



Department of
**Health, Social Services
and Public Safety**

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Care Standards for Nursing Homes

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Introduction

The Care Standards for Nursing Homes aim to improve the quality and consistency of care for people living in nursing homes. They also provide further detail on the criteria for registration and inspection set out in the Nursing Homes Regulations (Northern Ireland) 2005.

Article 38 of the Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 gives powers to the Department of Health, Social Services and Public Safety (DHSSPS) to publish minimum standards that the Regulation and Quality Improvement Authority (RQIA) must take into account in the regulation of establishments and agencies. The Care Standards for Nursing Homes are written under the provisions of Article 38 and represent the minimum provision below which no provider is expected to operate.

Standards will be used by providers to set a benchmark of quality care and also by the RQIA in registering and inspecting nursing home services.

These standards apply to all services registered with RQIA as nursing home providers under the regulations.

The standards aim to improve quality across the range of nursing homes settings in Northern Ireland regardless of the Trust area in which they are located; whether they are run by the voluntary or independent sector; the category of care they provide; and whether they provide long or short-term care for residents. Standards apply equally to the statutory sector where this is applicable.

People living in nursing homes have specific needs usually arising from their own healthcare requirements. These needs can make them more at risk of abuse, exploitation and neglect and homes have a complex job in balancing their care needs with their rights to quality of life alongside the measures necessary to protect them from harm.

In revising these standards, we have adopted a rights-based approach, but throughout the document there are references to appropriate risk assessment. This phrase is used in recognition of the particular needs some people in nursing home care have and that, sometimes (and particularly where they may not have the capacity to take decisions unsupported), their rights to safety and protection must be given priority over some of their own preferences regarding their care. However, it is clear throughout the standards that homes have a responsibility to engage with residents around their rights, preferences and choices for their care and to support them in making decisions.

These standards have been developed with the aim of keeping person-centred care to the fore, and the views of residents living in nursing homes were sought and are included in the document. Residents shared many examples of excellent care that was tailored to their individual needs. However, there was an overarching sense that the task-driven nature of much of the care delivered left little time for meaningful engagement with residents. This in turn has led in to feelings of a loss of individuality where the person behind the health and personal care needs becomes isolated with little opportunity to have their voice heard.

Residents and their families and carers must be engaged and involved in all aspects of their care and home life and staff should facilitate them not only to make their views known, but also to understand how their feelings and wishes have been taken into account.

The quality of care provided depends very much on the ethos and culture created in the home by the owner, managers and staff and is demonstrated in the practice adopted and evidenced in improved outcomes for residents. The fit between what the home can provide (as set out in its Statement of Purpose) and what the resident needs is known to be a key factor in influencing outcomes.

Specific models of care will inform how staff work with individual residents depending on their needs, but the quality of relationships that residents forge

with staff is crucial in maintaining their sense of self and a meaningful quality of life. The culture established through effective leadership enables these relationships to be developed, upheld and maintained throughout the time in the nursing home.

Leaders who continually seek to improve practice and empower and support committed staff through meaningful training and development as well as effective management systems are more likely to unite staff in achieving the vision and ethos of the home.

The minimum standards alone will not achieve quality care and improved outcomes for residents in nursing homes. They are the benchmark under which quality of care must not fall. They cannot be viewed in isolation, and it is vital to read them in conjunction with the regulations and other legislation, policy and best practice that apply to nursing home care. Providers, commissioners and regulators should be aware of and use all of these in addition to the minimum standards.

How to Use the Standards

There are 48 standards in this book and each one has a number of criteria. Most standards have examples of evidence to show how the criteria of the standard have been met. In most cases, RQIA will expect to see all these examples being met as a minimum indicator of achieving the standard. Where there is no evidence set out, the criteria must all be met.

Some of the criteria or evidence may not apply to all residents in the home and in some cases the length of time the person stays (for example in an intermediate care or respite placement) will be a deciding factor in how proportionate an approach should be adopted. In these cases, managers and staff will be expected to use their professional judgement in demonstrating how the standard has been met. Similarly, there will often be decisions made according to the risk assessment and Care Plan for each resident and as long as these are made in line with the rights of the resident and with their active

involvement in the process, documented and, more importantly, explained to and understood by the resident and their family or carers, such decisions will not be seen as an infringement of the standards.

The type of care and the capacity and dependency of the people living in the home will determine the types of evidence that inspectors will look for to demonstrate that a standard has been met. However, the majority of standards apply to some degree to all people living in a nursing home.

