Unannounced Primary Care Inspection

Name of establishment: **St Joseph's Private Nursing Home**

RQIA number: **1498**

Date of inspection: **16 October 2014**

Inspector's name: **Donna Rogan**

Inspection number: **IN017249**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of establishment:	St Joseph's Nursing Home
Address:	16 Princes Street Warrenpoint BT 34 3 NH
Telephone number:	028 417 53572
Email address:	stjosephs@kilmoreycare.com
Registered organisation/ Registered provider / Responsible individual	Kilmorey Care Ltd
Registered manager:	Mrs Jacqueline Rooney
Person in charge of the home at the time of inspection:	Mrs Jacqueline Rooney
Categories of care:	NH-I, NH-LD, NH-LD(E),NH-PH, NH-PH(E), RC- I, RC-PH, RC-PH(E) Day Care (10)
Number of registered places:	50
Number of patients / residents (delete as required) accommodated on day of inspection:	46
Date and type of previous inspection:	6 March 2014 Primary Unannounced Inspection
Date and time of inspection:	16 October 2014 09.35 – 17.30
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 is required.

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

3.0 Purpose of the inspection

The purpose of this inspection was to consider whether the service provided to patients/residents 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.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

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

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for the preliminary assessment of achievement by the Provider of the DHSSPS Nursing Homes Minimum Standards 2008.

The inspection process has three key parts; self-assessment (including completion of self- declaration), pre-inspection analysis and inspection visit by the inspector.

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

- Review of any notifiable events submitted to RQIA, in accordance with Regulation 30 of the Nursing Homes Regulations (NI) 2005, since the previous inspection.
- Analysis of pre-inspection information submitted by the registered person/s.

- Discussion with the registered manager.
- Discussion with Mrs P O'Neil, proprietor.
- Discussion with staff.
- Examination of records pertaining to staffing.
- Review of a sample of policies and procedures.
- Review of a sample of staff training records.
- Review of a sample of staff duty rotas.
- Evaluation and feedback.

5.0 Consultation process

During the course of the inspection, the inspector spoke with:

Patients/Residents	**25**
Staff	**12**
Relatives	**3**
Visiting professionals	**0**

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

Issued to	**Number issued**	**Number returned**
Patients / residents	**0**	**0**
Relatives / representatives	**0**	**0**
Staff	**10**	**4**

6.0 Inspection focus

The theme for the inspection year April 2014 – March 2015 is: 'Nursing Care'

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 regular reviewed. (Standard 5)

Under the 'Nursing Care' theme, inspection will focus on three areas of practice:

- management of wounds and pressure ulcers (Standard 11)
- management of nutritional needs of patients and weight loss (Standard 8 & 12)
- management of dehydration (Standard 12).

Only selected criteria from each of the four standards will be inspected across nine areas and incorporated into the Provider's Self-Assessment.

The inspector will also consider the management of patient's human rights during this inspection.

The inspection theme and focus for the 2014 – 2015 inspection year was outlined by RQIA at the annual Provider Roadshow in February 2014 and the self-assessment was made available on the RQIA website.

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

Guidance - Compliance statements		
Guidance - Compliance statements	**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

St Joseph's Private Nursing Home is located centrally within Warrenpoint town and can provide care for a maximum of fifty persons.

The home overlooks the sea front and some bedrooms have a sea view. There are adjacent gardens and car parking spaces available within the home grounds.

The home is registered to provide nursing and residential care, and respite care is also provided when occupancy levels allow. Day care is provided within a designated area of the home.

8.0 Summary of inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to St Joseph's Nursing Home. The inspection was undertaken by Donna Rogan on 16 October 2014 from 09 35 to 17 30 hours.

The inspection sought to establish the level of compliance achieved regarding the selected DHSSPS Nursing Homes Minimum Standards.

The inspector was welcomed into the home by registered nurse manager Jacqueline Rooney. The proprietor of the home Mrs Peggy O'Neil joined the inspection in the afternoon. Verbal feedback of the issues identified during the inspection was provided to Mrs Rooney and Mrs O'Neil at the conclusion of the inspection.

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 24 June 2014. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

During the course of the inspection, the inspector met with patients, relatives and staff to seek their opinions of the quality of care and service delivered. The inspector also examined the returned questionnaires from staff, 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.

