurse completes a comprehensive and holistic assessment of the resident's care needs using the assessment tools and uses these to formulate careplans which meet the needs of the individual patient. Any recommendations made by other members of the mutidisciplinary team are included in the care plan. The care plans	Compliant

have goals that are realistic and achievable. All Registered nurses in the home are fully aware of the process of referral to a TVN when necessary. There are referral forms held in a designated file in the nurse's office, the Tissue Viability Nurse's details are also held in this file - name, address and telephone no. Where a resident is assessed as being 'at risk' of developing pressure ulcers a care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. The care plan will give due consideration to advice received from other multidisciplinary members. The Home Manager completes a monthly wound care audit which is forwarded to the Regional Manager and any wounds above Grade 2 are notified to the RQIA. Each resident has a MUST score calculated on admission which is reassessed monthly, the resident will also be weighed monthly. The nurse will use this information and her own clinical judgement to determine if a ressident needs to be referred to a dietician. Dietician referral forms are held within the home. All advice, treatment or recommendations are recorded on the MDT form with a subsequent care plan being compiled or current care plan being updated to reflect the advice and recommendations. The care plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in the home and other members of the MDT are kept informed of any changes.	

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Risk assessments are reviewed by the patient's named nurse on a monthly basis or more frequently if their condition changes. The patient's care plan will indicate how often the assessment needs reviewed and the review date will be written in the diary. The Home Manager or her representative will carry out regular care plan audits and the named nurse will be made aware of any areas which are non compliant.	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**
Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to and are updated on a regular basis. The Home uses a validated pressure ulcer grading tool (EPUAP). If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime or if the condition of the pressure ulcer changes. Kitchen staff as well as care staff have access to up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', ' PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults. FSHC policies and procedures in relation to nutritional care, diabetic care, care of subcuteanous fluids and care of	Substantially compliant

percutaneous endoscopic gastrostomy (PEG) are also available.	

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines - Record keeping:Guidance for nurses and midwives. Records of the meals provided for each resident are recorded on a daily menu choice form. The Catering Manager also keeps records of the food served and include any specialist dietary needs. Residents who are assessed as being 'at risk' of malnutrition, dehyration or eating excessively have all their food and fluids recorded in detail on a daily basis using a FSHC food record booklet or fluid record booklet.	Substantially compliant

These charts are recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. Any patient who does not meet their required targets are referred to the appropriate professional for further review (Dietician, Gp etc…)The nurse utilises the information contained in these charts in their daily evaluation. Any changes to the resident's plan of care is discussed with them and/or their representative. Care records are audited on a regular basis by the Manager with an action plan compiled to address any deficits or areas for improvement - this is discussed during supervision sessions with each nurse as necessary.	

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The nurse documents daily progress in the patients nursing care file and all care plans are reviewed and evaluated on at least a monthly basis or more frequently if required or as specified in the care documentation. Residents and/or their represenatatives are involved in the evaluation process.	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**
Each patient wil have a care management review within six-eight weeks following admission and on an annual basis following this. If circumstances change and the patients care needs are not being met then the staff, patient, their representatives or any member of the MDT can arrange additional care review meetings. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff also attends. Any recommendations made are actioned by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The home follows FSHC policy and procedures in relation to nutrition and follows best practice guidelines as cited in section D. The patient has a dietary assessment on admission which is reviewed monthly. The care plan reflects type of diet, any special dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if necessary. The home has a 3 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives - residents meetings, one to one meetings and food questionnaires. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied. Copies of instructions and recommendations from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs.	Compliant

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

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Registered nurses have received training on dysphagia and enteral feeding techiques. Care staff and kitchen staff are trained on dysphagia and feeding techique. The Speech and Language therapist and dietician also give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document - 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for feeding, equipment to use and assistance required.	Provider to complete

The kitchen receive a copy of the SALT's recommendations and this is kept on file for reference by the kitchen. Special diets are displayed on a white board in the fridge room. Meals are served at the following times:- Breakfast - 9am-10.30am Morning tea - 11am Lunch - 12.40pm-12.50pm Afternoon tea - 3pm Evening tea - 4.50pm Supper - 7.30pm-8pm There are variations to the above if a resident requests to have their meals outside of these times. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. There are foods available outside of these times for those resident's who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedrooms, these are replenished on a regular basis. Any matters concerning a resident's eating and drinking are detailed on each individual care plan - including for eg. likes and dislikes, type of diet, consistency of fluid, any special equipment required and if assistance is required. A diet notification form is completed for each resident with a copy given to the kitchen and one held in the care file. Meals are not served unless a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Appropriate aids such as plate guards and specialised cutlery are available as necessary and as indicated in the plan of care. Each nurse has completed an education e-learning module on pressure area care. The home has a link nurse who has received enhanced training, to provide support and education to other nurses within the home on an ad hoc basis. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the home have a competency assessment completed.	