A Note on Terminology

Throughout the standards, we refer to “residents”. In developing the standards, we asked residents and providers which term they preferred and “residents” was the preference of the majority. Regulations refer to “patients” and RQIA use this term in inspection reports. For the purposes of these standards, “residents” should be understood to refer to “patients”.

Where the term “nurse” is used, this refers to a registered nurse.

For simplicity, the standards refer to residents’ “relatives”. This term should be taken to mean those people who have an interest in the care of the person in the home. This could be a family member, carer or other representative.

We use the term “representative” to refer to the person who has responsibility for making decisions for those residents who lack capacity to enter into any agreement regarding their care. This person may also be a relative or carer.

Acknowledgements

The development of these standards used a collaborative approach, led by the Department but informed by the expertise and time given freely by the members of the working group over an 18-month period.

The Department gratefully acknowledges the contribution of the HSC Board, Public Health Agency, HSC Trusts, RQIA and Patient and Client Council. Additionally, providers and managers of nursing homes gave their views during several dedicated events.

The Northern Ireland Human Rights Commission also provided a valuable role in evaluating these standards prior to consultation.

We are especially grateful for the work facilitated by Age NI in engaging with people living in nursing home care and the residents themselves for their valuable insight.

Human Rights

These standards are underpinned by the Human Rights Act and the European Convention on Human Rights. In particular (but not limited to), the right to life (Article 2); the right to not be tortured or treated in an inhumane or undignified way (Article 3); and the right to a private and family life, home and correspondence (Article 8).

In December 2008, Section 145 of the Health and Social Care Act (2008) came into force. Section 145 established that the obligations under the 1998 Human Rights Act extend to nursing homes that provide care to people who are partly or wholly funded by an HSC Trust. Providers of nursing homes should understand their obligations under the Human Rights Act to ensure that residents are supported and facilitated to exercise their human rights.

Standards refer frequently to meaningful engagement with residents. This has been central to the development of the standards with the intention of producing a person-centred document with criteria that are sensitive to the particular needs of people in nursing home care.

To accompany this version of the standards, we have also produced a residents' guide setting out the main principles of the standards.

Additionally, the standards have been developed with the United Nations Principles for Older Persons in mind. These are: independence; participation; care; self-fulfilment and dignity

Values and Principles Underpinning the Standards

The management and practice within a nursing home should create and maintain a caring and stimulating atmosphere where people are listened to and feel valued, their rights are upheld and their cultural and religious beliefs are respected. Living in the home should be a positive and beneficial experience. In order to achieve this, managers, staff and volunteers should have the following values firmly embedded and demonstrated in their practice.

Dignity and Respect

The uniqueness and intrinsic value of individuals is acknowledged and each person is treated with respect and their dignity protected.

Independence

People have as much control as possible over their lives whilst being protected against unreasonable risks.

Rights

Individual and human rights are safeguarded and actively promoted within the context of services provided by the home.

Equality and Diversity

People are treated equally and their backgrounds, gender identity, sexual orientation and cultures are valued. The services provided by the home fit within a framework of equal opportunities and anti-oppressive practice.

Choice

People are offered the opportunity to select independently from a range of options based on clear, accessible and accurate information.

Fulfilment

People are enabled to lead full and purposeful lives, and to realise their ability and potential.

Safety

People feel safe in all aspects of their care and can expect that every service will employ a zero tolerance of abuse, neglect, exploitation and harm and work to the highest standards of safeguarding practice.

Privacy

People have the right to be left alone, undisturbed and free from unnecessary intrusion into their affairs and there is a balance between the considerations of the individual's own and others' safety.

Confidentiality

People know that information about them is managed appropriately and will only be disclosed to others when this is in the interests of their welfare. Everyone involved in the service respects confidential matters.

Abbreviations

This table shows the full wording of the abbreviations used in the standards.

