Unannounced Care Inspection

Name of Establishment:	**Nightingale Care Home**
RQIA Number:	**1492**
Date of Inspection:	**22 January 2015**
Inspectors Name:	**Sharon Loane** **Aveen Donnelly**
Inspection ID:	**17017**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Nightingale Care Home
Address:	34 Old English Road Dungannon BT71 7PA
Telephone Number:	028 8775 2666
Email Address:	nightingale@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons (Bamford) Ltd Dr Maureen Claire Royston (registration pending)
Registered Manager:	Mrs Hazel Black
Person in Charge of the Home at the Time of Inspection:	Ms Frances Mc Keown, registered nurse
Categories of Care:	NH-PH, RC-PH, NH-I, NH-MP, RC-I
Number of Registered Places:	48
Number of Patients Accommodated on Day of Inspection:	42
Scale of Charges (per week):	£461.00 : Residential Care £581.00 : Nursing Care
Date and Type of Previous Inspection:	12 February 2014, primary unannounced inspection
Date and Time of Inspection:	22 January 2015 10:00 – 16:05 hours
Name of Inspectors:	Sharon Loane Aveen Donnelly

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The 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 deputy nurse manager
- discussion with staff
- discussion with patients individually and to 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 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/Residents	**9**
Staff	**9**
Relatives	**4**
Visiting Professionals	**0**

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**5**	**4**
Relatives/Representatives	**6**	**3**
Staff	**10**	**9**

6.0 Inspection Focus

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

However, due to workload pressures and contingency measures within the Regulation Directorate, the themes/standards within the self-assessment were not inspected on this occasion.

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

Standard 19 - Continence Management

Patients receive individual continence management and support.

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

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

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

7.0 Profile of Service

Nightingale Care Home is located centrally to the town of Dungannon.

The care home is owned and operated by Four Seasons Healthcare and the Registered manager is Mrs Hazel Black.

Nightingale Care Home is a purpose built single storey building and comprises of forty-four single bedrooms and two double bedrooms, two sitting rooms, foyer, two dining rooms, kitchen, laundry, toilet / washing facilities, staff accommodation and offices.

Suitable car parking facilities are available at the front of the premises and an enclosed landscaped area is to the rear of the building.

The home is registered to provide care for a maximum of 48 persons under the following categories of care:

Nursing care

I	old age not falling into any other category
PH	physical disability other than sensory impairment
MP	mental disorder excluding learning disability or dementia

Residential care

I	old age not falling into any other category
PH	physical disability other than sensory impairment

8.0 Executive Summary

The unannounced inspection of Nightingale Care Home was undertaken by inspectors Sharon Loane & Aveen Donnelly, on 22 January 2015 from 10: 00 – 16:05 hours. The inspection was initially facilitated by, Frances Mc Keown, designated nurse in charge, until the arrival of Mrs Wendy Spence, deputy manager who facilitated the remainder 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 12 February 2014.

Prior to the inspection taking place the completed self-assessment and other information was submitted by the registered manager as part of the pre-inspection process (refer to appendix 1).

During the course of the inspection, patients/residents, staff and visiting relatives were consulted. Inspectors observed care practices, examined a selection of records, issued patient, staff and representative questionnaires and carried out a general inspection of the nursing home environment as part of the inspection process.

Five patients' care records were examined in relation to continence management and support. The care records evidenced that the standard of record keeping in relation to this aspect of care reflected an assessment, care planning and evaluation process which included the promotion of continence / management of incontinence and patient dignity. However, two recommendations have been made for the effective management of the standard. Refer to section 10 of the report.

Two patients' records were reviewed in regards to the completion of baseline pain assessments and on-going pain assessments where indicated. Records examined identified the absence of both baseline and on-going pain assessments. Refer to section 11.1 of the report. The previous recommendation has been stated for a second time.

A range of policies / guidance and training was in place to support registered nurses and care staff in relation to continence management.

From a review of the available evidence and from discussion with relevant staff and observation, the level of compliance with standard 19 inspected was substantially compliant.

The home's general environment was comfortable and all areas were maintained to an acceptable standard of cleanliness. A number of issues pertaining to infection control and health and safety were identified. One requirement and one recommendation have been made.

