Unannounced Care Inspection

Name of Establishment:	**Kilbroney Private Nursing Home**
RQIA Number:	**1553**
Date of Inspection:	**25 November 2014**
Inspector's Name:	**Donna Rogan**
Inspection ID:	**IN017221**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Kilbroney Private Nursing Home
Address:	83 Kilbroney Road Rostrevor BT34 3BL
Telephone Number:	028 417 38600
Email Address:	kilbroneyhouse@btconnect.com
Registered Organisation/ Registered Provider:	Ms J Campbell
Registered Manager:	Ms J Campbell
Person in Charge of the Home at the Time of Inspection:	Mrs Pauline Campbell
Categories of Care:	Nursing Care – I, DE, MP, MP(e)PH,PH(e)
Number of Registered Places:	19
Number of Patients Accommodated on Day of Inspection:	19
Scale of Charges (per week):	£510.00 - £650.00
Date and Type of Previous Inspection:	3 December 2013 Primary Unannounced
Date and Time of Inspection:	25 November 2014 10.00 to 16.30
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 are required.

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- Discussion with Jaqueline Campbell, registered provider.
- Discussion with Pauline Campbell, nurse in charge.
- Discussion with staff.
- Discussion with patients individually and to others in groups.
- 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	**19**
Staff	**6**
Relatives	**2**
Visiting Professionals	**0**

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**3**	**3**
Relatives/Representatives	**0**	**0**
Staff	**4**	**4**

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.

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

Kilbroney House Private Nursing Home is located on the outskirts of Rostrevor situated in close proximity of Kilbroney Forest Park. The home is located within a rural setting and public transport facilities, shops and community services are a short distance away.

The two-storey building comprises five single bedrooms, four double and two treble bedrooms, a large sitting room, one dining room, toilet/washing facilities and a kitchen. Laundry facilities situated adjacent to the home are provided.

Car parking is available to the front of the premises and gardens and grounds are satisfactory.

The registered manager Mrs J Campbell RMN has responsibility for managing all aspects of care and services provided for patients.

The home is registered to accommodate a maximum of nineteen patients. The registered categories of care are for conditions associated with old age, dementia, mental disorder, and physical disability for patients under and over sixty-five years.

The registration certificate was displayed and reflected the categories of care accommodated in the home.

8.0 Summary

This summary provides an overview of the services examined during an unannounced secondary care inspection to Kilbroney Nursing Home. The inspection was undertaken by Donna Rogan on 25 November 2014 from 10.00 to 16.30.

The inspectors were welcomed into the home by Pauline Campbell, nurse manager. The registered provider Jacqueline Campbell joined the inspection shortly after it had commenced. Both were provided with feedback at the conclusion of the inspection.

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

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. This self-assessment was received by RQIA 14 May 2014. The inspector reviewed the responses provided, however, due to a change in inspection focus has been unable to validate all of the statements provided. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one. As a result of the previous inspection conducted on 3 December 2013, three requirements were made. They were reviewed during this inspection. The inspector evidenced that all three requirements were fully complied with. Details of the actions taken regarding the previous requirements can be viewed in the section immediately following this summary.

Conclusion

The inspector can confirm that at the time of this inspection the delivery of care to patients was evidenced to be of a good standard. There were processes in place to ensure the management of continence care. One requirement was made in regard to this theme.

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

- Care practices.
- Complaints.
- Patient finance questionnaire.
- NMC declaration.
- Patients/Residents and Relatives Comments and returned Questionnaires.
- Questionnaire Findings/Staff Comments.
- Environment.

A requirement is made in relation to the environment. A total of two requirements are made following this inspection. These requirements are detailed throughout the report and in the quality improvement plan (QIP).

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

The inspector would also like to thank the patients 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	21 (1) (b)	21 (1) The registered person shall not employ a person to work at the nursing home unless; (b) he has obtained the information and documents specified in paragraphs 1 to 7 of Schedule 2 Schedule 2, paragraph 6; The registered person shall receive a full employment history, together with a satisfactory written explanation of any gaps of employment. Schedule 2, paragraph 2 (a) The registered person shall ensure an enhanced criminal record certificate issued under section of the Police Act 1977. Ensure that at all times a full employment history is obtained and recorded and any gaps in employment should be	A review of two personnel files evidenced that the required information as stated in regulation 21 paragraphs 1 to 7 of schedule were in place prior to staff commencing employment. There was evidence of a full employment history available and where gaps in employment were identified, they were explained. All staff had an enhanced ACCESS NI check in place prior to them commencing employment. The inspector can confirm that the identified member of staff had the required checks in place prior to them commencing employment; the records had not been retained in the home. This has since been received and was available in the home for inspection.	Compliant

		explored in keeping with legislation. Provide confirmation to the RQIA that a full employment history has been sought for the identified member of staff. Provide confirmation to the RQIA that the identified member of staff's enhanced disclosure certificate has been received, prior to them working in the nursing home. Ensure that the registration number from ACCESS NI is retained in the home to validate that the relevant checks have been made.		