The inspector spent a period of ten minutes observing staff and patient interaction. Discussions and questionnaires are at times unlikely to capture the true experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience. These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool was designed to help evaluate the type and quality of communication which takes place in the nursing home.

As a result of the previous inspection conducted on 6 March 2013. Seven requirements and three recommendations were issued. These were reviewed during this inspection and the inspector evidenced that three requirements have achieved compliance, three are substantially compliant and one is moving towards compliance. All of the three recommendations have been fully complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

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. (Selected criteria)

Standard 8: Nutritional needs of patients are met. (Selected criteria)

Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)

Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria).

8.1 Inspection findings

8.1.1 Management of nursing care – Standard 5

There was evidence of comprehensive and detailed assessment of patient needs from date of admission. Assessments were found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patient need was evidenced to inform the care planning process. However one care record did not detail the name of the registered nurse completing the admission assessment or the date of the admission a requirement is made in this regard.

The following issues in relation to care records should be reviewed as follows;

Ensure weights are recorded at least monthly or more often if required. Details of how often the patient should be weighed should also be included.
Ensure the care record refers to the pressure relieving equipment in place.
Ensure the care plan in relation to nutritional supplements is updated and recorded in a clear manner.
Ensure the repositioning chart, fluid balance chart and nutritional intake chart is completed in accordance with the care plan.
Ensure the fluid target is recorded in the fluid balance chart.
Ensure the daily care record reflects accurately the care delivered.

A requirement is made in this regard.

Compliance Level: Moving towards compliance

8.1.2 Management of wounds and pressure ulcers – Standard 11 (selected criteria)

The inspector evidenced that wound/pressure ulcer management in the home was generally well delivered in accordance with best practice. There was evidence of appropriate assessment of the risk of development of pressure ulcers which demonstrated timely referral to tissue viability specialist nurses (TVN) for guidance and referral to the HSCT regarding the supply of pressure relieving equipment if appropriate. However the records reviewed did not record the delivery of care in accordance with best practice.

The following issues in relation to the care records should be reviewed as follows;

Ensure the Braden risk assessment includes the date that it is carried out.
Ensure the current state of wounds/pressure ulcer care is clearly recorded in relation to each wound.
Ensure there is an initial assessment is in place in relation to each wound.
Ensure there is an ongoing wound care assessment in place and that it is updated each time the wound is dressed.

A requirement is made in this regard.

Compliance Level: Moving towards compliance

8.1.3 Management of nutritional needs and weight loss – Standard 8 and 12 (selected criteria)

The inspector reviewed the management of nutrition and weight loss within the home. Systems were evidenced with risk assessments and appropriate referrals to General Practitioners (GP's), speech and language therapists (SALT) and or dieticians being made as required.

The inspector also observed the serving of the lunch time meal and can confirm that patients were offered a choice of meal and that the meal service was well managed and supervised by registered nurses.

Patients were observed to be assisted with dignity and respect throughout the meal. The meal served was well presented and appeared appetising.

Care records in relation to nutritional intake charts and food fluid intake and output charts should be reflective of the food and fluids offered and taken. A review of the nutritional intake charts and fluid balance charts evidenced large time delays in the recording of food and fluids offered and taken. Staff spoken to assured the inspector that food and fluids were offered and taken in a timely way. However they were finding it difficult to find the time to complete the records. These charts should be completed at the time of care delivered to patients to ensure they are contemporaneous and reflective of the care given.

A requirement is made in this regard.

Compliance Level: Substantially compliant

8.1.4 Management of dehydration – Standard 12 (selected criteria)

Patients were observed to be able to access fluids with ease throughout the inspection. Staff were observed offering patients additional fluids throughout the inspection. Fresh drinking water/various cordials were available to patients in lounges, dining rooms and bedrooms.

As previously stated care records in relation to nutritional intake charts and food fluid intake and output charts should be reflective of the food and fluids offered and taken. A review of the nutritional intake charts and fluid balance charts evidenced large time delays in the recording of food and fluids offered and taken. Staff spoken to assured the inspector that food and fluids were offered and taken in a timely way. However they were finding it difficult to find the time to complete the records. These charts should be completed at the time of care delivered to patients to ensure they are contemporaneous and reflective of the care given.