At the time of this inspection, the delivery of care to patients was evidenced to be of an acceptable standard. Compliance with the requirements and recommendations made as a result of this inspection will further enhance the processes in place to ensure the effective management of the standard inspected.

Additional areas were also examined including:

- care practices / care records
- complaints
- patient finance questionnaires
- NMC
- patients and relatives views
- staffing and staff views
- environment
- health and safety

Details regarding these areas are contained in section 11 of the report.

The inspectors reviewed and validated the home's progress regarding the one requirement and four recommendations made at the previous care inspection on 12 February 2014 and confirmed the one requirement had been fully complied with and three recommendations were compliant and one recommendation was not compliant and has been stated for the second time.

Details can be viewed in the section immediately following this summary.

Verbal feedback of the inspection outcomes was given to Mrs Wendy Spence, deputy nurse manager and Ms Frances Mc Keown, designated nurse in charge at the conclusion of the inspection process.

Details can be viewed in the section immediately following this summary.

Conclusion

As a result of this inspection, one requirement and three recommendations are made; one recommendation has been stated for the second time.

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

The inspectors would like to thank the patients/residents, the management, relatives and staff for their assistance and co-operation throughout the inspection process and for those who completed questionnaires.

9.0 Follow-Up on Previous Issues from 12 February 2014

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	Regulation 27(2)(p)	It is required that the home is heated appropriately and maintained at the recommended temperature of between 19 and 22 degrees centigrade. Therefore it is required that: • the registered manager inform RQIA of the timescale for completion of the upgrade to the radiator • in the interim the registered manager must record the temperature of the dining rooms at intervals throughout the day. Records must be maintained of the temperature checks.	Two radiators have been replaced in the dining room. Records of the temperatures of the dining room were available and staff are continuing to record the temperatures even though the radiators have been replaced. This was only an interim measure and no longer is required. The home on the day was found to be warm and comfortable throughout.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	16.2	It is recommended that all induction programmes are reviewed, and where required developed, to ensure that an awareness of the procedures for protecting vulnerable adults are included in the induction programme for all staff.	Review of two staff induction programmes, evidenced that standard 6 of the induction programme includes principles of safeguarding in health and social care. In addition, staff had completed Safeguarding training as part of their induction via E – Learning.	Compliant
2	5.1	It is recommended that at the time of each patient's admission to the home, a nurse draws up an agreed plan of care to meet the patient's immediate care needs.	Two recent patient admission records were examined and evidenced an agreed plan of care and risk assessments had been completed to meet the patient's immediate care needs within the required timeframe**.**	Compliant
3	5.1	It is recommended that all patients have a baseline pain assessment completed and an on-going pain assessment where indicated.	Two patient care records were reviewed and evidenced the non-completion of a baseline pain assessment and on-going pain assessments for patients who are in receipt of pain management intervention. This recommendation has been stated for a second time.	Not Compliant

4	11.1	It is recommended that information recorded on the pre admission assessment includes if the patient for admission has a pressure ulcer, wound or any skin condition.	Two pre-admission records were reviewed for recent admissions. Records examined, evidenced detailed information on a pressure ulcer that the patient had prior to their admission.	Compliant

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

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

Since the previous inspection in February 2014, RQIA have been notified by the home of ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues. All incidents were managed in accordance with SOVA regional guidance and there were no ongoing investigations at time of inspection.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of five patients' care records evidenced that bladder and bowel continence assessments were undertaken for all patients. However, one patient's continence assessment was incomplete and both the continence and bowel assessment had no signature of the registered nurse completing the assessments. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. A recommendation has been made to ensure that assessments have been completed for all patients and all signed by the registered nurse completing the assessment. Patient's bowel functions were recorded inconsistently and the inspectors were unable to evidence that bowel function was being effectively monitored. A recommendation has been made. Two patients who had a catheter inserted, had only records of fluid output and not fluid intake. It is recommended that a record of fluid balanced against urinary output should be monitored for all patients who have a catheter and have additional renal function / failure. A recommendation has been made. There was evidence in four patients care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. 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. Review of five 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.	Moving towards compliance

Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home. Two recommendations were made in relation to this criterion.	

