Unannounced Care Inspection

Name of Establishment:	**Iveagh House**
RQIA Number:	**1487**
Date of Inspection:	**25 November 2014**
Inspector's Name:	**Karen Scarlett**
Inspection ID:	**17108**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Iveagh House
Address:	62 Castlewellan Road Banbridge BT32 4JD
Telephone Number:	028 40628055
Email Address:	connie@haroldmitchellgroup.com
Registered Organisation/ Registered Provider:	Harold Mitchell (Belfast) Ltd Mr Harold Leslie Mitchell
Registered Manager:	Ms Constance Mitchell
Person in Charge of the Home at the Time of Inspection:	Ms Constance Mitchell
Categories of Care:	NH-I,RC-I
Number of Registered Places:	33
Number of Patients Accommodated on Day of Inspection:	32 (31 nursing and 1 residential)
Scale of Charges (per week):	£567 + £35.00 top up per week
Date and Type of Previous Inspection:	28 February 2014, primary unannounced inspection
Date and Time of Inspection:	25 November 2014 08.50 – 18:00
Name of Inspector:	Karen Scarlett

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 included the following:

- Discussion with the Registered Provider
- Discussion with the Registered Nurse Manager
- Discussion with staff
- Discussion with patients individually and with others in groups
- Consultation with relatives
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- Review of a sample of care records
- Review of the complaints, accidents and incidents records
- Monthly quality reports
- Structured observation of the lunch time meal service (QUIS)
- 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	14
Staff	6
Relatives	1
Visiting Professionals	1

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	0	0
Relatives/Representatives	1	0
Staff	10	8

6.0 Inspection Focus

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible person/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

However, due to workload pressures and contingency measures within the Regulation Directorate, only elements of the wound care theme/standard within the self-assessment were inspected on this occasion.

This inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

Standard 19 - Continence Management

Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

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

7.0 Profile of Service

Iveagh House nursing home is set in its own grounds on the outskirts of Banbridge. The accommodation is provided over two floors with access to the first floor by stairs and a passenger lift. There are twenty-seven single bedrooms, some of which are en-suite and three double bedrooms. There are two lounges on the ground floor, one of which is a large conservatory with views over the garden. A quiet room for use by patients/visitors and staff is available on the first floor. There is also a dining room, kitchen, laundry, toilet/washing facilities, staff accommodation and offices.

The gardens and grounds are positioned to the front and rear of the home. Car parking space, including access for disabled parking is available to the front of the building.

The registered manager is Ms Connie Mitchell.

The certificate of registration was appropriately displayed at the entrance area of the home.

The home is registered to provide care for a maximum of thirty-three persons under the following categories of care:

Nursing care

I old age not falling into any other category

Residential care

I old age not falling into any other category

8.0 Executive Summary

The unannounced inspection of Iveagh House was undertaken by Karen Scarlett on 25 November 2014 between 08.50 and 18.00. The inspection was facilitated throughout by Ms Connie Mitchell, registered manager, and Mr Leslie Mitchell, responsible person, who was available until 13.30.

Ms Mitchell was available for verbal feedback at the conclusion of the inspection. Feedback was also given to Mr Leslie Mitchell in an email on 2 December 2014.

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 28 February 2014.

The registered manager is required to return a number of documents to RQIA pre-inspection and all of these documents were returned within the required timeframe and provided the required assurances.

The patients and one resident were found to be well presented and appropriately dressed for the season. They were observed to be comfortable and relaxed in their surroundings. The inspector talked with the majority of patients and one resident and all comments were positive in regards to the staff and the care provided. Interactions between patients and the one resident and staff were observed to be positive and respectful. No issues were raised by patients/resident or by one relative consulted. For further details refer to section 11.5 of the report.

The level of compliance with standard 19 regarding continence care was reviewed. There was evidence that a continence assessment had been completed for patients/residents in the three care records reviewed. This 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 patient needs was evidenced to inform the care planning process. Comprehensive reviews of both the assessments of need and the care plans were maintained on a regular basis and as required.

Discussion with the registered manager confirmed that staff were trained and assessed as competent in continence care. However, although some nurses had received training on male catheterisation there were none yet deemed competent due to lack of opportunities for supervised practice. A recommendation has been made for sufficient registered nurses to update their knowledge and expertise in male catheterisation in order to meet the needs of the patients /resident.

The continence policy was found to be in need of review and updating. A recommendation has been made. A further recommendation has been made for evidence based guidelines to be made available to staff and used on a daily basis. During an inspection of the premises it was observed that continence products had been removed from their packaging and were being stored in bathroom cabinets posing potential risks of cross contamination. This is not in keeping with best infection control practice. In addition the efficacy of the products could also be compromised. A recommendation has been made in this regard.

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 substantially compliant. A total of four recommendations have been made in relation to this standard.