AHP	Allied Health Professional
CNO	Chief Nursing Officer
DHSSPS	Department of Health, Social Services & Public Safety
GAIN	Guidelines and Audit Implementation Network
GP	General Practitioner
HSC	Health and Social Care
HSCT	Health and Social Care Trust
LGBT	Lesbian, gay, bisexual and transgender
NIAIC	Northern Ireland Adverse Incidents Centre
NICE	National Institute for Health and Care Excellence
NIFRS	Northern Ireland Fire and Rescue Service
NISCC	Northern Ireland Social Care Council
NMC	Nursing and Midwifery Council
PCC	Patient and Client Council
PHA	Public Health Agency
PSNI	Police Service of Northern Ireland
RCN	Royal College of Nursing
RQIA	Regulation and Quality Improvement Authority
SALT	Speech and Language Therapist
SCIE	Social Care Institute for Excellence
SOP	Standardised Operating Procedure
VBS	Vetting & Barring Service

Before Admission

It is vital that at the pre-admission stage prospective residents, their relatives and representatives have all the information they need to make an informed choice about moving into the home. This is particularly important for those residents whose capacity to make informed choices might be limited due to learning disability, mental health issues or cognitive impairment such as dementia.

The manager or other appropriate staff of the home should visit the prospective resident in their current location (which may be their home or in hospital) and undertake a pre-admission assessment. This also helps to establish communication and relationships with the potential resident and their relatives as well as addressing the emotional impact of the move.

Life story work is considered fundamental to being informed about a resident's life experiences and so is integral to the assessment process. Where an individual life story book has already been prepared by families or another agency, it will provide vital information on the resident's life, skills and interests. By considering this material, staff will be able to provide more empathetic person-centred care.

The home must have clearly set out policies and procedures for emergency or unplanned admissions where it is not possible to have a pre-admission visit.

The home must provide accurate information about the services and facilities it offers and be written in a way that can be easily understood by the reader. Information should be kept up to date and reflect the reality of what is delivered. Similarly, residents and prospective residents and their relatives must be given accurate, transparent information about the costs of living in the home – particularly any third-party or “top-up” payments required. People can only make the best decisions for themselves and their families when they have the necessary accurate information.

Standard 1 – Before Admission

Prospective residents (and where appropriate their relatives) have all the information they need to make an informed choice about moving into the home. No resident moves into the home without having their needs assessed and been assured that these will be met.

Criteria

1. Prospective residents are given an information pack or residents' guide which sets out up-to-date information about the home and the services it provides. This information is written in plain English or in a language and format suited to the prospective resident and contains the following:
 - A summary of the Statement of Purpose;
 - The aims, objectives and philosophy of the home;
 - A summary of the services and facilities provided in the home;
 - Where specialist care is provided (eg dementia, learning disability and palliative care), the qualifications of the staff providing this care are specified;
 - The referral and admission procedures;
 - The location and description of the home;
 - The name of the Registered Manager and general staffing arrangements;
 - The organisation, its structure and the name of the Registered Person;
 - Accurate, accessible and transparent information on the home's fees and charges to include arrangements for third party payments and changes to fees;
 - The arrangements for obtaining equipment required by the resident;
 - The arrangements necessary for residents to bring their belongings to the home (eg labelling, hygiene etc);
 - The arrangements in place for residents who require treatment at outpatients' services or admission to hospital, including arrangements

for accompanying the resident and ensuring that their medical notes are transported with them;

- The general terms and conditions of living in the home;
 - Information on bedroom accommodation and communal facilities available;
 - Arrangements for personal property and valuables including insurance arrangements;
 - The current programme of activities and events – including any additional costs;
 - Arrangements for transport costs incurred in the resident's care;
 - The arrangements for resident involvement in the running of the home;
 - The views of residents and their relatives on the quality of services and facilities;
 - The arrangements for inspection of the home and how to access inspection reports;
 - The arrangements for communication with families when the resident's needs may change and can no longer be met in the home; and
 - The arrangements in place for termination of the accommodation.
2. There are opportunities for prospective residents and their relatives to visit the home at least once, meet the manager and staff as well as other residents before making a decision about moving in.
3. Prior to admission and in line with timeframes agreed by the commissioning Trust, a suitably qualified or suitably trained person, visits the prospective resident and carries out and records an assessment of nursing care needs. This assessment includes information received from other care providers including family members as appropriate. Any associated factors or risks are documented. A written record of the assessment and the decision as to whether or not the placement is appropriate is retained and made available on request to the resident or their representative.'

