Unannounced Care Inspection

Name of Establishment:	**Rathfriland Manor**
RQIA Number:	**1494**
Date of Inspection:	**22 December 2014**
Inspector's Name:	**Donna Rogan**
Inspection ID:	**17286**

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

1.0 General Information

Name of Establishment:	Rathfriland Manor
Address:	Rosconnor Terrace Rathfriland Newry BT34 5DJ
Telephone Number:	028 40638383
Email Address:	rathfrilandmanor@hotmail.co.uk
Registered Organisation/ Registered Provider:	Manor Healthcare Ltd Mr Eoghain King
Registered Manager:	Mrs Brenda McPolin (Acting)
Person in Charge of the Home at the Time of Inspection:	Cherith Rogers (deputy manager)
Categories of Care:	NH - I, over 65 NH- DE(Dementia) RC-DE (Dementia) Day Care – 1allocated place in the nursing unit and 2 allocated places in the nursing dementia unit
Number of Registered Places:	53
Number of Patients Accommodated on Day of Inspection:	52
Scale of Charges (per week):	£560.00 - £640.00
Date and Type of Previous Inspection:	20 March 2014
Date and Time of Inspection:	22 December 2014 10.30 – 15.30 hours
Name of Inspector:	Donna Rogan

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- 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	35
Staff	12
Relatives	3
Visiting Professionals	0

Questionnaires were provided by the inspector, 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	1
Relatives/Representatives	0	0
Staff	10	3

6.0 Inspection Focus

The 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

Rathfriland Manor Private Nursing Home is situated in a residential area in close proximity to Rathfriland Town. The local community, shopping areas, and community services are located nearby.

A maximum of 53 beds are available in three designated units within the home.

Bright and spacious accommodation is provided. To aid identification for patients and residents, doors within the dementia units were painted in primary colours.

Designated communal sitting and dining rooms are provided in each unit.

Bedroom accommodation is provided in single rooms. Forty nine single bedrooms have en-suite shower facilities, and of the remaining four beds, two share an en-suite and two have access to a bath/shower close to their room. Each bedroom has been furnished with a profiling bed and a range of furniture providing storage including locked storage for patients' and residents' personal possessions**.**

A number of bathrooms and shower rooms are located throughout the home ensuring that bathing/showering facilities are available to meet the needs of patients and residents. Toilets are located throughout the home and for ease of identification they are clearly signed.

A designated hairdressing salon has also been provided.

A passenger lift is available and ensures that facilities on the first floor are accessible to all patients/residents and visitors.

A car park is available with an area identified for disabled users with a covered area available for emergency vehicles. An enclosed courtyard is provided for patients/residents.

The registration certificate was appropriately displayed in the entrance foyer of the home, and accurately reflected the categories of residents and patients accommodated.

Nursing Care

I	Old age not falling into any other category (29 beds)
DE	Dementia care (11 beds)

Residential Care

DE	Dementia care (13 beds)

Day Care

1 day care place is allocated over a seven day period in the general nursing unit, and in the nursing dementia unit; two day care places are allocated.

8.0 Executive Summary

This summary provides an overview of the services examined during an unannounced secondary care inspection to Rathfriland Manor Private Nursing Home. The inspection was undertaken by Donna Rogan on 22 December 2014 from 10.30 to 15.30 hours.

The inspector was welcomed into the home by Cherith Rogers, deputy nurse manager of the home. The inspector also spoke briefly with the responsible person by telephone, during the inspection. Ms Rogers was provided with feedback at the conclusion of the inspection.

During the course of the inspection, the inspector met with patients and staff and relatives. The inspector observed care practices, examined a selection of records, and carried out a general inspection of the nursing home environment as part of the inspection process.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. This self-assessment was received by RQIA on 17 July 2014. The inspector reviewed the responses provided, however, due to a change in inspection focus has been unable to validate all of the statements provided. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

As a result of the previous inspection conducted on 20 March 2014, five requirements and five recommendations were made. They were reviewed during this inspection. The inspector evidenced that all requirements with the exception of one in part were complied with. All five recommendations were fully complied with. The part of one requirement in relation to the photography of pressure ulcers/wound care is stated for a second time following this inspection. Details of the previous requirements and recommendations findings can be viewed in the section immediately following this summary.

Conclusion

The inspector can confirm that at the time of this inspection the delivery of care to patients was evidenced to be of a good standard. There were processes in place to ensure the management of continence care. There were no requirements or recommendations made in regard to this theme.