A requirement is made in regards to this standard.

Compliance Level: Substantially compliant

8.4 A number of additional areas were also examined.

- Records required to be held in the nursing home
- Human Rights Act 1998 and European Convention on Human Rights (ECHR)
- Patient and staff quality of interactions (QUIS)
- Complaints
- Patient finance pre-inspection questionnaire
- NMC declaration
- Patient and relatives comments
- Staffing and staff comments
- Environment
- Management and control of infection

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 effective management of the themes inspected.

The home's general environment was well maintained and patients were observed to be treated with dignity and respect.

Overall, other areas for improvement were identified in relation to the staffing and the management of the laundry.

There were six requirements and one recommendation made as result of this inspection. The requirements made are detailed throughout the report and in the quality improvement plan (QIP).

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

The inspector would also like to thank the staff who completed questionnaires.

9.0 Follow-up on the requirements and recommendations issued as a result of the previous primary unannounced care inspection conducted on 6 March 2013

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
1	15 (2)	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, by ensuring: • The admission assessment process is reviewed and an appropriate model of care is used for those admitted for respite/short term care. • All risk assessments and a body map are completed on the day of admission. • A pain assessment is undertaken when patients are prescribed analgesia. • A bedrail risk assessment is undertaken in relation to one patient.	The inspector reviewed the care records of five patients. The following was evident; The admission process has been reviewed with an appropriate model of care for those admitted for respite/short term care. One of the five care records reviewed did not have the date of admission recorded. The admitting registered did not include their signature. A body map and risk assessments were completed on admission. There was evidence of pain assessments being undertaken when patients were prescribed analgesia. Bed rail assessments were observed to be appropriately undertaken.	Moving towards compliance

		• The date is recorded on all assessment records. • Pressure ulcers are graded using the European Pressure Ulcer Advisory Panel Classification System. • a fluid balance chart should be in place, accurately recorded and the overall total fluid intake and output recorded over the 24 hour period when patients have a urinary catheter in situ. • Wound assessments are supported with the use of photography. • All records (including repositioning charts) should be dated and signed.	As previously stated with the exception of one care record assessment records were dated. There was evidence in the care record that pressure ulcers were appropriately graded. Where patients were identified as being at risk of dehydration a fluid balance chart was in place. However they were not accurately recorded and the overall total fluid intake and output record was not consolidated. Wound assessments were observed to be supported with the use of photography. The repositioning charts, fluid balance chart and nutritional intake charts were not always appropriately completed. Staff spoken with stated they did not always have time to complete them in a contemporaneous manner. A requirement is made for a second time following this inspection to ensure the above issues identified are addressed without delay.	

2	12 (1)	Ensure the care plan audits are further developed to evidence that any action required is brought to the appropriate registered nurses' attention and confirm that the action required has been addressed. Audit records should include the date and signatures of the auditor and the person being audited.	Care plan audits are being completed by the deputy manager. There is evidence that any action required is brought to the appropriate registered nurses attention. The audit records included the date and signatures of the auditor and the person being audited. However the audits should be increased to ensure the management of wounds/pressure ulcer care, fluid and nutritional care is appropriately recorded and managed.	Substantially compliant
3	14 (4)	The registered person shall make arrangements by training staff or by other measures, to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse by ensuring that: • all nursing staff are competent in reporting suspected, alleged or actual incidents of abuse to the relevant persons and agencies in accordance with procedures and in a timely way. • Competency and capability assessments for all nurses who take charge of the home includes the action to be taken in	Staff training records evidenced that staff had received training in safeguarding vulnerable adults. Registered nurses spoken with competent and were able to demonstrate the appropriate action should suspected/alleged abuse be reported to them. Competency and capability assessments have been undertaken for all registered nurses who take charge of the home in relation to	Compliant