4. There are arrangements in place to ensure appropriate staff are available to complete the necessary assessments as quickly as possible to avoid unnecessary delays in hospital.
5. Prior to admission (or as soon as possible after admission in the case of emergencies) there is a record of the resident's medical history; medications history; treatments past and present; stage of illness; plan of care; and prognosis.
6. The Registered Manager ensures that referral forms providing all necessary information, including any risk assessment relating to the resident and the delivery of their care and services are completed before admission. Referral forms include records of all discussions and decisions made. Documents from the referring Trust are dated and signed on receipt.
7. Aids or specialist assessed equipment are in place before admission.
8. There are arrangements in place for responding to and ensuring appropriate placement for self-referred residents. In cases of self-referral, the home advises the resident or their relative to contact the local Trust's care management service.
9. For any unplanned admission, referral information is obtained or completed within two working days of admission. When referral information is not received, records are kept of requests made for it. Within a further two days, an assessment by an HSC professional takes place to determine the needs of the resident and the appropriateness of the ongoing placement in the home. During this period, the home makes a more detailed assessment as to whether the resident's needs can be met on an ongoing basis in the home.

Standard 2 – Individual Agreement

Every resident has an individual written agreement setting out the terms and conditions with the home.

Criteria

1. Each resident is provided with an individual written agreement that sets out the terms of their residency. This agreement is made available in a format and language suitable for the resident as required. The agreement is provided in advance of the placement, except in the case of unplanned admissions where it is provided within five working days of the admission.

2. As a minimum, the agreement sets out:
 - The date of admission and duration of stay (if known);
 - The accommodation, services and facilities provided by the home (these are the general services and facilities agreed as part of the contracting arrangements with the HSC Trust);
 - What the individual can reasonably expect in terms of care and treatment;
 - The weekly fee (including any third party top-up charge);
 - An accurate and transparent itemised list of all agreed services and facilities over and above the general services and facilities;
 - The individual charges for all the agreed itemised services and facilities; the rationale for such additional charges; arrangements for the payment of all agreed charges; and the minimum period of notice for any change to the charges;
 - The arrangements for any financial transactions undertaken on behalf of the resident by the home and the records to be kept (including, where appropriate, the details of any appointee and the records to be kept of this appointment);
 - The general terms and conditions of residency with reference to any of the home's relevant policies;

- The arrangements for the management of the resident's valuables – including insurance arrangements;
 - How the resident will be supported to be involved in the daily life of the home;
 - A copy of the complaints procedure;
 - Signposting to independent advocacy services;
 - The arrangements for regularly reviewing the signed agreement and the circumstances when the agreement can be reviewed outside these arrangements;
 - The frequency of summary reports for persons staying for respite and rehabilitative care; and
 - The notice period for terminating the agreement.
3. The agreement should be in place before admission. Where this is not possible, it must be in place within five working days of the date of admission. For residents admitted to the home on an unplanned basis, the agreement must be signed within two weeks of admission.
 4. The terms and conditions of the agreement are in line with and do not contradict or attempt to override the content of the Trusts' regional contract for Trust-managed residents.
 5. The resident (or their representative) and the Registered Person sign the agreement prior to, or within five days of, admission. Where the resident or their representative is unable or chooses not to sign, this is recorded. Neither the Registered Person nor any staff member acting as an appointee or agent on behalf of a resident may sign the written agreement on the resident's behalf.
 6. The resident, their representative and (in the case of Trust-managed residents) the Trust (in accordance with local arrangements) are given written notice of all changes to the agreement and these are agreed in writing. Where the resident is unable to sign or chooses not to, this is recorded.

7. A minimum of four weeks' notice is given for the introduction of new charges, together with a statement setting out the rationale for such an increase.
8. Any changes to the individual agreement are agreed in writing by the resident or their representative. The individual agreement is updated to reflect any increases in charges payable. Where the resident or their representative is unable to or chooses not to sign the revised agreement, this is recorded.
9. Charges are levied in accordance with current DHSSPS guidelines on the care assessment process¹.

¹ The DHSSPS guidance can be accessed at:
<http://www.dhsspsni.gov.uk/hsc-eccu-1-2010.pdf>

Standard 3 - Informed Consent

Every resident is presumed to have the mental capacity to consent to or refuse care or treatment. Residents are involved in decision making in line with the Department's guidance on consent, treatment and care.

Criteria

1. There are written policies and procedures on obtaining valid and informed consent. Policies and procedures are in line with the DHSSPS guidance on Consent, Treatment and Care² and with relevant professional guidelines.
2. Residents and their relatives (when appropriate) are effectively involved in making decisions about their treatment and are provided with information about the implications of the treatment and any options available to them. The information is presented in plain English and in a format that is accessible, including alternative languages, according to the individual communication needs of the resident.
3. Residents are given information so that they are clear about what is involved in the procedures for their treatment and care.
4. The process for "best interest" decisions when an individual does not have capacity is documented within the case record. This includes records of discussions with representatives as well as multi-disciplinary professionals and outcomes for the resident. Any such intervention is the least restrictive option. Records show evidence of the options considered, human rights implications, safety needs and outcomes for the resident.
5. Residents and their relatives are signposted to independent advocacy services as required.

