Unannounced Care Inspection

Name of Establishment:	**Rockfield Care Home**
RQIA Number:	**1496**
Date of Inspection:	**20 January 2015**
Inspector's Name:	**Donna Rogan**
Inspection ID:	**IN017242**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Rockfield Care Centre
Address:	Windmill Road Newry Co Down BT34 2QW
Telephone Number:	(028) 3026 9546
Email Address:	rockfield@schealthcare.co.uk
Registered Organisation/ Registered Provider:	HC-One Limited
Registered Manager:	Ms Ciara Powers
Person in Charge of the Home at the Time of Inspection:	Ms Ciara Powers
Categories of Care:	Nursing Care -(I), (MP) and (PH) Residential Care -(I)
Number of Registered Places:	40 (38 are actually used)
Number of Patients Accommodated on Day of Inspection:	35
Date and Type of Previous Inspection:	23 December 2013 Primary Unannounced Inspection
Date and Time of Inspection:	20 January 2015 11.00 – 16.30 hours
Name of Inspector:	Donna Rogan

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- Discussion with the registered nurse manager.
- Discussion with 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	**22**
Staff	**8**
Relatives	**7**
Visiting Professionals	**0**

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**3**	**3**
Relatives/Representatives	**3**	**2**
Staff	**8**	**3**

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

Rockfield Care Centre was initially registered in May 1991.

The facility is a single story building located on the outskirts of Newry City and bedroom accommodation is comprised of thirty-two single and four shared bedrooms.

There are two sitting rooms, two dining rooms, a kitchen, laundry, toilet /washing facilities, staff accommodation and offices. The grounds around the home are landscaped and private secure areas are provided for the patients.

There is adequate car parking facilities in the ground of the home.

The home is registered to provide nursing care for a maximum of forty patients. A condition of registration is recorded on the certificate to indicate that up to two residential clients may be admitted.

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) was appropriately displayed in the main reception area of the home.

The home is registered for the following categories of care:

Nursing Care

NH-I Old age not falling into any other category
MP Mental Disorder excluding learning disability or dementia
RC-I Old age not falling into any other category

8.0 Executive Summary

The unannounced inspection of Rockfield Care Home was undertaken by Donna Rogan on 20 January 2015 between 11.00 and 16:30 hours. The inspection was facilitated by Ciara Power, registered manager who was also available for verbal feedback at the conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection of 23 December 2013.

As a result of the previous inspection three requirements were issued. These were reviewed during this inspection and it was evidenced that all three requirements have been fully complied with. Details of the findings can be viewed in the section immediately following this summary.

At the time of this inspection, the delivery of care to patients was evidenced to be of a good standard and patients were observed to be treated by staff with dignity and respect. Good relationships were evident between staff and patients. Patients were well groomed, appropriately dressed and appeared comfortable in their surroundings. Those patients who were unable to verbally express their views were also observed to be well groomed, appropriately dressed in clean matching attire and were relaxed and comfortable in their surroundings.

Assessments and care plans in regard to management of continence in the home were reviewed. Review of four patient's care records evidenced that patients and/or their representatives were informed of changes to patient need and/or condition and the action taken. Nursing staff spoken with on the day of the inspection were knowledgeable regarding the management of urinary catheters and the frequency with which the catheters within the home required to be changed. Discussion with staff and review of training records confirmed that staff were trained and assessed as competent in urinary catheterisation. There were no areas for improvement identified within this theme.

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

Additional Areas Examined

Care Practices
Complaints
Patient Finance Questionnaire
NMC Declaration
Patients/relatives questionnaires and comments
Staff questionnaires and comments
Environment
Care Records

Details regarding the inspection findings for these areas are available in the main body of the report. Some areas of for improvement were raised with the registered manager regarding care practices and the management of the environment. Issues raised are listed in section 11.1 and 11.7 of this report.

Conclusion

At the time of this inspection, the delivery of care to patients was evidenced to be of a good standard and patients were observed to be treated by staff with dignity and respect.

As a result of this inspection two requirements were made. Details of the requirements made can be found in the quality improvement plan (QIP) of this report.

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

The inspector would also like to thank the patients, relatives and staff who completed questionnaires.

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	19	The registered person shall ensure all records required by regulation are retained in the home and available for inspection.	All requested records required by regulation were available for inspection in the home.	Compliant
2	15 and 16	The registered person shall ensure that patients' care plans are kept under review and updated care plan is updated to guide staff to the appropriate care to be delivered.	The inspector reviewed four care records. All those reviewed were kept under review and were updated as necessary.	Compliant
3	13 (7)	Ensure linen is appropriately stored in keeping with best practice.	Linen was observed to be appropriately stored.	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.