In the main, staff made very positive comments about working in the home. Two staff members raised concerns regarding staffing arrangements which were discussed with the registered manager. This discussion and an examination of the rota evidenced that staffing levels were within the RQIA staffing guidelines for nursing homes (2009). For further information refer to section 11.6 and 11.6.1 of the report.

The home is well maintained and was presented to a high standard of décor and hygiene throughout. On the day of inspection work was underway to upgrade the fire alarm system. In relation to infection prevention and control, two issues were identified; one concerning the absence of drip trays in the sluices and another regarding flooring in a cleaner's store which required repair/replacement. A requirement has been made. For further information refer to section 11.7 of the report.

A period of enhanced observation was also undertaken for 30 minutes during the lunch time meal service. The lunches were attractively presented and patients and one resident were observed to be enjoying their meal. The interactions observed between staff and patients were mainly positive. A few issues were discussed with the registered manager; these were regarding practices which could be unintentionally demeaning and the accessibility of fluids at meal times. Two recommendations have been made. For further information refer to section 11.8 of the report.

The inspector can confirm that, the delivery of care to patients and one resident was evidenced to be of a good standard and overall observations indicated that staff treated patients and one resident with dignity and respect.

The inspector reviewed and validated the home's progress regarding the eight requirements and eight recommendations made at the last inspection on 28 February 2014. Four requirements had been fully complied with; two requirements have been fully restated for a second time and elements of another two requirements have been restated, each for a second time. Five recommendations had been fully complied with; one recommendation concerning pain assessment was substantially compliant and will not be restated and another, regarding staff training in challenging behaviours, was found to be moving towards compliance and will not be restated, one recommendation regarding Safeguarding of Vulnerable Adults(SOVA) training has been stated for a second time.

As a result of this inspection, five requirements, four restated and eight recommendations, one restated, have been made.

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

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

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	14 (4)	The registered person must make arrangements by training staff or by other measures, to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse by ensuring that: • all nursing staff are competent in reporting suspected, alleged or actual incidents of abuse to the relevant persons and agencies in accordance with procedures and in a timely way. **Ref: previous report**	A review of the training records confirmed that not all of the nursing staff had attended this training. It was noted that training has been planned for March 2015. There was evidence that some nursing staff had undertaken supervision with the registered manager which included safeguarding scenarios. Since not all nursing staff have undertaken this training/ supervision this requirement has been stated for a second time.	Substantially compliant

2.	14 (2) (c)	The registered person must ensure as far as reasonably practicable that unnecessary risks to the health or safety of patients are identified and so far as possible eliminated by • undertaking an urgent bedrail re-assessment in partnership with all relevant stakeholders for an identified patient and taking any corrective action • check that the identified bedrails are safe to use • liaising with the occupational therapist in reviewing the seating (with lap straps) for one identified patient and advise RQIA regarding the outcome when returning the QIP **Ref: previous report**	An examination of the care records evidenced that bed rail assessments were being consistently completed and reviewed. All profiling beds have integral bedrails therefore reducing risks to patients/residents. There is a rolling programme of replacement of the padded bumpers for the bed rails to further assure health and safety. The care record for the identified patient was examined and evidenced that the Occupational Therapist had assessed the seating arrangements for this patient. This requirement has been addressed.	Compliant

3.	30 (1) (d)	The registered person must give notice to RQIA without delay of the occurrence of any event in the nursing home which adversely affects the wellbeing or safety of any patient including • any safeguarding issue • any pressure ulcers grade 2 or above **Ref: previous report**	The incident/accident file was reviewed and all incidents sampled were being appropriately reported to RQIA, including pressure ulcers and safeguarding issues. A weekly quality report is also compiled to detail all notifications. This is good practice. This requirement has been addressed.	Compliant

4.	15 (2) (a) & (b)	The registered person must ensure that the assessment of the patient's needs is; kept under review; and 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, and by ensuring: • a full re-assessment is undertaken on a patient's discharge from hospital. • MUST risk assessment should be recorded on admission • the continence assessment should determine if a patient is continent or incontinent • information provided by the Trust prior to patients' admission to the home should be reflected on a timely basis in the care planning process. • all risk assessments should be validated / supported with an evidence base. • review identified patient's moving and handling risk assessment and corresponding care plan • patients' weights and MUST scores are assessed at least monthly • accurate records should be	Three care records were reviewed along with a sample of fluid balance and repositioning charts. The records were found to be maintained to a high standard. • Full re-assessments had been carried out on discharge from hospital. • MUST risk assessments were consistently completed and reviewed. • The continence assessment gave full details of the continence status of the patient. • Information provided by the Trust had been reflected in the care plans • There were a range of evidence based risk assessments in use including Braden, MUST and Abbey pain scale. • Manual handling assessments had been completed and care plans put in place to address patient's needs. • MUST assessments were completed monthly along with patient weights • There were accurate records of fluid intake/output and detailed food charts were in place. • Fluid input/output charts were in place for patients with a urinary catheter. • The records of the progress of patient's wounds were kept in great detail,	Substantially compliant