² DHSSPS guidance on Consent, Treatment and Care can be accessed at: http://www.dhsspsni.gov.uk/public_health_consent

Standard 4 – Individualised Care and Support

Each resident’s health, personal and social care needs are set out in an individual care plan which provides the basis of the care to be delivered and is re-evaluated in response to the resident’s changing needs.

Criteria

1. An initial plan of care based on the pre-admission assessment and referral information is in place within 24 hours of admission. A detailed plan of care for each resident is generated from a comprehensive, holistic assessment and drawn up with each resident. The assessment is commenced on the day of admission and completed within five days of admission to the home.
2. All residents have a named nurse who has responsibility for discussing, planning and agreeing the nursing interventions necessary to meet residents’ assessed needs. This is done in partnership with the resident and their relatives and includes their values and preferences in terms of physical safety and promoting independence and how emotional, social and psychological needs will be met alongside the physical and other healthcare needs.
3. Where a resident does not already have a life story book, staff develop one with the involvement of families and carers as appropriate. The information contained within the life story book informs the resident’s care and how best to engage with them.
4. The care plan clearly demonstrates the promotion of maximum independence and rehabilitation and takes into account advice and recommendations from relevant health and social care professionals. The plan is shared with other health and social care professionals as necessary and appropriate.
5. The care plan records evidence of the involvement of the resident and their relatives in the development and review of care plans, incorporating the

decisions made, the agreements reached and the information which was shared.

6. The care plan is written in a suitable format and so as to be accessible to and understood by the resident and their relatives. Copies of the care plan are shared with the resident and arrangements are in place to ensure confidentiality is not compromised by this sharing of the plan. Where the resident has agreed, copies of the plan are shared with relatives as requested.
7. Re-assessment is an ongoing process that is carried out daily and at identified, agreed time intervals as recorded in care plans.
8. All nursing and social care interventions, activities and procedures are appropriate to the resident's individual needs and supported by current evidence and best practice guidelines as set by both national and local standard setting organisations and professional bodies.
9. In accordance with NMC guidelines³, contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each resident. The outcomes of such actions are recorded. Any variance from the care plan, reasons and outcomes are also documented.
10. There is a policy and procedure for maintaining and managing accurate and up to date individual case records. The policy and procedure comply with guidelines from professional and regulatory bodies.
11. Residents and their relatives and representatives are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend or contribute to formal multi-disciplinary review meetings arranged by HSC Trusts.

³ The NMC guidance on record keeping can be accessed at:
<http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Record-Keeping-Guidance.pdf>

12. The signed record of meetings includes the decisions made, agreements reached and any information shared.

Evidence

- Staff are trained in developing care plans.
- The outcome of care delivered is monitored and recorded contemporaneously. In addition, it is subject to review at agreed intervals and there is evidence of evaluations (using benchmarks where appropriate) with the involvement of residents and their representatives.
- The results of all reviews and the minutes of review meetings are recorded and, where required and with the resident's agreement, changes are made to the care plan.
- All entries in case records are meaningful; contemporaneous; dated; timed; signed; and accompanied with the name and designation of the signatory. The language used is reflective of person-centred principles.
- Any changes or alterations to the case records are dated, timed and signed (including the job role) and made in such a way that the original entry can still be read.
- There is evidence that the care plan is shared with the Trust Care Manager, Key Worker or other professional staff as required.

Quality of Life

The quality of life for people living in nursing homes is determined by a holistic approach to wellbeing where residents' social, emotional, spiritual and psychological needs are provided for, along with physical health and care needs, to promote an overall sense of wellbeing. Central to the quality of life is the quality of relationships built in the home between residents themselves and between residents and staff. All those involved need to feel that they are being treated with dignity and respect – the resident, their relatives and the staff of the home.

Person centred-care is key to building effective relationships that maintain the resident's sense of self. Every interaction with a resident should be recognised and used as an opportunity for engagement and involvement which in turn will maintain and promote the individuality of each resident.

The human and individual rights of residents living in nursing homes must be upheld and this can only be done when all staff understand what these rights are and how they can be supported within the home.