There are currently no ongoing safeguarding issues in the 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 four patients' care records evidenced that bladder and bowel continence assessments were undertaken. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. The continence assessment in use was regularly revised. The assessment viewed by the inspector evidenced the decision making processes used to identify the continence needs of the individual. 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 general practitioners as appropriate. Review of four 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 following policies and procedures were in place; • Continence management / incontinence management. • Stoma care. • Catheter care. 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 applicable	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 registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the registered manager and a review of the staff training records revealed that five registered nurses in the home were deemed competent in female catheterisation, male catheterisation, suprapubic catheterisation and the management of stoma appliances. Care staff completed training in continence care as part of their induction. The promotion of continence and the management of incontinence are completed by all staff at the time of induction. The review of one staff induction training record evidenced this training had been completed and had been validated by the registered manager. Regular audits of the management of continence products are undertaken by the registered manager. The registered manager informed the inspector that the deputy nurse manager is the incontinence link nurse in the home.	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.

It was observed that two members of staff were using an inappropriate moving and handling technique. This was immediately discussed with the registered manager who addressed this issue with the staff members during the inspection. The registered manager provided assurances that further supervision and training will be provided to the identified staff members. A requirement is made in this regard.

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 management of complaints was discussed with the nurse 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 and Relatives Comments

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

"This is the best home in Newry"
"We are well looked after indeed"
"Brilliant, homely and good craic"
"Staff are brilliant"
"Excellent"
"I really want to stay here; I don't ever want to go home"

Three patient questionnaires were issued. All were returned. There were no issues raised by patients in the returned questionnaires.

Three questionnaires were issued to relatives during the inspection for completion. Two were returned. The following comments were made by seven relatives visiting and in the returned questionnaires on the day of inspection;

"My father is so well looked after"
"My mother is really content and staff take great care of her"
"Staff keep us informed"
"I could not say a bad work about this place"
"It's always so warm and welcoming here"
"I'm content and happy that my relative get all the care and attention they deserve"
"Staff listen to my views about my relatives care"
"Staff treat my relative with dignity and respect"

There were no issues raised by relatives or their representatives during the inspection.

11.6 Questionnaire Findings/Staff Comments

During the inspection the inspector spoke with eight staff. The inspector was able to speak to a number of these staff both individually and in private. Eight staff questionnaires were issued during the inspection, three staff returned the 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.

The following comments were made during the inspection and returned in the staff questionnaires;

"We are a good team, I enjoy my work"
"Patients are treated with dignity and respect"
"We all try our best to care for all patients in the way they deserve"
"Very buzy"
"We try to spend every spare minute with patients talking and listening to them"
"I love this home and we all get on well".

There were no issues raised 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' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortably heated and most areas unless otherwise stated were maintained to a high standard of hygiene.

The following areas are required to be addressed all identified areas room numbers etc. were provided to the registered manager during the inspection;

- Replace the flooring in the identified bathroom.
- Ensure creams and lotions are only used for the person for whom they are provided for.
- Slings should not be stored in toilet areas.
- The identified store should not contain equipment such as medical/nursing equipment alongside clean linen.
- Address the strong odour detected in the identified bathroom.

11.8 Care records

Four care records were reviewed. The inspector commended the improvements in the overall management of care records on this occasion. The care records were observed to be relevant, descriptive, individualised and person centred to meet the patients' needs. There was evidence of patient involvement where required in the care records. Following discussion with patients, relatives and staff the inspector evidenced that the care records were up dated when patients' needs changed in a timely way and in keeping with best practice.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ciara Power, registered 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:

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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**
A full comprehensive pre admission assessment is completed by the Home Manager, Deputy Manager or Senior Nurse. The assessment takes into account the patient's skin condition and their nutritional needs and if any equipment is required. The social worker or Care Manager will also provide the Home with a nursing assessment. On admission a comprehensive, holistic assessment is completed which includes validated tools such as the Malnutrition Universal Assessment and the Braden pressure ulcer risk assessment. Based on this assessment a seven day care plan is implemented.	Provider to complete

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

Nurse facilitator and Tissue viability (Nursing Homes) Southern Health & Social Care Trust. Each patient has a Braden pressure ulcer risk assessment in place which is reviewed monthly or if the patients condition changes. Based on this assessment a plan of care is drawn up which promotes skin integrity. For patients with lower limb or foot ulceration there are referral arrangements in place to obtain advice and support from the tissue viability facilitator and the tissue viability podiatrist. The dietician can be accessed directly by nursing staff.	