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 following policies and procedures were in place; • continence management / incontinence management • catheter care A policy in regards to stoma care is currently under review. The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence • British Geriatrics Society Continence Care in Residential and Nursing Homes Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines. In addition the majority of care staff had completed Four Seasons Health Care workbooks on both bowel management and catheter care. This is to be commended.	**Compliant**

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not applicable	
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the deputy manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the deputy manager revealed that all the registered nurses in the home had completed training in female / male catheterisation in March / August 2014. Training in the management of stoma care has been scheduled for February 2015. Two continence link nurses were working in the home and were involved in the review of continence management and education programmes for staff. This is good practice and is commended.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices / Care Records

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.

Care records were examined in regards to the standard inspected. In addition care records were reviewed with regards to the assessment of pain and the management of pain. Two care records examined, identified the absence of both a baseline assessment and on-going pain assessments for patients who were receiving treatment for pain. This matter was discussed with the deputy manager and the registered nurse in charge who were advised that all patients on admission should have a baseline pain assessment completed and thereafter as identified. All patients who are receiving analgesic should have on-going pain assessments completed to determine the effectiveness of the prescribed treatment. The previously stated recommendation has been stated for a second time.

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 management of complaints was discussed with the deputy manager and the complaint record reviewed. This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements.

11.3 Patient Finance Questionnaire

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

11.4 NMC Declaration

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

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

11.5 Patients/Residents and Relatives Comments

During the inspection, nine patients/residents were spoken with individually and with the majority of others in smaller groups.

Patients spoken with and the questionnaire responses confirmed that patients were treated with dignity and respect, that 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 happy living in the home. One patient comment included;
"the staff are like angels without wings"

Four relatives were spoken with during the inspection. The relatives consulted commented positively and expressed satisfaction regarding the management of the home, staff attitudes and the standard of care provided. One relative spoken with felt that they were not kept informed as much as they would like and had some issues regarding the care of their relative. This matter was discussed with the deputy manager and the designated nurse in charge during feedback. The management team agreed to discuss these concerns with the identified relative and address accordingly.

11.6 Staff Comments

During the inspection, nine staff were spoken with individually; including registered nurses, care assistants, catering, ancillary staff and the activity co-ordinator. Nine staff completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes. Staff comments included;

- "I feel not just because am employed here this is " a real home"
- "I get great satisfaction from all the service users they make my day meaningful, and I hope I add something to theirs"
- "all staff in Nightingale endeavour to provide a positive care experience to all residents regardless of their illness or situation"

No issues were raised by staff.

11.7 Environment

An inspection of the premises was undertaken of the majority of patient's bedrooms, bathrooms, shower and toilet facilities and communal areas. The home was comfortable and was generally maintained to an acceptable standard of décor and cleanliness, however a number of infection prevention and control issues were identified

- a number of bedroom vanity units with veneer were worn and had visible areas of bare wood exposed
- a number of toileting seats, toileting equipment were unclean and did not meet infection prevention and control guidance
- a number of radiator covers were in poor state of repair and had bare wood exposed. This matter had also been identified in a regulation 29 report completed in December 2014.

- wheelchairs were observed being stored in a linen store

These issues were discussed during feedback and have been incorporated into a requirement relating to infection prevention and control.

11.8 Health and Safety

During an inspection of the premises a number of topical creams were observed in patient's bedrooms. There was evidence that the original label on the jar identifying for whom the cream had been prescribed, had been removed and another patient's name hand written on the jar. There was also evidence of creams / dressings which had been prescribed for one patient having been shared with other patients.

A recommendation has been made.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Wendy Spence, Deputy Nurse Manager and Ms Frances McKeown, designated nurse in charge, 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**
Criteria 5.1 each planned and where possible emergency admission receives a preadmission assessment from nurse manager, deputy manager or nurse in charge, when inisital assessment of patient and needs is carried out. On admission to home each new patient is assessed and an intitial plan of care formulated in conjunction with patient and/or their representive using the roper logan tierney model. this plan of care is informed by the preadmission visit assessment, information provided by the commissioning trust care management team and other members of the multi-disciplinary team as appropriate. Criteria 5.2	Substantially compliant

Each resident is assigned a primary nurse who is responsible for their individual plan of care, a comprehensive holistic assessment of the patient care needs using validated assessment tools is complted within 11 days of admission by the primary care nurse in conjunction with the patient and/or their representive. Crterion 8.1 Nutritional screening is carried out on all patients on the day of their admission using the malnutrition universal screening tool. All nurses receive training on how to carry out this assessment and interpret these results. Criterion 11.1 On admission to the home a validated pressure ulcer risk assessment for rpedicting pressure ulcer risk is carried out, which includes assessment of the patients sensory perception, nutritional intake and level of skin moisture realted to continence (Braden Score)	