		maintained in relation to fluid and food taken • a fluid balance chart should be in place when patients have a urinary catheter in situ. • pressure ulcers should be graded in accordance with the European Pressure Ulcer Advisory Panel (EPUAP) classification • daily repositioning and skin inspection charts should be completed consistently throughout the 24 hour period • wound assessment charts should be fully completed and supported with regular photography of wounds. **Ref: previous report**	evidencing best practice in wound care and grading pressure ulcers in accordance with EUPAP guidelines. • Repositioning charts were in place but were inconsistently completed and did not always document the condition of the skin at least twice daily. • Wound assessment charts were in place but were not currently supported by photography of wounds Two elements of this requirement, regarding repositioning charts and photography of wounds, will be stated for a second time.	

5.	16 (2) (b)	The registered person must ensure that care plans are kept under review and the following information is recorded : • care plans should be developed on a timely basis to meet the immediate needs of a patient on admission. • care plans should reflect the patients' wishes for example to sit out of bed for short periods • care plans should reflect how patients' present level of continence is maintained and promoted • care plans should be reviewed when patients' moving and handling needs change • care plans need to be further developed to include the specific type of pressure relieving equipment used • a care plan should be in place for each wound and reflect specialist advice (if applicable) . **Ref: previous report**	The care plans examined were found to be appropriately developed to meet the identified needs of patients. They reflected, patients' wishes regarding seating, continence care, moving and handling needs and specified the pressure relieving equipment in use. Care plans were reviewed at least monthly or more often to reflect changes in the patients' condition. Wound care plans were found to be maintained to a high standard and reflected evidence based guidelines and the input of tissue viability specialist nurses and podiatry as appropriate. This requirement has been addressed.	Compliant

6.	12 (1) (c)	The registered person shall provide treatment, and any other services to patients in accordance with the statement of purpose, and shall ensure that the treatment and other services provided to each patient- are (where necessary) provided by means of appropriate aids or equipment; • by ensuring that suitable weighing scales are available at all times. **Ref: previous report**	The weighing scales were found to be fully functioning. Care records evidenced that patients were being weighed at least monthly. This requirement has been addressed.	Compliant

7.	13 (1) (b)	The registered person must ensure that the nursing home is conducted so as to make proper provision for the nursing and where appropriate, treatment and supervision of patients by ensuring • appropriate referrals are made to assess any patients with wounds / broken skin to ensure that the correct grading of pressure ulcer (where applicable), dressing regime/treatment plan is in place to maximise wound healing. • a root cause analysis is undertaken in respect of the development of one patient's pressure ulcer • all registered nurses undertake wound care training and the classification of pressure ulcers using the European Pressure Ulcer Advisory Panel Classification System • all staff complete training in relation to pressure area care and the prevention of pressure ulcers. **Ref: previous report**	From an examination of three care records it could be evidenced that appropriate referrals had been made to tissue viability nurse specialists and podiatry as appropriate. A root cause analysis had been carried out in May 2014 in relation to one patient who developed a pressure ulcer. This identified a number of factors contributing to the development of what was later identified as a moisture lesion and the need for further staff training in identification and grading. All registered nurses and care staff have yet to attend wound care or pressure ulcer prevention training although this is currently ongoing. The training elements of this requirement have been stated for the second time.	Moving towards compliance

8.	27 (4) (d) (1)	The registered person must make adequate arrangements for detecting, containing and extinguishing fires : • it is required that the management of the identified fire door is reviewed urgently. If patients request that their bedroom door is kept open, the door must be held open by a mechanism which is linked to the fire alarm system. **Ref: previous report**	Phase 1 of a programme of works to upgrade the fire alarm system, were underway on the day of inspection. On discussion with the responsible person it is estimated that phase 2, which will include the door closures, will be completed by Feb/Mar 2016. This requirement has, therefore, been stated for a second time.	Moving towards compliance

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	12.1	The registered manager should ensure that an oral health assessment is completed for all patients on admission and records of the findings are maintained. **Ref: previous report**	There was an oral health assessment undertaken in the records examined. This recommendation has been addressed.	Compliant
2.	5.1	The registered manager should also ensure that the following assessments are consistently implemented: • a cognitive assessment for patients with dementia. • a validated pain assessment for patients on prescribed analgesia. **Ref: previous report**	A cognitive assessment had been completed in the care records examined. Pain assessments were carried out using validated tools and in the records examined were mainly found to be completed on admission and reviewed as required. This recommendation has been addressed and has not been restated.	Substantially compliant