Knowing and appreciating each resident as an individual through effective life story work and promoting and facilitating their contact with family, friends and the wider community maintains the resident's sense of self and connection with their life outside the home. The routines and policies of the home must allow for residents to maintain their identity in ways that are important to them such as making their guests a hot drink, keeping up a routine of a favourite take-away meal or going out to their usual community or church groups where possible. It is recognised that dependency levels may restrict some residents' ability to participate in all of these examples, but homes must do their utmost to help every resident achieve their maximum level of independence.

Increasingly (and certainly in future) technology plays a greater role in supporting communication. Homes must facilitate the use of technology such as online communication to make sure residents can maintain their connections with those important to them.

Standard 5 – Human and Individual Rights

Residents' human and individual rights are respected and protected through care which is person-centred; focused on individual outcomes; and promotes and supports rights, dignity, privacy, choice and control.

Criteria

1. The Registered Person ensures that residents have their human and individual rights protected and are enabled to exercise these rights directly.
2. The Registered Person, Registered Manager and all staff in the home know and understand the human rights of residents and facilitate the exercising of these rights. Residents and their relatives are supported to know and understand their rights.
3. The individual rights of the resident are taken into account in appropriate risk management planning (which involves the resident) and the home adopts the least restrictive option in all cases.
4. Reasons and decisions for restrictive practice are recorded in the care plan.
5. Staff know how to access independent advocacy services in their area and facilitate access for any resident who requires it. Residents and their relatives are made aware of how to access such services⁴.
6. In accordance with their rights to respect for private and family life, home and correspondence, residents receive their mail unopened unless they have expressed a preference otherwise.

⁴ The Patient and Client Council has produced a guide for older people in homes:
http://www.patientclientcouncil.hscni.net/uploads/research/Patient_and_Client_Council_-_AdvocacyToolkit.pdf

7. Residents' rights to vote and participate in all aspects of political processes are respected, upheld and facilitated where necessary.
8. Residents' rights to confidentiality and privacy are respected and information is not shared about their life and choices within or outside of the home without their consent – unless there are exceptional circumstances where there is a risk to the safety of the resident or others in the home.
9. There is adherence to guidance on supporting the needs of minority groups such as residents with disabilities, LGBT people⁵ or black and minority ethnic residents⁶.

Evidence

- Staff have been trained and demonstrate that they understand the rights of residents and how to promote and uphold these rights.
- Risk assessment, analysis and decision making around the need for any restrictive intervention is recorded in detail – including the options considered and the outcome of any intervention.
- Residents report that their choices and rights are respected and upheld.

⁵ Advice on supporting LGBT people in nursing homes can be found at:
http://www.publichealth.hscni.net/sites/default/files/Guidelines%20V3_0.pdf

⁶ Some information on the issues faced by BAME residents can be accessed at:
http://www.panicoa.org.uk/sites/assets/dignity_and_respect_in_residential_care.pdf

Standard 6 – Privacy, Dignity and Personal Care

Residents are treated with respect and their right to privacy is upheld.

Criteria

1. The arrangements for health and personal care ensure that residents are respected and their rights to privacy and dignity are upheld at all times⁷.
2. All staff address residents by their preferred names, introduce themselves and explain the purpose of their interaction.
3. Residents are enabled to exercise choices and to give their consent regarding the provision of intimate care, including, but not limited to:
 - The gender of the staff providing the intimate care where possible and practical;
 - The preference for a type of personal care such as bathing over showering;
 - Continence promotion and management; and
 - The frequency or timing of such care.
4. Routines and systems within the home are flexible enough to accommodate residents' choices and where these choices cannot be accommodated, these are explained to and understood by the resident.
5. The routines and systems of the home are designed so as not to unduly intrude on residents' sleep. Residents' need for quality sleep is respected and supported and interruptions and disruptions at night-times are kept to a minimum.