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**
Criterion 5.3 Each patient is assigned a Primary nurse who is the key individual with respect to discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients and their representatives both at	Compliant

thetime of admission and during the course of the patient's stay. Communication sheets are held in Care Records to evidence ongoing communication with representatives. The details of each patients primary nurse is displayed in their bedroom. Care Plans are formulated with maximum independence and rehabilitation in mind and reflect changing patient functionality. Care Plans reflect recommendations from various members of the multi-disciplinary team including Dieticians, Speech & Language Therapists, Physiotherapists, Occupational Therapists, Podiatrists and Tissue Viability Nurses. Criterion 11.2 All nurses have received appropriate training in wound care and are aware of when a referral with respect to tissue viability is required. If staff have any concerns regarding a particular wound referrals are made to the Tissue Viability Nurse, Patient's GP and Podiatrist as required. Details of referrals are appropriately completed in the relevant Care Records. Recommendations made are implemented and appropriately recorded. Criterion 11.3 Those patients who are identified as being "at risk" of developing a pressure ulcer have an individualised prevention/treatment plan formulated. Where required further advice may be requested as per criterion 11.2. Individual plans may include the use of pressure relieving equipment such as mattresses or cushions, use of repositioning charts, monitoring food and fluid intake and the use of particular moving and handling aids. Criterion 11.8 Patients with lower limb or foot ulceration are referred as appropriate to their GP, Podiatrist or Tissue Viability Nurse. All referrals are recorded in the appropriate Care Records and all recommendations implemented in full with Care Plans being updated as required. Criterion 8.3 Following MUST assessment if required or at any other required time referrals are made to the Community Dietician. Referrals are recorded. Nutritional treatment plans recommended are retained in the relevant Care Records and implemented in full.	

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**
Re-assessment of care is undertaken daily and appropriately recorded by Nursing Staff in the appropriate sections of Care Records. Assessments and care plans are updated monthly or more often as required.	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**
Criterion 5.5 Validated assessment tools such as Roper, Logan & Tierney, MUST and Braden Scale are used. Advice and guidelines from relevant professional bodies and national standard setting organisations such as NICE, NMC, RQIA & DHSSPS are adhered to at all times. Criterion 11.4 Pressure ulcers are graded by Nursing Staff in accordance with the European Pressure Ulcer Advisory Panel as set out in NICE guidelines. Patients with identified skin damage have an appropriate treatment plan implemented which may be formulated in conjunction with members of the multi-disciplinary team including the Tissue Viability Nurse. Criterion 8.4 Nutritional Guidelines used by staff include: 1. Nutritional Guidelines and Menu Checklist for Residential & Nursing Homes (2014 Edition). 2. Eating Well:supporting older people and older people with dementia (The Caroline Walker Trust). 3. Food and Nutrition for people with dementia (The Dementia Services Development Centre).	Compliant

4. NICE guidelines	

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**
Criterion 5.6 Registered Nurses have received record keeping training and are aware of their accountability and responsibility with respect to record keeping. Nursing records are updated daily with Nurses recording statements which reflect the care and treatment given to each patientAll entries are dated and signed accordingly. Criterion 12.11 A record is maintained of the food served at each mealtime including special dietary needs. Any changes or variations to the menu are recorded by the cook. Criterion 12.12 Daily food records are maintained for all patients. Fluid balance charts are used for patients assessed as being at risk of dehydration.	Substantially compliant

Referrals are made to the Dietitian, Speech & Language Therapist and GP as required. Records are kept of all referrals with recommendations being recorded in Care Records. All recommendations are discussed with the patient or their representative..	