3.	10.4	Ensure staff are trained in the management of behaviours that challenge. **Ref: previous report**	From the training records it could be evidenced that a number of staff have undertaken this training. The majority of staff have also undertaken SOVA training of which management of behaviours that challenge is an element. On discussion with the manager there were currently no patients in the home with behaviours that challenge. This recommendation has not been restated.	Moving towards compliance
4.	25.12	It is recommended that; • the registered manager / nurse in charge of the home at the time of the Regulation 29 unannounced visit should also sign the report. **Ref: previous report**	The Regulation 29 reports were found to be consistently signed by the registered manager. The registered manager and the responsible person met monthly to discuss the findings of the report. This recommendation has been addressed.	Compliant

5.	28.4	It is recommended that: • The registered manager provides confirmation to RQIA when returning the quality improvement plan in relation to the progression of on-going training in relation to Safeguarding Vulnerable Adults **Ref: previous report**	An examination of the training records evidenced that not all staff had attended this training. Further training is planned in to next year. On discussion some staff members were still not confident in the reporting process in relation to vulnerable adult issues. This recommendation has been stated for a second time.	Moving towards compliance
6.	10.7 &11.4	It is recommended that: • The evidence based document "Let's talk about restraint Rights, risk and responsibility" (RCN 2008) is available for all nurses to reference and incorporated / referenced into the policy / procedure for the management of restraint. • evidenced based literature(as discussed) is made available to staff and included in revised policies regarding wound care and the prevention and management of pressure ulcers **Ref: previous report**	The document "Let's talk about restraint Rights, risk and responsibility" (RCN 2008) was available in the home and referenced in the policy for the management of restraint. EUPAP and NICE guidelines on wound care and pressure ulcer prevention and management were available in a resource folder for staff. This recommendation has been addressed.	Compliant

7.	5.7	It is recommended that: • the quality of the meals is monitored and corrective action taken if required advise on the outcome of the comments made by a relative regarding the meals and menu planning, when returning the QIP **Ref: previous report**	Patient and relative questionnaires had been completed in relation to the meals and feedback on meals was also included in the monthly quality reports. Observation of the lunch time service and discussion with patients evidenced that meals were of a good standard and no complaints were made. This recommendation has been addressed.	Compliant
8.	30.2	It is recommended that: • staff arrangements are monitored by the registered manager to ensure that a suitable skill mix is available to meet the needs of patients over the 24 hour period. **Ref: previous report**	An examination of the duty rota found that staffing levels and skill mix were in accordance with RQIA staffing guidance for nursing homes (2009). As an outcome of a safeguarding investigation an extra care assistant was put on a twilight shift which had improved staffing levels in the evening period. The registered manager was also in discussion with staff regarding the standardisation of the shift patterns. This recommendation has been addressed.	Compliant

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

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

Since the previous inspection on 28 February 2014, RQIA have been notified by the home of one investigation in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues. The SHSCT safeguarding team have managed the SOVA issues under the regional adult protection policy/procedures. The outcomes of this investigation have been discussed with the registered manager and the registered provider and the appropriate recommended actions have been taken. A joint notice signed by the registered provider and the Trust representative on 2 July 2014 was on display on a notice board in the reception area. This acknowledged that generally the quality of care provided within the home effectively supported the needs of residents.

RQIA is satisfied that the registered manager has dealt with SOVA issues in the appropriate manner and in accordance with regional guidelines and legislative requirements.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of three patients' care records evidenced that bladder and bowel continence assessments were undertaken for all three patients. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. There was evidence in three patients care records that bladder and bowel assessments and continence care plans were reviewed and updated as 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. Staff referred to the Bristol stool chart when completing the patients' bowel chart which is commendable. Review of three patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. The care plans reviewed addressed the patients' assessed needs in regard to continence management. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home. However, during an inspection of the premises it was observed that continence pads had been removed from their packaging and were being stored in cabinets in the bathrooms. This practice could potentially compromise the efficacy of the products and does not meet with best practice guidance in terms of infection prevention and control. A recommendation has been made.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place; • continence management / incontinence management • catheter care However, the continence management policy requires review and updating. A recommendation has been made. There were no current guideline documents available for staff in relation to continence care. 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 The registered manager was sourcing these documents on the day of the inspection in order to compile a resource folder for staff.	Moving towards compliance

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 staff confirmed that they were knowledgeable about the important aspects of continence care including privacy, dignity, fluid intake, skin care and reporting any concerns. The majority of staff had undertaken training in continence care. On discussion with the manager it was found that none of the registered nurses were deemed competent in male catheterisation. To ensure the individual needs of patients are met in relation to male catheterisation, staff should have the required training/ opportunities for supervised practice as appropriate. A recommendation has been made in this regard. There were no patients with stomas but the registered manager demonstrated knowledge in their care and management. Monthly care audits are undertaken and these include the management of incontinence.	Substantially compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

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

Patients and one resident were observed to be 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.

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 and had been satisfactorily resolved.

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 and confirmed satisfactory resolution.