⁷ DHSSPS Standards for Patient and Client Experience can be accessed at: http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf

6. Residents have control over who goes into their room or living space and when this happens. Bedrooms have a locking system that the resident can control, but may be opened by staff in case of emergencies. Staff knock before entering bedrooms and individual living spaces.
7. There are arrangements for residents to spend time privately alone or with other residents or visitors as they choose in accordance with their right to respect for a private and family life, home and correspondence.
8. There are arrangements to ensure the privacy and dignity of individual residents who share bedrooms and to uphold and support their rights.
9. Where residents prefer to share bedrooms in line with their right to respect for a private and family life, for example as a couple, this is facilitated by the home where possible.
10. Residents are afforded dignity and privacy to express their sexual needs and their right to a private life is maintained. There is space and time made for couples to be together for intimate and private time. Issues around sex and sexuality are dealt with sensitively and confidentiality is upheld. Staff do not impose their own moral code on residents' sexual preferences or behaviour.
11. At all times residents wear their own clothes and are able to keep their clothes, personal requisites and toiletries for their own exclusive use.
12. The home has arrangements in place to ensure residents are always dressed in their choice of their own clothes. If residents do not have the capacity to make a choice, the home ensures they are always dressed in their own clothes. Residents' clothes are marked with an individual and discreet name tag.
13. Where residents prefer to undertake their own laundry or have their clothing laundered by their relatives, appropriate guidance is given regarding the

collection of the laundry and any precautions to be taken in handling laundry that is infected or potentially infected.

14. Residents' personal care and grooming needs are regularly assessed and met. This includes (but is not limited to) residents' hair and nails; dentition and oral care; dentures; eyecare; ensuring residents are using their glasses or hearing aids; and are dressed appropriately in clean clothes.
15. Where residents have continence management difficulties, they are regularly and discreetly checked. In the case where a resident may be found to have wet or soiled clothing this is changed immediately.
16. Residents are enabled to discuss their needs, feelings and wishes in confidence and in private with whomever they choose.
17. There are arrangements in place for residents to make and receive telephone calls in private and receive mail (including emails) un-opened if this is the preference of the resident.

Standard 7 - Engagement, Participation and Involvement

The culture of the home is based on quality relationship-centred care that nurtures the wellbeing of the residents, enables them to feel valued, and promotes and supports their engagement and participation in the running of the home and decisions about their daily lives.

Criteria

1. Residents' views, feelings and wishes regarding the day to day running of the home that affect their lives and care are sought through a variety of established, innovative or imaginative means. Residents are supported as far as possible to make choices about their own care.
2. Residents understand how their views have been taken into account and are helped to understand why it may not be possible to act on their wishes in all cases.
3. Where residents need assistance to communicate their needs and wishes, through for example the use of specialist technology or equipment, this is facilitated by the home.
4. Residents have access to independent advocacy services to support them where necessary in making their views, feelings and wishes known. Arrangements for accessing independent advocacy are publicised within the home. Staff understand the role of the Patient Client Council in advocating for residents.
5. The views, feelings and wishes of residents and those important to them are taken into account in delivering their care and explanations are provided to help them understand where these could not be reflected in the care delivered.
6. Residents and their relatives know how to make a complaint and are supported to take up issues in the most appropriate way without fear of

adverse consequences. Residents receive feedback on any concerns, issues raised or complaints and are kept informed of progress within agreed timescales. A record is maintained of discussions and advice given around complaints.

7. Policies and procedures within the home are flexible enough to be adapted to individual residents' needs and a "blanket approach" is not in operation.
8. Information is presented in a way that is suited to the needs of those receiving it and is accessible to them. Where residents require interpreter services or other aids to ensure effective communication, these are provided by the home.
9. Residents' religious, cultural, racial and linguistic backgrounds as well as their gender and sexual orientation and any disabilities or communication needs are considered and responded to when engaging with and involving them.

Evidence

- A record is made of the matters raised by the residents and their relatives and the action taken.
- The views and opinions of residents, former residents (where appropriate) and their relatives about the running of the home are sought formally at least once a year, preferably by an organisation or person independent of the home.
- There is evidence of residents' involvement in decisions made about the home and its policies.
- A report is prepared that identifies the methods used to obtain the views and opinions of residents and their relatives, which incorporates the comments made, compliments received, issues raised and any actions to be taken for

improvement. A copy of this report is provided to residents and their relatives.

- Residents and their relatives are informed about planned inspections by the RQIA and of the arrangements for them to give their views about the home to the inspectors. The process of unplanned inspections is also explained to and understood by residents and families and carers.
- There are opportunities for relatives to meet with the provider individually and collectively to share their views and raise issues.

Standard 8 - Contact with Family, Friends and the Community

Residents maintain contact with family, friends and the community according to their wishes and preferences.