		the event of an allegation of abuse. • Safeguarding Vulnerable Adults Regional Adult Policy and Procedural Guidance and Safeguarding Vulnerable Adults, A Shared Responsibility (1st edition 2010) guidance are referenced within the home's SOVA policies/procedural documents.	safeguarding vulnerable adults. The home's safeguarding policy and procedures have been updated and reference best practice guidance.	
4	20 (1) (c) (1)	The registered person shall having regard to the size of the nursing home, the statement of purpose and the number and needs of patients - (c) ensure that the persons employed by the registered person to work at the nursing home receive. (1) appraisal, mandatory training and other appropriate training to the work they are to perform to include; • ensuring all registered nurses undertake training in relation to wound care and the classification of pressure ulcers using the European Pressure Ulcer Advisory Panel Classification System.	A review of appraisals and mandatory training records is provided for all staff. Training also included the management of wound care and the classification of pressure ulcers. Care staff confirmed that they have received training in pressure ulcer care. The inspector can confirm that compliance rates with the above training have been received by RQIA. However following a review of the care records in relation to wound care/pressure ulcer care, a requirement is made that the training is embedded into practice.	Substantially compliant

		• All care staff complete training in relation to pressure area care and the prevention of pressure ulcers. The registered manager is requested to confirm compliance rates with the above training when returning the Quality Improvement Plan (QIP).		
5	16 (2) (b)	The registered person shall ensure that – (b) the patient's plan is kept under review by ensuring that • A care plan is put in place for all actual or potential problems (including the prevention of pressure ulcers) requiring nursing care. • Care plans are discontinued when problems are resolved.	A review of care records did not evidence best practice in the recording of the management of wounds and pressure ulcer care. However the inspector evidenced from discussion with staff and a review of the desk diary that wound care/pressure ulcer care was being delivered in keeping with best practice. The records are required to be updated to reflect this care delivery. Care plans were being discontinued when problems were resolved.	Substantially compliant
6	24 (4)	The registered person must inform the person who makes a complaint of the investigative action, outcome and action (if any) that is to be taken.	A review of the complaints record evidenced that the person who makes a complaint have been informed of the outcome and action (if any) is taken.	Compliant

7	18 (2) (j)	The registered person must having regard to the size of the nursing home and needs of patients, keep the nursing home free from offensive odours by: • Addressing the mal-odour from the identified toilet area.	There were no offensive odours detected on the day of inspection.	Compliant

No	Minimum Standard Ref.	Recommendations	Action taken – as confirmed during this inspection	Inspector's validation of compliance
1	29.1	Ensure that all staff including care staff receives formal supervision.	Care staff spoken with informed the inspector that they receive formal supervision.	Compliant
2	10.7	It is recommended that: • The evidence based document "Let's talk about restraint Rights, risk and responsibility" (RCN 2008) is available for all nurses to reference and that it is incorporated/referenced into the policy/procedure for the management of restraint.	The guidance documents were available in the home for all registered nurses. The policy has been updated to reference best practice guidance in regard to restraint.	Compliant
3	5.3	It is recommended that: • The current consent documentation is reviewed to reflect best practice guidance.	The consent document for use in restraint has been reviewed to reflect best practice guidelines.	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 the remit of RQIA to investigate complaints made by or on 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 have been notifications to RQIA regarding incidents since the previous inspection. The incidents were being managed in accordance with best practice guidelines and The Nursing Home Regulations (Northern Ireland) 2005.

10.0 Additional areas examined

10.1 Records required to be held in the nursing home

Prior to the inspection a check list of records required to be held in the home under Regulation 19 (2) Schedule 4 of The Nursing Homes Regulations (Northern Ireland) 2005 was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required records were maintained in the home and were available for inspection.

10.2 Patients/residents under guardianship

There were no patients currently under guardianship resident at the time of inspection in the home.

10.3 Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspector discussed the Human Rights Act and Human Rights Legislation with the acting manager and two of the registered nurses. All three were knowledgeable regarding Human Rights Act 1998.

10.4 Quality of interaction schedule (QUIS)

The inspector undertook a period of observation in the home which lasted for approximately 10 minutes.

The inspector observed the interactions between patient and staff during the serving of lunch in the dining room.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area being observed.

Positive interactions	12
Basic care interactions	0
Neutral interactions	1
Negative interactions	0

The inspector evidenced that the quality of interactions between staff and patients/residents was positive.

10.5 Complaints

Prior to the inspection 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 reviewed the complaints records. This review evidenced that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought and recorded.

The acting manager informed the inspector that lessons learnt from investigations were acted upon.

10.6 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.

10.7 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. This was also evidenced by the inspector on the day of inspection.