11.3 Patient Finance Questionnaire

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

11.4 NMC Declaration

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

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

11.5 Patients'/Relatives' Views

The inspector spoke with fourteen patients individually and to others in groups. High levels of satisfaction were expressed with the standard of care, facilities and services provided in the home. A number of patients were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients' comments were as follows:

"It's a good home."
"The food is good."
"They are very good to me."
"Connie is very good and works hard. I have no complaints."

On discussion, one relative commented very positively about the home and the staff, stating:

"I can't fault them. It's nice to know you can leave and xxxx is looked after so well."

11.6 Questionnaire Findings/Staff Comments

During the inspection the inspector spoke with six staff including domestic assistants, care assistants and registered nurses. The inspector was able to speak to a number of these staff individually and in private. Eight staff kindly completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

Two staff members raised concerns about staffing in relation to increasing patient dependency and use of agency staff which were discussed with the registered manager. For further information regarding staffing refer to section 11.6.1 of the report.

Examples of staff comments were as follows;

"I am proud to work in Iveagh."
"In all the homes I have worked in, Iveagh undoubtedly has the best quality of staff and the most comprehensive care."
"Patients are treated with respect."

The inspector took the opportunity to speak with a visiting professional. They commented positively about the staff team and their proactivity in addressing any issues identified.

11.6.1 Staffing

An examination of the duty rota verified that staffing numbers were within RQIA staffing guidelines for nursing homes (2009). As an outcome of a recently concluded safeguarding investigation by the SHSCT, an extra care assistant had been put on to a twilight shift which had improved staffing in the evenings. Two staff members raised issues in relation to staffing. One staff member expressed the view that the dependency levels of patients had increased and the added workload had reduced the time available to talk with patients. Another was concerned about the use of agency nurses which could potentially affect the continuity of care.

Other staff members consulted did report that although they were very busy the staffing levels were appropriate at present.

On discussion with the registered manager there have been difficulties recruiting registered nurses and in particular, agency nurses were being used to cover the twilight shift. Recruitment of registered nurses is still ongoing. An examination of patient dependency levels using the Rhys Hearn tool evidenced that staffing was sufficient to meet the current dependency levels of the patients. Review of the monthly reports and discussion with the registered manager evidenced that dependency levels were regularly reviewed.

The current registered manager plans to leave in January 2015 to take up another position, and the responsible individual has commenced the recruitment process for a new manager. An assurance was provided that RQIA would be informed of progress.

11.7 Environment

The premises were viewed including the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were well maintained to a high standard of hygiene.

Two issues were noted in relation to infection prevention and control. Drip trays were not in place under the bed pan racks in the two sluices. Flooring in the cleaner's store was also in need of repair/replacement where a toilet had been removed, to enable effective cleaning. A requirement has been made.

11.8 Quality of Interaction Schedule (QUIS)

The inspector undertook a period of enhanced observation in the home which lasted for thirty minutes and took place in the dining room during lunch service.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area. A description of the coding categories of the Quality of Interaction Tool is appended to this report.

Total number of observations	
Positive interactions	6
Basic care interactions	5
Neutral interactions	0
Negative interactions	1

The inspector evidenced that the quality of interactions between staff and patients/residents was in the main very positive and relaxed. The meals provided were of good quality and patients/residents were observed to be enjoying their meals. A choice of main course, deserts and drinks was also offered.

There was one negative interaction observed in relation to clothing protectors, when a member of staff referred to them as a "bib" which may be considered demeaning to patients.

It was observed that wipes had been placed on each table for hand hygiene purposes. Whilst this is good practice the wipes in use were "baby wipes" which again may be demeaning to patients and impinge on dignity.

These issues were discussed with the registered manager and a recommendation has been made.

The majority of staff were observed to be very positive in their interaction with the patients. However, there were two occasions when a staff member placed a meal in front of the patient without interacting with them.

It was observed that juice was being served from the fridge at patients' request but it is the inspector's professional opinion that jugs of water and juice should be placed in a visible and accessible location for patients in order to act as a visual cue to encourage fluid intake.

Any issues observed were brought to the attention of the registered manager during the inspection and any staff training needs identified are to be addressed by the manager.

11.9 Care Documentation

The quality of documentation was evidenced to be of a consistently high standard. An examination of the care records evidenced that a consent/discussion form was in place for a patient who required a tab alarm and alarm mat to help to manage behaviours which may increase the patient's risk of falls. However, the section to indicate whether or not the patient or their representative agreed with the use of these devices had not been appropriately completed to evidence the outcome of this discussion. A recommendation has been made that these decisions are accurately documented.