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**
Care file documentation is reviewed monthly as a minimum and more often if there is an identified need. A daily statement of well being is updated daily. Evaluations of care planned are outcome based.	Substantially compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All nursing interventions are based on research evidence and guidelines as set by professional bodies and national standard setting organisation. The Braden pressure ulcer risk assessment tool is used in the Home this is reviewed monthly as a minimum and a plan of care is developed which is evaluated monthly at a minimum. HC-One operate a food in focus programme which takes responsibility for providing residents with food and beverages taking into account individual resident's preferences, their choices and which meets the required regulatory standards. We provide a system of menu planning that ensures sound nutritional outcomes at either end of the dietary spectrum from 'health' to 'high energy' and texture modified diets. We also have the 2014 National guidelines and menu checklist for residential and nursing homes which we use as additional guidance.	Substantially 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**
Contemporaneous Nursing records are maintained for all patients in accordance with NMC guidelines which detail nursing interventions and outcomes. Patients are offered a choice of meals and snacks daily and a record is kept of the meals provided. When it is required fluid intake and output is recorded and/or a food intake record is maintained. When it is required referrals are made to the relevant professional and a record is kept.	Substantially 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**
Prior to admission there is a comprehensive assessment of needs and this is maintained on admission. A daily statement of well being is documented twice daily as a minimum. Assessments are reviewed monthly and care plans are evaluated monthly or more often if needed and includes input from patients and their representatives. The monthly reviews detail outcomes of care	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**
When formal review meetings are held by the Local SHSC Trust patients and their representatives are invited to attend. An overview of the review is documented in the Home and any actions required are included in the care plan. Once the record of the review has been sent this is retained with the patients care records. Patients and their representatives are updated with the outcomes of any actions required, this will be documented on the relatives communication record and kept in the patient's file. The Home will also arrange it's own internal care review 6 monthly or more often if required. A record of this is retained in the patient's care file records.	Moving towards compliance

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**
Each patient has an individual diet notification record which details the patients food likes and dislikes and any special dietary requirement. This is then reflected in the care plan. Any guidance from the dieticians or other professional will be included on the diet notification record and will be included in the care plan. The menu offers patients a choice at each meal time. When the patient does not want the choice offered an alternative will be provided. Residents on modified or specific diets are offered a choice.	Substantially 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**
The nutritional needs of each patient is assessed during pre admission and is reviewed at the time of admission and reflected in the 7 day care plan. Guidelines drawn up by the speech and language therapists are reflected in the individual plan of care for that patient. A copy is retained in the care plan and in the kitchen and cascaded to the staff. Meals are proveded at conventional times, snacks, hot and cold drinks are provided throughout the day and drinking water and diluted juice is available in bedrooms and lounge areas. Staff are informed of the patients nutritional needs and all direct care and nursing staff are involved in meal service and assisting patients who require. The catering team are also involved in meal service and the dining room experience.	Substantially compliant

A wound care resource folder is available for staff to access information, Nursing staff are encouraged to attend wound management training run by the Health & Social Care Trust. HC-One has a module on the Touch training programme on 'promoting healthy skin'. All wounds are documented in an individual wound book which details the initial and ongoing wound assessments with a care plan devised based on the assessment and which is evaluated at each stage of assessment. The care plan will include any treatment prescribed by the Tissue viability Facilitator if their advice has been sought.	

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

Secondary Unannounced Care Inspection

Rockfield Care Centre

20 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 Ciara Power, registered manager during the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	14 (3)	Ensure at all times staff use safe and effective means of moving and handling patients. **Ref 11.1**	One	Staff have received supervision record in relation to manual handling techniques. Also discussed at daily flash meetings. Manual handling training arranged for 10th and 11th March 2015.	From the date of inspection
2	13 (7)	Ensure creams and lotions are only used for the person for whom they are provided for. Slings should not be stored in toilet areas. The identified store should not contain equipment such as medical/nursing equipment alongside clean linen. Address the strong odour detected in the identified bathroom. Replace the flooring in the identified bathroom. **Ref 11.7**	One	Discussed at daily flash meeting. Supervision record received with care and nursing staff. Manager to monitor on daily walkrounds. Slings removed from bathroom and stored in linen cupboard on designated hooks. Estates have sent contractor to quote for works to refurbish entire shower room in Quartz.corridor which will include the flooring. Manager will inform when works have been completed.	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	CIARA POWER
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	PAULA KEYS

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