10.8 Questionnaire findings

10.8.1 Staffing/staff comments

Discussion with the registered manager and a number of staff and review of a sample of staff duty rosters evidenced that the registered nursing and care staffing levels were found to be in line with the RQIA's recommended minimum staffing guidelines for the number of patients currently in the home.

Ancillary staffing should be reviewed in the laundry to provide cover over seven days a week. On the day of inspection there was a backlog of laundry to be completed. This included soiled and infected linen. Staff spoken with stated that laundry in the home is not completed on a Sunday. It is required that the management of staffing in the laundry is reviewed to ensure that laundry is completed in a timely manner and that infected and soiled linen should be cleared daily in accordance with best practice.

Staff were provided with a variety of relevant training including mandatory training since the previous inspection.

During the inspection the inspector spoke with approximately twelve staff. All staff spoken with expressed dissatisfaction with the staffing levels in the home. All stated that staffing has been decreased recently. Although the inspector did not evidence that staffing was below the RQIA minimum staffing levels and evidenced that care delivery was being conducted in a timely way. It is recommended that a review of the staffing levels and the deployment of staff is conducted in order to ensure that records are maintained in accordance with best practice. Registered nurses spoken with stated that they are unable to update their care records in a timely way. The inspector evidenced that care staff were not completing charts such as fluid balance, nutritional intake and repositioning charts in a contemporaneous manner. Care staff spoken with stated that they no longer had the time to complete the task.

The inspector was able to speak to a number of these staff individually and in private. On the day of inspection, four staff completed questionnaires. The following are examples of staff comments made in the returned questionnaires;

"I don't feel that the care staff have enough time in between meals to sit and talk with patients"
"I feel we all work well as a team"
"I am happy to ask the nurse or manager for help"
"Overall I am very happy here"
"I feel we do not have enough time to chat and listen to patients"
"I think the care is of a good standard, little improvements would be great"
"The carers work well as a team"

10.8.2 Patients' comments

During the inspection the inspector spoke with 25 patients individually and with a number in groups. Those patients who could communicate with the inspector expressed satisfaction with the care they were receiving. There were no negative comments verbalised.

The following are examples of patients' comments made to the inspector;

"The staff do their best, they are always very helpful"
"I think we are all well cared for"
"I am very happy and content"
"The food is great"
"Staff work very hard, and they are kind"

10.8.3 Patient representative/relatives' comments

The inspector spoke with three relatives visiting during the inspection. All comments made were positive regarding the care their relatives were receiving;

"My mother is doing so well since her admission to the home"
"I can go home content that my mother is being well cared for"
"Staff are always very attentive and sensitive"

The inspector examined four patient care records as part of the inspection process to validate the provider's self-assessment. In general the care records were evidenced to be maintained to an acceptable standard.

10.9 Environment

The home was well presented, and the environment was welcoming clean and free from malodours. There is an ongoing refurbishment/redecoration plan in place. The inspector evidenced that the refurbishment/redecoration plan is being adhered to.

10.10 Management and control of infection

There have been a number of infection control audits carried out which are usually completed monthly. With the exception of the backlog of infected/soiled linen in the laundry (previously stated in section 10.8.1) there were no issues raised in relation to the control of infection.

11.0 Quality Improvement Plan

The details of the quality improvement plan appended to this report were discussed with Emma Murphy, acting 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

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**
All planned admissions to the Home are pre-assessed by either the nurse Manager or a Senior Nurse, using the Roper Tierney Logan model in conjunction with the information received from the Care Management team. When patient's are admitted a Nurse undertakes an activities of living assessment, based on the pre-assessment tool and information gained from the Patient and their representatives, and the care management team. This is undertaken within 11days of admission. The only exceptions are where an emergency/out of hours admission has been arranged. The Roper Tierney Logan tool is used to complete the comprehensive, holistic assessment of patient care needs and includes the Braden and MUST risk assessments.	Substantially 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 patient is allocated a named Nurse who developes a care plan with both the Patient and their representatives to promote independence in conjunction with the disciplinary team. Nursing Staff have access to MDT including TVN's by telephone, email and a formal referral system.	Compliant

The Braden Scale assists Nurses to identify those patients at risk of developing pressure ulcers. A care plan is then developed to minimise risk and promote comfort for the patient. Advice may be sought from other health care professionals. All Nursing Staff have access to the referral system for TVN and podiatry input. Dietetic services are engaged when the MUST tool and food records indicate the need for specialist intervention. The nutritional plans developed with the Dietician and patient are adhered to, reported upon and reviewed on a monthly basis or sooner if there are concerns.	