12.0 Quality Improvement Plan

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

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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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
5.1 At the time of each resident's admission to the Home, a nurse carries out and records an initial assessment, using a validated assessment tool, based on Roper, Logan and Tierney's 12 activities of daily living. The nurse also utilises the information from a pre-assessment, and all the information provided from the care management teams to draw up an agreed plan of care, taking into account the resident's wishes. 5.2 A comprehensive, holistic assessment of the resident's care needs is completed within 11 days from admission. 8.1 Nutritional screening is carried out on admission using the Malnutrition Universal Screening Tool, (MUST). 11.1 A pressure ulcer risk assessment, Braden, including nutritional, pain and continence assessments along with clinical judgement is carried out, where possible prior to admission to the Home and on admission to the Home, to include resident's choices.	Compliant

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

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
5.3 The named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual residents' and their representatives, while promoting the resident's choices. The nursing care plan demonstrates the promotion of maximum independence and rehabilitation, where appropriate. Also advice and recommendations from other relevant health professionals is taken into account, to promote holistic care provision for each resident. 11.2 Referral criteria and arrangements are in place to obtain advice and support from the Trust's Tissue Viability Nurse, TVN is available for telephone advice with followup service. 11.3 If a resident is assessed as "at risk" of developing pressure ulcers, a pressure ulcer prevention care plan is drawn up to indicate the type of pressure relieving equipment in use while the resident is in bed and up sitting in their chair, and the frequency of repositioning required, while in bed and chair. A contemporaneous record of repositioning is maintained in the resident's care file. Resident's wishes to refuse treatment are also recorded in their care file. A treatment programme is included, also nutritional support, to ensure the resident's needs are met and to ensure their wishes are respected. Guidance is sought from the relevant healthcare professionals as indicated by the resident's needs and incorporated into the care and treatment plan. 11.8 Referral arrangements are in place, to relevant healthcare professionals who have the required knowledge and expertise to diagnose, treat and care for residents with lower limb or foot ulceration. 8.3 Referral arrangements, for the dietician, are in place to ensure resident's individual nutritional needs can be assessed and a nutritional treatment plan can be drawn up, to include the resident's choices. A nutritional plan is developed taking into account the relevant healthcare professionals recommendations and these plans are adhered to and reassessed by the health professional as needed.	Compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.4 Residents' needs are re-assessed on an on-going basis; this process is carried out daily and is evaluated at least monthly, or if an event/change occurs which requires a change/adaption to the resident's identified needs. As a resident progresses or deteriorates, or refuses treatment these changes are reflected in the care plan with daily progress updates.	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**
5.5 Nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. Policies and procedures are derived from the Nursing Home Regulations (Northern Ireland) 2005 and the Nursing Home Minimum Standards. All relevant guidelines are made available for staff. The Royal Marsden (eigth edition) is available to all nursing staff. 11.4 Braden pressure ulcer assessment tool is used to screen residents who have skin damage and an appropriate treatment plan is implemented with the resident's consent. Professional guidance is sought, when appropriate criteria for referral applies, to ensure a comprehensive treatment plan is available to provide the best outcomes for the residents. The Northern Ireland Wound care formulary is used to inform and guide care practice in line with evidence based approach to care provision. NICE guidelines for the management of pressure ulcers in primary and secondary care are also available. 8.4 There are up to date nutritional guidelines in use by staff on a daily basis.	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
5.6 Contemporaneous nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident, including outcomes for residents and are maintained in accordance with NMC guidelines. 12.11 A daily record of residents meals is maintained, in sufficient detail to enable any person inspecting it to judge whether the diet for each resident is satisfactory. 12.12 A daily record of each resident's oral intake is maintained and indicates if a resident chooses not to eat a meal. A fluid record is maintained daily. A record of the resident's choice not to eat is also recorded in the daily nursing record. Alternatives are offered if the resident does not want what is on the menu to encourage oral intake. If a resident is eating excessively a record is maintained. All such occurrences are reported to the nurse in charge and where necessary, a referral is made to the relevant healthcare professional, with a record of the referral being kept.	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**
5.7 The outcome of care delivered is monitored and recorded on a day to day basis, and contempouraneously as care is delivered and is reviewed at least monthly, more often if a change occurs in the resident's needs. Residents' and their representatives are involved and kept updated regularly of any changes, particularly following visits from other health professionals. Information imparted to resident's representatives is maintained on a separate record within the resident's folder.	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**
5.8 Residents are encouraged and facilitated to participate in all aspects of reviewing outcomes of care, they are encouraged to voice their opinions either positive or negative with these views being recorded. Residents choices are taken into account and encorporated into their care. Residents are encouraged to participate in formal multidisciplinary meetings and if they are not physically able to attend then the meeting is convened with the resident in their room, if appropriate. If this is not appropriate then the Care Manager ensures that they speak with the resident to ascertain their wishes and ensure the care provision meets their needs. 5.9 The results of all reviews and minutes of review meetings are recorded, where required, changes are made to the nursing care plan with agreement from the resident and representative. Residents and their representatives are kept informed of progress towards 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**
12.1 Residents are provided with a nutritious and varied diet which meets their individual needs and preferences. Full account is taken of relevant guidance documents and guidance provided by dieticians and other professionals and disciplines. Records of guidance from other health professionals is maintained within the resident's folder and appropriate copies being maintained for kitchen staff. 12.3 The menu offers a choice of meal at each mealtime and where it offers only one option and the resident does not want this, the resident is offered their choice of meal or hot/cold snack. A choice is offered for those on therapeutic or specific diets. The menu is reviewed at least bi-annually, with residents individual preferences and their representatives views influencing the review each time. A resident questionnaire is undertaken to assist the review and update of the menu.	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
8.6 Nurses have up to date knowledge and skills in managing feeding techniques for residents who have swallowing difficulties. They also ensure that instructions drawn up by the Speech and Language therapist are adhered to and that a copy of this information is available to the kitchen staff to ensure residents needs are met at all times. 12.5 Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and on demand. Fresh drinking water is available at all times via a water cooler for relatives and visitors. A fridge in the dining room is available for residents and relatives, with dinking water and juice and cold snackpots. 12.10 Staff are aware of any matters concerning residents' eating and drinking, as this is detailed in the care plan. There are appropriate numbers of staff present when meals are being served to ensure the risks are mimimised when residents are eating and drinking. Sufficient staff are available to ensure residents who require assistance to eat and drink are assisted. Necessary aids and equipment is available for use to facilitate residents needs for eating and drinking. 11.7 Where a resident requires a wound dressing, nurses are skilled sufficiently to carry out a wound assessment and apply wound care products and dressings. Where specialist knowledge is required from other health care professionals this is sought in a timely manner to ensure best outcomes for the resident.	Substantially compliant