In addition to the theme inspected the inspector also reviewed the following;

- Care practices
- Patients' views
- Staffing/staff views
- Relatives views
- NMC checks
- Complaints
- Patients' finances
- Environment
- Care records

In total two requirements are made following this inspection, one in relation to the environment and one in relation to care records. The requirement in relation to care records is restated in part from the previous inspection. One recommendation is also made in relation to the care records. Details of the requirements and recommendation are specified throughout the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, the deputy manager, relatives and staff for their assistance and co-operation throughout the inspection process. The inspector would also like to thank those 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.	20 (1) (c)	The registered person must ensure all staff receive • Mandatory first aid. **Ref - Follow up on previous issue**	A review of staff training records evidenced that first aid training has been arranged for 13 January 2015. Since the inspection RQIA have received written confirmation that all staff have received training in first aid.	Compliant
2.	30 (1) (d)& (g)	The registered persons must ensure that notice is given to RQIA without delay of the occurrence of – • any event in the nursing home which adversely affects the wellbeing or safety of any patient/resident / any allegation of misconduct by any person who works at the nursing home **Ref - Follow up on previous issue, 16.4 & 17.13**	The inspector can confirm that RQIA receives notification of untoward incidents in a timely way.	Compliant

3.	15 (2) (a) & (b)	The registered person shall 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 re-assessment of patients' care needs takes place on a timely basis • all initial risk assessments are completed on immediate admission to the home • the assessment of wounds is supported by photographic evidence • repositioning schedules are adhered to and records kept up to date • Pressure ulcers should be graded in accordance with the European Pressure Ulcer Advisory Panel (EPUAP) classification	The inspector reviewed six care records. They were assessed as being up to date and reviewed when changes occur. Initial risk assessments were completed following admission to the home. However there was no evidence that wounds were supported with photographic evidence in keeping with best practice. This part of the requirement is stated for a second time. There was evidence in the care records that pressure ulcers were graded in accordance with the European Pressure Ulcer Advisory Panel (EPUAP) classification.	Substantially compliant

		Ref - 10.7, 5.1, 5.3, 5.5, 5.6, 11.3, 11.4 & 11.7		
4.	16 (1)	The registered person shall ensure a written nursing plan is prepared by a nurse in consultation with the patient or patient's representative as to how the patient's needs in respect of his health and welfare are to be met by: • ensuring the identified care plan is further developed in relation to the prevention of pressure ulcers by; stating the specific pressure relieving devices while the patient is in bed and when seated • developing care plans based on the outcome of a pain assessment for patients who are prescribed analgesia **Ref - 5.3 & 11.3**	Following a review of six care records the inspector evidenced that nursing care plans were prepared by a nurse in consultation with the patient or their representative. Care plans were developed in relation to the prevention of pressure ulcers and the specific equipment used when the patient is both seated and whilst in bed. Care plans evidenced that they were developed following the outcome of assessments including pain assessments, particularly with those who have been prescribed analgesia.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	5.1	The registered manager should ensure that a validated pain assessment tool should be in use for any patients on prescribed analgesia **Ref - Follow up on previous issue**	A review of six care records evidenced that there was a validated pain assessment tool used for any patient prescribed analgesia.	Compliant
2.	12.1	Review the home's policy/procedures in regard to the management of nutrition and dietary intake in accordance with the regional document, "Promoting Good Nutrition: A Strategy for good nutritional care for adults in all care settings in Northern Ireland 2011-2016 (DHSSPS)" **Ref - Follow up on previous issue**	The inspector evidenced that the home's policy on the management of nutrition was updated to include the most up to date best practice.	Compliant

3.	25.12	It is recommended that: • the identity of patients / relatives is redacted in the Regulation 29 reports. **Ref: - Theme 1, Section B**	A review of the Regulation 29 inspection visit reports evidenced that the identity of patients/relatives was redacted and confidentiality is maintained of all those spoken with.	Complaint
4.	16.1 & 10.7	It is recommended that: • guidance documents relevant to N Ireland are incorporated in the home's Safeguarding Vulnerable Adults' (SOVA) policy / procedures • the policy for the management of restraint is further developed to reflect legislative and best practice guidance • evidence based guidance in relation to the management of restraint is made available to registered nurses and included in the relevant training **Ref: - 16.1, 10.7,**	The inspector can confirm that the safeguarding policy has been updated to reflect best practice. The policy regarding the management of restraint has also been updated to reflect legislative guidance. The RCN guidance document "Let's talk about restraint" was available in the home. Registered nurses spoken with were aware of the guidance available.	Compliant

5.	5.5 & 11.7	It is recommended that: • 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. • evidenced based literature (as discussed) is included in policies regarding wound care and the prevention and management of pressure ulcers **Ref: - 5.5 & 11.7**	A wound care link nurse has been identified in the home and they have received up to date training in the management of pressure ulcer/wound care. A review of the training records evidence that training is provided to all care staff in the home.	Compliant

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

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if there is considered to be a breach of regulation as stated in the Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

Since the previous care inspection, RQIA have received notifications of incidents occurring in the home, all have been managed appropriately. There are currently no safeguarding of vulnerable adult (SOVA) incidents on-going in respect of Rathfriland Manor Private Nursing Home.