2	12 (1) (b)	12 (1) The registered person shall provide treatment, and any other services to patients in accordance with the statement of purpose, and shall ensure that the treatment and other services provided to each patient – (b) reflect current best practice Ensure a meaningful entry in patients' formal evaluation includes the detail of the care delivered over a specified time and it should include the outcome. The term "no change in care" should not be used. Ensure the agreed supervision session is conducted with the identified registered nurse. Information which is no longer relevant to the current plan of care should be archived in accordance	A review of three care record evidenced that there was a meaningful entry regarding patients' care delivery. The term "no change in care" was not observed in the care records. The nurse manager confirmed that the agreed supervision with the identified member of staff was conducted, records are maintained. The care records evidenced that there was only relevant information recorded in the patients' care record.	Compliant

		to the home's record management policy.		
3	12 (1) (b)	Ensure the comments made in the staff questionnaire is investigated by the registered manager and if appropriate ensure that when care staff are on duty are designated care hours that they do not carry out domestic duties.	The inspector can confirm that there are designated hours to ensure domestic duties are carried out by designated staff.	Compliant

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

RQIA is satisfied that the registered manager has dealt with all notification of incidents/issues in the appropriate manner and in accordance with regional guidelines and legislative requirements.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**Compliance Level**
Inspection Findings:	
Review of three patients' care records evidenced that bladder and bowel continence assessments were undertaken for patients. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. There was evidence in three patients care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. Review of three patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. One care plan required to be more specific regarding the management of their fluid balance care plan and the management of their catheter. A requirement is made that this care plan is updated to reflect the direct care required in accordance with the homes' policies and procedures. 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.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**Compliance Level**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place; • Continence management / incontinence management. • Stoma care. • Catheter care. They were up to date and reflective of best practice guidelines. The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines for improving continence care were available. • NICE guidelines for urinary faecal incontinence. • British Geriatrics Society Continence Care in Nursing and Residential Care. Discussion with staff revealed that they had an awareness of the guidelines. There is a continence link nurse aligned to the home from the local Healthcare Trust, staff confirmed that they would often contact the continence link nurse for advice and guidance.	Complaint

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**Compliance Level**
Inspection Findings:	
Not inspected	Not validated
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**Compliance Level**
Inspection Findings:	
Discussion with the nurse manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the nurse manager revealed that all two registered nurses in the home had received recent training and were deemed competent in female and male catheterisation and the management of stoma appliances. Both registered nurses were identified in the home as the continence link nurses working in the home and were involved in the review of continence management and education programmes for staff. All care staff have recently received training in Effective Fluid Management, the content of the training included dysphasia management and the practice of thickening fluids. This is good practice and is commended. A review of two members of staff induction programme evidenced that continence care was included in the programme for all grades of care staff.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

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

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

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

There was a good atmosphere in the home. There is an organised activity programme ongoing. Patients spoken with stated they enjoyed the activities organised and were looking forward to the social activities organised for Christmas.

11.2 Complaints

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

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

11.3 Patient Finance Questionnaire

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

11.4 NMC Declaration

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

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

11.5 Patients/Residents and Relatives Comments and returned Questionnaires

During the inspection the inspector spoke with all patients in the home either individually or in groups. All 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 just home from home"
"You could not ask for any better"
"This is the best home in the country"
"I am happy and content in my stay in Kilbroney"
"I am happy to stay in Kilbroney House for the rest of my life"
"Staff are so considerate and kind, I feel they listen to me"
"The management are great"
"We can come and go as we please"
"The food is great"

The inspector also spoke with two relatives visiting at the time of the inspection. Both were very positive regarding the care their relatives were receiving in the home. They were confident that they could approach management if they had any issues in the home. All stated that they felt they were kept well informed of changes in their relatives needs and felt they were involved in their care. There were no issues raised by patients/residents or relatives to the inspector during the inspection.

11.6 Questionnaire Findings/Staff Comments

During the inspection the inspector spoke with 6 staff. The inspector was able to speak to a number of these staff individually and in private. Staff responses during discussion indicated that staff received an induction, completed mandatory training, completed additional training in relation to continence care 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. There were no issues raised by staff to the inspector during the inspection nor were any issues raised in the retuned in the staff questionnaires.

Examples of staff comments were as follows;

"I know that I have given all I can to enable the residents that live here have a happy and meaningful life"
"Working here is very rewarding, the home is small and personal we all work as a close team"
"We are well supported by the management"
"The quality of care here is superior"
"This is a beautiful nursing home"
"I love working here, care is second to none"

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 comfortable and all areas were maintained to a high standard of hygiene. The inspector commended the domestic on duty on the day of inspection regarding the overall cleanliness of the home.