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

Appendix 2

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

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

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

References

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

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

Quality Improvement Plan

Unannounced Care Inspection

Iveagh House

25 November 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 the registered manager during 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.	14 (4)	The registered person must make arrangements by training staff or by other measures, to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse by ensuring that: • all nursing staff are competent in reporting suspected, alleged or actual incidents of abuse to the relevant persons and agencies in accordance with procedures and in a timely way. **Ref: Follow up of issues in previous report**	Two	The registered person will ensure that nursing staff are competent in reporting suspected, alleged or actual incidents of abuse to the relevant persons and agencies in accordance with procedures and in a timely way. A small number of nurses require to undertake competency updates and this shall be completed by the nurse manager as quickly as possible. A quick reference flow chart to highlight the SHSCT Safeguarding Specialist Team first point of contact has been compiled with telephone numbers and generic email address to ensure timely reporting with the appropriate PVA1 and bodymap also attached. This is situated within easy access for nurses and has been added to the Safeguarding policy. A rolling pattern of training has been scheduled for 2015, with the first session of SOVA taking	From date of inspection

				place on 26.3.15 and repeating again in December.	
2.	15 (2) (a) & (b)	The registered person must ensure that the assessment of the patient's needs is; kept under review; and 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, and by ensuring: • daily repositioning and skin inspection charts should be completed consistently throughout the 24 hour period • wound assessment charts should be fully completed and supported with regular photography of wounds. **Ref: Follow up of issues in previous report**	Two	The nurse manager has reiterated to all staff, verbally and with writen notices the importance of consistent documentation, evidencing their care provision. This has been reinforced during "Pressure Ulcer Prevention" training. Wound assessments charts will be fully completed and supported with photography of the wounds.	From date of inspection

3.	13 (1) (b)	The registered person must ensure that the nursing home is conducted so as to make proper provision for the nursing and where appropriate, treatment and supervision of patients by ensuring: • all registered nurses undertake wound care training and the classification of pressure ulcers using the European Pressure Ulcer Advisory Panel Classification System • all staff complete training in relation to pressure area care and the prevention of pressure ulcers. **Ref: Follow up of issues in previous report**	Two	A substantial number of staff have undertaken the Pressure Ulcer Prevention and classification training, however those who have not have access to a comprehensive Skin Care folder, which includes the training presentation and all relevant guidelines from RCN and NICE. Pressure ulcer classification has greatly improved, since the training commenced, as evidenced in the report. The Company has contact details of a training facilitator to continue pressure ulcer prevention and classification training	From date of inspection

4.	27 (4) (d) (1)	The registered person must make adequate arrangements for detecting, containing and extinguishing fires : • it is required that the management of the identified fire door is reviewed urgently. If patients request that their bedroom door is kept open, the door must be held open by a mechanism which is linked to the fire alarm system. **Ref: Follow up of issues in previous report**	Two	Our buildings services contractors have been instructed to fit an automatic swing free door closure device (linked to the fire alarm), to the identified door and they have undertaken to have this completed by 31.1 2015. It is our present intention, cet. par., to have such automatic door closer devices fitted to all bedroom doors by the end of 2015.	From date of inspection