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**
All care given is evaluated daily. This is a reflection of the risk assessment and subsequent care plan, which are reviewed monthly by the named Nurse. This ensures changing needs are identified, and referrals are followed up.	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**
Care is evidence based using NICE guidelines. Advice and guidance is also taken from the MDT members. All Nurses have received Wound Management Training in June 2014 and are familiar with and use the European Pressure Ulcer Grading Tool. Nurses and Catering Staff are familiar with Nutritional Guidelines. It is intended to provide MUST training updates for all Nurses within the next three months.	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**
	Provider to complete

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**
Timely accurate records are maintained for each patient reflecting the agreed outcomes. Meal choices, meals taken or not and actions planned are recorded. Referrals are made as necessary and follow up action taken and recorded as appropriate.	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**
Patients and their representatives are encouraged to participate and contribute to the review process through the formal multidisciplinary review meetings as arranged by the relevant HSC Trusts. These reviews are recorded, agreed and signed, and Care plans further developed to reflect any change identified and goals as agreed. Patients and their representatives are kept informed of progress.	Substantially 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**
On admission, new patients or their representatives meet with Catering Staff to discuss food preferences, a record of same is kept in Kitchen and patients folder. Menus are planned to provide as nutritious and varied diet as possible; suited to the individuals needs. Advice from Dietician, SALT and other relevant MDT's is followed and documented. Menus are displayed and choice is evident. Cooks are flexible and will cook for the individual should their preference not be on the nemu.	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**
All Nurses are experienced in managing feeding techniques for those patients who have swallowing difficulties. They are also responsible for the supervision of Care Staff thus ensuring that instructions as drawn up by SALT are understood and adhered to. Meals are provided also throughout the year. Patients birthday's are celebrated with a traditionally decorated cake. Menus reflect that beverages and snacks are available throughout the day. Those patients who wish to have their meals outside the conventional times are catered for.	Substantially compliant

Staffing levels allow adequete supervision and assistance at mealtimes. Risks are assessed and managed as per Care plans and SALT advice and any necessary aids to further reduce risk are provided. Nurses have received Wound Care Management Training in June 2014. This in conjunction with advice from TVN assests them to carry out Wound assessments and choosing the appropriate wound care products and dressings.	

Provider's Overall Assessment of The Nursing Home's Compliance Level Against Standard 5	Compliance Level
	Provider to complete

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

Primary Unannounced Care Inspection

St Joseph's Private Nursing Home

16 October 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 Jacqueline Rooney, registered manager and Peggy O'Neil, proprietor 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	15 (2)	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, by ensuring: The date of admission and the signature of the person completing the admission records should always be recorded. A fluid balance chart should be in place, accurately recorded and the overall total fluid intake and output recorded and consolidated over the 24 hour period. All records including repositioning charts, fluid balance charts and nutritional intake charts should be dated and signed and completed in an accurate and contemporaneous manner. **Ref Previous requirement**	Two	All care plans are reviewed before the 11th day post admission. All other care plans are reviewed as the patient's condition determines and on a monthly basis. The care plan audit sheet has now been amended to include the checking of date and signature on the profile page. All residents on a fluid balance chart have the charts checked at the end of each shift and consolidated by a nurse at the end of the 24 hour period. All records, repositioning charts, nutrional charts, fluid balance charts - are dated, signed at each entry and are completed by nursing and care staff at the end of each task and checked at the end of each shift.	From the date of inspection