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

Secondary Unannounced Care Inspection

Seapatrick Care Home

9 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 Ms Hilary Clarke, deputy manager, either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	20 (1) (c) (i)	The registered persons shall ensure that the persons employed by the registered person to work at the nursing home receive, appraisal, mandatory training and other training appropriate to the work they are to perform. • All nursing and care staff must receive training and be assessed and deemed competent in continence and bowel management, and nursing staff employed in Seapatrick, must receive training in male/female catheterisation and the management of stoma appliances including the management of an ileostomy. **Ref : Follow up on previous issues and section 10, 19.4**	Three	Training scheduled for registered Nurses by the Training Department for February 2015 (date to be confirmed). To include male/female catheterisation and the management of stoma and ileostomy. Care staff to receive training from Tena on assessement for the correct type of pads and continence aids available. All nursing staff to be instructed in completion of continence and bowel assessment as part of their induction programme.	14 February 2015
2	20 (3)	The registered person must ensure that a competency and a capability assessment has been completed with any nurse who is given the responsibility of being in charge of the home in the absence of the manager. **Ref : Follow up on previous issues and additional information 11.7**	One	All nurses who are in charge have completed their Nurse in Charge competency assessments and copies are retained in their files.	31 January 2015

3	16(1)	The registered person must ensure that a written nursing plan is prepared by a nurse in consultation with the patient or patient's representative as to how the patient's needs in respect of their health and welfare are to be met, and at all times planned care is delivered as prescribed. **Ref: Section 10, 19.1, 19.2 and 19.4**	One	All care plans are written in a patient centered way and the expressed needs and wishes of the patient have been taken into account when compiling the care plan.	From date of inspection
4	13(1)(a)(b)	The registered person must ensure that effective systems are in place for meeting the health and welfare needs of patients accommodated in the nursing home at all times. **Ref: Section 10, 19.1, 19.2 and 19.4**	One	The patient's health and welfare needs are assessed on a monthly basis, or more frequently if their condition warrants it, and their care is structured and planned accordingly.	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 person must ensure that where patients require continence management and support, bladder and bowel assessments are completed in full on admission. To enable traceability of bowel function, a consistent record referencing the bristol stool chart should be recorded in the progress record for each patient. **Ref: Section 10, 19.1**	One	All patient's have their continence needs assessed prior to admission during the pre admission assessment and then by the nurse on admission. The patient's continence and bowel needs are managed according to their assessment on admission and are reviewed and updated on a monthly basis or more frequently if required. Each unit has a bowel chart in place which records the patient's daily bowel function and nursing staff are encouraged to reference the Bristol Stool chart in their daily progress notes.	31 January 2015
2	5.6	The registered person must ensure that contemporaneous records in respect of continence management are further developed to include outcomes for patients. **Ref: Section 10, 19.1**	One	All staff must ensure that accurate records are maintained and that any variance or irregularities in a patient's bowel or continence routines are investigated and actioned in a timely manner.	31 January 2015

3	19.2	The registered person must ensure that Four Seasons Healthcare, catheter care policy is embedded into day to day practice, and the following guidance documents are available to staff and are used on a daily basis: • 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 • RCN continence care guidelines **Ref: Section 10, 19.2**	One	Continence care files are in place on each unit which contain up to date information on all aspects of continece care including catheter care and the management of stomas and ileostomys. NICE and RCN guidelines are included in the file as well as the BGS Continence Care in Residential and Nursing Homes. The files will be kept updated as guidelines change.	31 January 2015
4	19.4	The registered person must ensure that a copy of the continence training programme is submitted to RQA. **Ref: Section 10, 19.4**	One	Please see attached.	When returning the Quality Improvement Plan.
5	25.2	The registered person should appoint a continence link nurse(s) within the home and regular audits of the management of incontinence are undertaken and the findings acted upon to enhance standards of care. **Ref: Section 10, 19.4**	One	A continence link nurse has been appointed in each unit (3) and we have developed a continece audit which will be completed monthly. The link nurse will feed back to other staff with the findings of the audit and appropriate action will be taken.	28 February 2015

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Edel McCaughley
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	JP Platson Jim McCall DIRECTOR OF OPERATIONS 27/1/15.

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	✓	JPlatson	11/2/2015
Further information requested from provider			