5.	13 (7)	The registered person shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff. This is particularly in relation to: • the absence of drip trays below the bed pan racks in the two sluice rooms • the absence of flooring around a toilet previously removed in the cleaner's store which cannot be effectively cleaned. **Ref: section 11.7 of report**	One	The registered person has now commissioned the manufacture of a suitable drip tray for the ground floor sluice bed pan rack which will then be fitted ASAP. The second drip tray (for the 1st floor sluice) will be ordered (to the appropriate size) as soon as a new bed pan rack (now ordered) has been obtained & fitted. Our buildings services Contractors have been asked to suggest a suitable remedy to eliminate/prevent any hygiene hazard, and we await their advice - should they advise that the problerm is only a cosmetic issue (without any health & safety implications) then no further action will be taken because the area is only seen by and used by our staff.	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.	28.4	It is recommended that: • The registered manager provides confirmation to RQIA when returning the quality improvement plan in relation to the progression of on-going training in relation to Safeguarding Vulnerable Adults **Ref: Follow up of issues in previous report**	Two	On-going training has been scheduled in a rolling pattern to provide all staff with Safeguarding Vulnerable Adults training with the first session on 26th March 2015 and the second session to occur in December 2015. The small number of nurses who require their comptency updated have been provided with the appropriate competency documents to read and discuss with the nurse manager.	From date of inspection

2.	35.1	It is recommended that continence pads are stored in a manner which maintains this equipment safely, in accordance with manufacturers' instructions and to ensure effective infection prevention and control. **Ref: Section 10.0 of report**	One	Pads are are stored in closable cabinets in the bathrooms. Following the inspection the nurse manager obtained the manufacturer's guidelines on maintaining continence products and, following discussion with the Inspector to achieve clarification, the home may now maintain a small number of continence products in the closed cabinets in the ground floor bathrooms, providing they are used within a 24 hour period in order to ensure effective infection prevention and control. All staff have been made aware of this.	From date of inspection
3.	19.2	The registered person should ensure that the following best practice guidelines are readily available to staff and used on a daily basis: • British Geriatrics Society Continence Care Residential and Nursing Homes • RCN continence care guidelines • NICE guidelines on the management of urinary incontinence in women • NICE guidelines on the management of faecal incontinence **Ref: Section 10.0 of report**	One	The nurse manager has compiled a continence management folder, as a resource for all staff, including all the listed guidelines per NICE and RCN, and Continence Care policy has now been updated.	From date of inspection

4.	26.6	The following policy must be reviewed and updated as required and ratified by the responsible person: • Continence Care **Ref: Section 10.0 of report**	One	The nurse manager has reviewed and updated the Continence Care policy	From date of inspection
5.	19.4	The registered manager should ensure that sufficient registered nurses have up to date knowledge and expertise in catheterisation, including male catheterisation. **Ref: Section 10.0 of report**	One	The nurse manager reviewed all registered nurses knowledge and expertise in catheterisation. A number of nurses are trained in male catheterisation - however due to a lack of supervised practice (due to the smaller propoprtion of male residents) their competencies would not be up to date. A training and competency session is being sourced, no date confirmed at this time.	From date of inspection

6.	10.2	When a patient's behaviour is uncharacteristic and causes concern, a documented plan of care that meets the individual's assessed needs and comfort is drawn up and agreed with patients, their representatives and relevant professionals, as required. The outcome of discussions with patients and their representatives regarding the use of devices including, but not limited to, bed rails, alarm mats and tab alarms must be recorded. **Ref: Section 11.9 of report**	One	The outcome of discussions with patients and their representatives regarding the use of devices such as bed rails, alarm mats and tab alerts will be recorded on the consent record. A new Falls Prevention Policy has been introduced and this includes a Bedrails Risk Assessment Tool.	From date of inspection
7.	12.5	It is recommended that fresh drinking water and juice are made available at all times and placed in a visible and accessible location to encourage fluid intake. **Ref: Section 11.8 of report**	One	Fresh drinking water and juice is available at all times, this is kept in the residents fridge in the dining room, however from date of inspection fresh drinking water and juice is placed on the dining tables during mealtimes to be a visual stimulant to residents and encourage fluid intake. Our exisiting Policy on Hydration as now been updated to include the "GULP" Dehydration Risk Screening Tool.	From date of inspection

8.	1.1	The registered manager should review any practice which has the potential to demean patients / residents: • staff should not refer to clothing protectors as “bibs” • Baby wipes should be replaced with generic hand wipes **Ref: Section 11.8 of report**	One	Staff have been advised regarding appropriate terminology for clothing protectors. We introduced the the use of baby wipes for hygiene reasons following a suggestion made by a different RQIA Inpsector during an earlier inspection - however in response to this recommendation we shall shortly commence using a different brand of wipes as soon as our exisiting stock has been exhausted. In the meantime, due to the volume of stock of baby wipes, staff have been instructed to keep the exisiting wipes out of sight in the dining room cupboard and offer and provide them to residents prior to and after mealtimes.	From date of inspection

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	Connie Mitchell (14.01.15)
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Harold Leslie Mitchell (14.01.15)

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Karen Scarlett	16/1/15
Further information requested from provider			