2	12 (1)	Ensure care plan audits are completed on patients with wounds/pressure ulcers to ensure they are appropriately completed in keeping with best practice guidelines. **Ref previous requirements**	One	Care plan audits now have a wound care section attached. Any shortfalls will be addressed through formal supervision	From the date of inspection
3	20 (1) (c) (1)	Ensure that when training is provided to staff that it is embedded into practice and where shortfalls are identified that they are actioned through formal supervision. **Ref Previous requirements**	One	All training that has not been fully embedded into practice will be dealt with through formal supervision	From the date of inspection
4	16 (2) (b)	The registered person shall ensure that – (b) the patient's plan is kept under review by ensuring that • a care plan is put in place for all actual or potential problems (including the prevention of pressure ulcers) requiring nursing care. • care plans are updated when there changes in the patients' needs. • best practice regarding the record keeping of wound/pressure ulcer care should be in keeping with best practice guidelines. **Ref Previous requirements**	Two	Patients' care plans are in place for actual and potential problems, including prevention of pressure ulcers. All wound care is routinely audited on a monthly basis. All nursing staff have received training in best practice and have access to TVN and NICE guidelines.	From the date of inspection

5	13 (7)	The registered manager shall ensure that the management of staffing in the laundry is reviewed to ensure that laundry is completed in a timely manner and that infected and soiled linen should be cleared daily in accordance with best practice. **Ref 10.8.1 Staffing/staff comments**	One	Laundry hours have been increased to address the issue and laundry is routinely checked to ensure infected linen is cleaned and cleared daily. The machinery is sufficient for 80 people.	From the date of inspection

6	15 and 16	Ensure the identified care records are updated to ensure the following issues are addressed; Ensure weights are recorded at least monthly or more often if required. Details of how often the patient should be weighed should also be included. Ensure the care record refers to the pressure relieving equipment in place. Ensure the care plan in relation to nutritional supplements is updated and recorded in a clear manner. Ensure the repositioning chart, fluid balance chart and nutritional intake chart is completed in accordance with the care plan. Ensure the fluid target is recorded in the fluid balance chart. Ensure the daily care record reflects accurately the care delivered. Ensure the Braden risk assessment includes the date that it is carried out. Ensure the current state of wounds/pressure ulcer care is clearly recorded in relation to each wound.	One	Weights for each resident are checked monthly or more often if weight loss is evident. The method of weighing the patient is recorded in the care plan. The type of mattress and or cushion is recorded in the care plan. Care plans are changed and the type of supplements prescribed recorded in care plan and changed accordingly. The fluid target is now recorded on the fluid balance chart. The daily care record gives detailed information of the care delivered. Date of Braden risk assessment is recorded and date of review recorded. All identified wounds are recorded ,photographed the	From the date of inspection

		Ensure there is an initial assessment is in place in relation to each wound. Ensure there is an ongoing wound care assessment in place and that it is updated each time the wound is dressed. Ensure care records in relation to nutritional intake charts and food fluid intake and output charts should be reflective of the food and fluids offered and taken and are completed contemporaneously.		dimensions of the wound are accurrately recorded using the recognised tool provided by the Tissue Viability Nurse ,this is updated at each dressing. All fluid balance charts and food charts are completed contamporaneously to reflect the resident's intake accurately	

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	30.1	The registered manager shall ensure that a review of the staffing levels and the deployment of staff are carried out in order to ensure that records are maintained in accordance with best practice. Registered nurses should be able to complete care records in a timely way. Time should be included in the care hours to ensure that fluid balance, nutritional intake and repositioning charts are completed in a contemporaneous manner. **Ref 10.8.1Staffing/staff comments**	One	From 22nd October 2014 a Kitchen Assistant has been employed to take breakfast trays to each room where Care Assistant assists patients with eating or drinking and completes Fluid Balance charts immediately. As evidenced on the day of the unannounced inspection, the staffing levels were above the minimum required. The removal of breakfast duties and the employment of a Kitchen Assistant has ensured Care Assistants can assist patients to eat and then assist with personal hygiene needs in a timely manner. Care Assistants confirm that they now have sufficient time in the mornings. Nurses - 2 additional hours continues to be provided monthly to up-date care plans and we now ensure this time is taken up. A third nurse has been employed Monday -	From the date of inspection

				Friday to ensure record keeping accurately reflects, at all times, the high quality of care and attention delivered to patients by carers and nurses. We have employed agency nurses, when available, to provide support to nursing staff. Meetings were held with carers and nurses in October 2014 and small group meetings on several occasions since then, to ensure that work processes are smoother and staff morale has improved.	

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	J ROONEY
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	Donna Logan	19/1/15.
Further information requested from provider			