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 six patients' care records evidenced that bladder and bowel continence assessments were undertaken for all 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 all 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 six 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.	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 • stoma care • catheter care The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines • British Geriatrics Society Continence Care in Residential and Nursing Homes • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not inspected.	Not validated
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 nurse revealed that 12 registered nurses in the home were deemed competent in female catheterisation and 10 registered nurses were trained in male catheterisation and all were trained in the management of stoma appliances. There is a continence link nurse working in the home who is 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	**Compliant**

11.0 Additional Areas Examined

11.1 Care Practices

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

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

The afternoon routine was observed to be well organised in all suites of the home. Patients/residents spoken with stated that they could choose where to have their lunch. Patients/residents also informed the inspector that their continence needs were tended to in a timely way, they stated that when they sounded the nurse call system that their request was usually answered promptly.

There was a good atmosphere in the home. There is a well organised activity programme ongoing. It was clearly evident that activities organised were patient led and individualised through choice and need. Patients/residents spoken with stated they enjoyed the activities organised and were looking forward to the social activities organised for Christmas. On the day of inspection a local children's school choir were entertaining the patients/residents all were observed to thoroughly enjoy the entertainment. The inspector commends the commitment of the activity therapist to provide a meaningful activity programme for the patients.

The inspector observed one issue regarding a member of staff. The issue was immediately brought to the attention of the deputy nurse manager who addressed the concern with the member of staff during the inspection. On leaving the inspection, the inspector was assured that the matter had been addressed.

11.2 Complaints

A complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being pro-actively managed.

The inspector discussed the management of complaints with the deputy manager and reviewed the complaint record. 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 the inspector spoke with approximately 35 patients/residents individually and with the majority of others in smaller groups.

Patient 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.

Examples of patients' comments were as follows;

- "I'm spoilt"
- "we are all treated like china here"
- "we get the best of care here"
- "we are all so well looked after"
- "I have enjoyed my stay this past one and a half years, I could recommend it to anyone"
- "There is nothing I would change".

Three relatives spoken with were very satisfied with the care their relatives were receiving. Each stated they thought the home was very well presented, all stated that they were always kept informed, they stated the staff were approachable caring and mannerly.

There were no negative issues raised by patients/residents or their relatives.

11.6 Questionnaire Findings/Staff Comments

During the inspection the inspector spoke with 12 staff consisting of registered nurses, care staff and ancillary staff. The inspector was able to speak to a number of these staff individually and in private. Three 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 that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

Examples of staff comments were as follows;

- "we are well supported"
- "we receive appropriate training in order to carry out our roles and responsibilities"
- "the home is well managed"
- "Staff stability is good in the home".

There were no negative comments made by staff to the inspector during the inspection.

11.7 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients/residents' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a high standard of hygiene.

The following issues should be addressed as discussed during feedback;

- Ensure the storage of equipment is reviewed in the identified bathrooms/shower rooms in keeping with best practice in terms of infection control and management.
- Review and replace the light coverings in the en-suite toilets/shower rooms.
- Repair the lock on the identified medication fridge in the dementia unit.
- Ensure all staff are able to demonstrate the correct action to take in the event of a fire.
- Ensure equipment such as pressure ulcer mattresses are used for the purpose for which they are intended in keeping with the manufacturers' instructions.