Both the lounge and the dining room have been totally refurbished. All patients and relatives visiting felt that they were very grand and have enhanced the quality of these areas. All areas

in the home were decorated to a high standard. There is an ongoing redecoration programme in place. A privacy curtain is required in the identified bedroom as discussed. The identified bed should be reviewed to ensure the mattress is an appropriate fit for the bed and is appropriate to meet the needs of the patient.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Jacqueline Campbell, registered provider 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 pre admission assessment is carried out by the registered Manager who is mental health trained and the Nurse Manager who is a Registered General Nurse. this allows an holistic assessment of needs to be carried out on the patient before they come to the home. All assessments are done using validated assessment tools and information received from the care management team. with in 11 days another comprehensive holistic assessment is carried out to ensure the home is able to meet all the	Compliant

patients needs. the home uses the ' Malnutrition Universal Screening Tool' to assess the patients nutritional needs and establish if there are any risks of either malnutritiobn or dehydration. all other care areas are assessed including a pressure ulcer risk assessment using the Braden Score, continence needs,any pain requirments or any other physical or mental health needs the patient may have.	

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**
the home operates a named nurse system and this ensures that identified needs with individual patients and their representatives are discussed and agreed on. the nursing care plan clearly demonstrates this process and takes into account advice and recommendations from relative health professionals.	Compliant

the home works closely with Tissue Viability when necessary and we have had great success in our wound care. all patients at' risk 'of developing pressure ulcers have care plans documented and implemented including detailed record keeping of all nursing care intervention. if input is required from other health care professional this is sought and both the patient and representatives are kept informed of all care . the home is very familiar with the referral arrangements to involve the multi disciplinary team in any patients care and we are quick to involve them when deemed necessary. there are referral arrangements in the home to involve the dietition in nutritional care when a patient shows signs of malnutrition. the nutritional care plan is then developed and implemented. this is then reviewed to check if this care is having the desired effect.	

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
re assessment of all care areas is ongoing and regular. This is addressed primarily by the named nurse.All care areas are looked at daily by the nurse in charge and the care team . All care plan reviewing is documented.	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 care interventions , activities and proceedures are supported by research evidence and guidelines as defined by professional bodiesand national standard setting organisations. we update our care interventions as guided by these organisations The home uses a pressure ulcer grading tool to screen patients who have skin damage and appropriate care is care planned, carried out and reviewed regularly. the most up to date nutritional guidelines have been received by the home and are currently in use.	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**
all nurses are up to date on the NMC guidelines for recored keeping. contemporanous nursing records are kept of care interventions, activities andproceedures. this includes outcomes for patients. detailed daily records are kept on all meals and drinks taken by all patients. the home quicky responds to any problems in this area that may lead to malnutrition, dehydration or over indulgence in these areas. the dietition is involved when necessary. the patient and their represeatative is kept informed.	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**
the home keeps very detailed daily notes on care delivered to patients. the notes state the care given and who gave the care. this care is reviewed at agreed time intervals and evaluated using appropriate benchmarks. the home actively promotes the involvement of patients and their reperesents with all care given.	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**
the home actively promotes patient and representative participation in all aspects of reviewing outcomes of care. they are invited to attend and contribute to formal multidisciplinary review meetings arranged by local HSC trust as appropriate. these meetings are recorded in detail and signed by all those attending. this will include details of any changes to the nursing care plans and goals to be achieved.	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**
the home is using the up to date nutritional guidelines. all patients where possible are provided with a nutritious diet which meets their individual needs and preferences. when necessary dietetic guidence is sought and guidence followed where necessary. the menue rotates weekly with plenty of choice and options, snacks and meal time variation is available to all patients at any time through the day. therapeutic and specific diets are catered for.	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 care staff have completed training on nutrition and swallow difficulties. all staff in the home are undertaking food hygiene training and all staff will be updated on the the recent risks and care involved in preventing dehydration. any patient displaying swallow difficulties will be referred to the Speech and language therapist for assessment. this care will be documented, all staff updated on same and outcomes documentated and reviewed. all staff are made aware of all patients eating and drinking needs, including any assistance required and aids or equipmentment needed. all Nurses have updated trainig in the wound care formulary. in addition they are currently undertaking training on	Substantially compliant

wound assessment, wound healing, wound exudate, infected wounds, skin functions and skin care and management of pressure ulcers.	

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

Secondary Unannounced Care Inspection

Kilbroney Private Nursing Home

25 November 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Jacqueline Campbell, registered provider 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 identified care plan is updated to reflect the direct care required in accordance with the homes' policies and procedures. **Ref 19.1**	One	THIS PERSONS IDENTIFIED CARE PLAN HAS BEEN APPROPRIATELY UPDATED.	From the date of inspection
2	27	The registered person shall ensure the identified bedroom has a privacy curtain put in place. The registered person shall ensure that the identified bed is reviewed to ensure the mattress is appropriate in size to fit the bed and appropriate to meet the needs of the patient. **Ref 11.7**	One	PRIVACY CURTAIN ON ORDER + WILL BE PUT UP IMMEDIATELY UPON DELIVERY THE IDENTIFIED MATTRESS HAS BEEN CHANGED TO FIT THE BED & PATIENTS NEEDS.	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	JACKIE CAMPBELL.
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	PAULINE CAMPBELL NURSE MANAGER.

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Anne Roger	23/2/15
Further information requested from provider			