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**
Daily progress notes are recorded for each patient within their nursing progress notes by both day and night Nursing staff. Care plans are evaluated monthly or more frequently as required. Patients and their representatives are involved in the care planning formulation and evaluation processes.	Substantially compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Criterion 5.8 Patient care is evaluated by their Primary Nurse in discussion with the patient. Patients are encouraged and facilitated to attend Care Management Review Meetings. Care Management Review Meetings are also attended typically by the Patient's Primary Nurse and either the Nurse Manager or Deputy Manager. Patients are invited to attend any other multi-disciplinary meeting which may be arranged to discuss aspects of their care. Criterion 5.9 The minutes with respect to all care management review meetings are recorded and kept in the appropriate Care Record. Care Plans and other relevant assessments are updated to reflect recommendations made at review meetings. Patients and their representative are kept informed of such updates.	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**
Criterion 12.1 All food is prepared freshly in Nightingale and Menus operate on a 3 weekly cycle with a variety of dishes offered. Seasonal adjustments are made to the menus. The documents listed in under Criterion 8.4 are taken into consideration when planning menus. Modified diets are accommodated as required. Criterion 12.3 A choice of meal is offered at each mealtime. If the patient refuses either option every effort is made to offer a dish of their choice. Choice is also afforded to patients on modified diets. A choice of drinks is also offered at each mealtime.	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**
Criterion 8.6 Nurses work closely with Speech and Language Therapists with any instructions being fully adhered to with all relevant members of the care and catering team being made aware. Criterion 12.5 Breakfast, lunch and evening tea are provided at conventional times and served in the dining room or the patient's bedroom if required. A choice of hot and cold drinks and freshly made scones, biscuits, cheese and tray bakes is available with midmorning	Compliant

and afternoon tea. A variety of snacks including freshly made sandwiches, fruit, yogurt and cereals are freely available throughout the day and the kitchen remains accessible throughout the night. Fresh drinking water and a choice of juices are readily available at all times and are refreshed regularly in the dayrooms and patient bedrooms. Late suppers are also provided if requested by the resident. Criterion 12.10 Al patients are assessed with respect to their eating and drinking requirements with risks being identified and appropriately addressed. Assistance is given to residents if required by care staff. Any patient who would benefit from an appropriate aid or specialist piece of equipment is supplied with this as required so as to promote independence. Criterion 11.7 Nurses receive wound care training with records maintained with respect to competency and capability assessments	

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

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Care Inspection

Nightingale Care Home

22 January 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with Wendy Spence (deputy manager) & Frances Mc Keown (designated nurse in charge) 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	13 (7)	The registered manager shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff. The following issues were identified which require to be addressed: • a number of bedroom vanity units with veneer were worn and had visible areas of bare wood exposed • a number of toileting seats, toileting equipment were unclean and did not meet infection prevention and control guidance • a number of radiator covers were in poor state of repair and had bare wood exposed • wheelchairs were observed being stored in a linen store Ref: Section 11.7	One	There is a refurbishment plan in place for 2015/2016 which includes a phased replacement of bedroom furniture. Toileting seats and equipment have been cleaned and this is being monitored on the monthly infection control audit. 17 new radiator covers have been ordered and we are waiting for delivery and installation Wheelchairs are being stored beside residents in the lounge or in their bedroom	2 months

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	5.1	It is recommended that all patients have a baseline pain assessment completed and an on-going pain assessment where indicated. Ref: Section 9 & 11.1	Two	A pain baseline is being established on admission and updated as needed.	Ongoing
2	6.2 & 19.1	The registered manager should ensure that all assessment documentation is fully completed, signed by the assessing registered nurse and dated. Ref: Section 10 & 19.1	One	Assessment documentation is now being fully completed by the assessing nurse and signed and dated.	One Month

3	19.1	The registered manager should ensure accurate records in keeping with schedule 3 are maintained. Records such as; • Bowel function referencing Bristol Stool should be recorded and effectively monitored and recorded in the individuals patient's progress notes. • Fluid intake and output records must be maintained for all patients who have a catheter. Entries should be totalled and the information transferred into daily progress records. Ref: Section 10 & 19.1	One	records are now being maintained in the residents' daily progress notes of their daily bowel function referencing Bristol Stool All residents with a catherer have fluid intake and output records which are totalled and entered into the daily progress notes.	One Month
4	40.4	The registered manager should ensure prescribed medicines are only administered to the patient for whom they are prescribed. Ref: Section 11.8	One	Creams have been removed from the bedrooms and are being administered to the patient for whom they are prescribed	One Month

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	Hazel Black
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall 23/4/15 for JR Watson Managing Director

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	YES	Aveen Donnelly	27/05/2015
Further information requested from provider			