11.8 Care Records

The inspector reviewed six care records throughout all suites in the home. The inspector commends the improvements made in driving up the overall standard in records management. The home has both electronic and hand written care records in the home, all records reviewed were being maintained in keeping with good practice. The inspector evidenced that they were individualised, person centred, and were recorded contemporaneously and updated when changes to care or circumstance occurred. One issue identified for further improvement for staff was the use of the term, "all care given, or no changes" in the daily progress notes or in the formal evaluation of care. The records should be meaningful and reflective of the actual care provided. The deputy manager agreed to address this issue with staff during supervision and training. A recommendation is made in this regard.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Cherith Rogers, deputy manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
On admission the admitting nurse completes the residents 12 activities of daily living, identifing current and potential problems. Individulised person centre care plans are then created involving the resident and their family. This is completed on admission to the home within 7days of admission. Information from the MDT is received via care management prior to admission. On admission MUST and braden is completed within 4hrs as well as a full skin check. These are also completed at the preassessment visit if possible.	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
Each resident has a named nurse and CA. The named nurse is responaible for identifying and assessing the needs of the patient and creating care plans for these, taking into account the residntes wishes and MDT input, promoting patients voice and choice. Referals to TVN are made as required. TVN link nurse within in home consulted when advice needed. Referals to poditary are made as required. Both private and NHS podiarty attend home. Individuals residntens who are identified as being at risk have an individulised care plan in place for prevention, this may include dietican, OT, TVN, SALT input as apporiate. Referals are made to the dietican for all residents with pressure damage.	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**
Daily evaluations are completed every 12hours for all residents. Care plans and assessments are completed monthly and more often if needed, e.g a change in condition	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**
GAIN and NICE guidelines are used as a basis for nursing interventions, activities and procedures. Any new recommendations are communicated to staff by notices and staff meetings. The European Pressure Ulcer Advisary Panel Clasifacation System is used to grade pressure ulcers and create an apporate treatment plan. Nutritional guidelines and menu checklist for residental and nursing homes (PHA, 2014) is used by kitchen staff on a daily basis, care staff are kept up to date in their knowledge about nutritional needs and guidelines.	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**
Comprenhesive computer records are kept for all residents in the dementia units, in the gerenal unit these are paper records. They include interventions and outcomes. Menu plans are on a three week rota, residents are offered choices for each meal and a record of their choice is kept. Food charts are completed for each meal and snacks offered. Fluid intake charts are kept for residents that have a decreased fluid intake and all residents on antibiotic therapy.	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**
Daily evaluations of care delivered are recoreded every 12 hours. Care plans are recorded and updated monthly or more frequently if needed, eg if a change in clients condition. 6 monthly reviews are carried out in house with resident and their family. Every 12 months a review is carried out with the resident their family and the social worker/care manager.	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**
Residents are invited and encouraged to attend formal reviews every 12months with their repersentives with the local HSC trust. The minutes of reviews are received by the Nurse Manager or Deputy Nurse Manager on recieveing them. Any action to be taken is noted and then followed up on.	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**
A varried diet is offered at all meal times. Choices are offered to the resident taking into accoutn advice for SALT, dietican etc. Food fortification is ongoing within the home. At least two choices are offered to residents at meals times including those on specific diets.	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
Dysphasia traing has been orgainsed for the 4th July 2014. SALT recommendations are highlighted to all staff on induction and at handovers on the unit. Any recommendations and risks would be highlighted at this time. Meals are provided at conventional times which the residents would be used to. breakfast is offered shortly after rising, or in bed if the patient chooses. Main meal is offered at 12.30 and tea is offered at 1630. Hot and cold drinks are routinely offered to all residents at mid morning, mid afternoon and evening time. There is cold drinks and glasses in comunial areas and occupied bedrooms at alll times. Hot drinks are avaliable on request at all times within the units. Staffing levels are apporiate to the level of dependance at meal times. Staff are encouraged to keep up to date with wound care training. Regular training is organised. Training is to take place on wound care and dressing selection on 30th June 2014.	Substantially compliant

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

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Secondary Unannounced Care Inspection

Rathfriland Manor

22 December 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Cherith Rogers, deputy 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	27 (2)	The registered persons shall ensure the following issues are addressed; • Ensure the storage of equipment is reviewed in the identified bathrooms/shower rooms in keeping with best practice in terms of infection control and management. • Review and replace the light coverings in the en-suite toilets/shower rooms. • Repair the lock on the identified medication fridge in the dementia unit. • Ensure all staff are able to demonstrate the correct action to take in the event of a fire. • Ensure equipment such as pressure ulcer mattresses are used for the purpose for which they are intended in keeping with the manufacturers' instructions. **Ref: 11.7**	One	Toiletries removed and now stored in residents bedroom. All bathrooms and en-suite toilets have new light coverings in place. Medication lock on identified fridge has been replaced. All staff attend fire training bi-annually and regular fire drills are arranged to ensure staff are aware of the correct action to take in the event of a fire. Any specific equipment not used for their intended purpose, a care plan and risk assessment is in place with consent form relatives net of kin.	From the date of inspection
2	12 (1) (b)	Ensure the assessment of wounds is supported by photography in keeping with best practice guidelines. **Ref: Previous requirements**	Two	We have now implemeted photography into our woundcare, in keeping with best pratice guidelines and consent obtained from next of kin.	From the 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	5.7	The registered manager shall ensure the use of the term, "all care given, or no changes" in the daily progress notes or in the formal evaluation of care is not used. The registered manager shall ensure that entries are meaningful and reflective of the actual care provided. **Ref 11.8**	One	Discussed with, and informed staff that the term no changes or all care given is not meaningful and reflective of the care provided and is no longer to be used and will be monitored through monthly audits.	From the 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	Brenda McPolin
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Dawn Rogers	11/3/15
Further information requested from provider			