Criteria

1. Residents are able to maintain contact as they wish with their family, friends and local community. Where contact is made using technology, such as email or online video calling, the home facilitates this and provides access to and adequate time on the internet for residents.
2. Residents can have visitors at any reasonable time. Residents' rights to a private and family life are supported by being able to receive visitors in private as they wish.
3. Residents can choose whom they see and do not see.
4. Where residents wish to maintain visits and relationships outside of the home, for example to attend a church, community or social group, this is promoted, supported and facilitated by the home.
5. Residents' rights to develop and maintain intimate personal relationships with people of their choice are respected in accordance with their right to respect for private and family life.
6. If a resident is assessed as lacking the capacity to consent to such a relationship, information and guidance is sought as appropriate from the Trust.
7. Residents are consulted about visits by community groups and volunteers and their wishes are taken into account. The manager or senior member of staff on duty monitors these visits to ensure they benefit residents. Where

an individual resident prefers not to be involved in such visits, this decision is respected, supported and facilitated.

Evidence

- Each resident's existing links with family, friends and the local community are identified and recorded at the time of their admission to the home and the care plan identifies how these links will be supported and maintained by the home.
- A record is maintained of residents' preferences as to who they do and do not wish to see. There is evidence that staff support residents, should "unwanted" visitors arrive.
- There is evidence to show how the home supports and maintains links with the local community.
- Relatives, friends and representatives of residents are given written information about the home's policy on maintaining their involvement with their relatives at the time of moving into the home.

Standard 9 – Daily Life

Residents are given opportunities for as full an experience of a supportive, homely environment as possible.

Criteria

1. The opportunities made available and the routines of daily living are flexible, responsive and varied to suit residents' individual expectations, preferences and capacities. Residents are supported to participate in the daily life of the home based on their capability and choices as stated in the care plan.
2. The home adopts an appropriate and proportionate approach to risk and recognises that taking risks is a normal part of daily living. Where there are lessons to be learned from the outcomes of taking risks, these are applied proportionately and individually. Risks are individually assessed and reviewed rather than blanket bans or sanctions applied on actions or activities. Staff are trained in and demonstrate understanding of effective and appropriate risk assessment and management.
3. Residents and their relatives are involved in the process of assessing and managing risk. In assessing and managing risk, the home takes into account the human rights of the individual and adopts a risk management strategy which reflects the least restrictive option.
4. Residents are encouraged and facilitated to bring cherished or favourite possessions with them when they move into the home and there are arrangements for respecting and keeping their possessions securely. These items are assessed for the risk of fire or health and safety concerns and proportionate measures taken to minimise such risks.
5. Residents are enabled to exercise choice in relation to their lives in the home, including, but not limited to:
 - Leisure and social activities and cultural interests;

- Food, drinks, meals and mealtimes - including receiving food aside from that provided by the home such as takeaway food or food prepared by relatives and the types of drinks (including alcoholic drinks) they prefer or would have had as part of their established routine;
 - Routines of daily living, including bedtimes and times for getting up;
 - Personal and social relationships; and
 - Religious observance.
6. Subject to an appropriate and proportionate risk assessment, residents have access to all areas of the home such as a snack kitchen, the garden and bathroom as one might expect in their own home.
 7. Residents are supported and encouraged to use local services such as shops and post offices as appropriate.
 8. Residents are supported to participate in the daily chores within the home such as dusting, setting tables, putting away laundry etc if they wish to do so and are able.

Evidence

- With the permission of residents, the home has photographs of residents on display as might be seen in any family home.
- Significant events such as birthdays or culturally important dates are celebrated as appropriate.
- Residents are able to exercise choice in the personal requisites they buy or are purchased on their behalf.
- The home accommodates residents' preferences to receive takeaway or homemade meals provided by visitors.

- Residents are, appropriate to their needs and abilities, actively involved in the daily routines of the home.
- Staff collect, communicate and display information about local activities and events that may be of interest to residents and facilitate their participation where possible.

Standard 10 - Memory, Life Story Work and Reminiscence

Memory, life story work and reminiscence are used as part of the process of effective engagement and activity for residents.

Criteria

1. Staff use a range of aids to assist with memory such as diaries and note books, visual stimuli and pictures. Each resident has a memory aid appropriate to their condition.
2. Staff are trained in effective reminiscence work and use this as part of the process of engagement and activity.
3. A range of methods are used to stimulate memory, including reading from old books or newspapers, music, listening to or watching old broadcasts of radio or television programmes and using objects such as packaging of household products to introduce conversation.
4. As appropriate, staff engage with larger groups of residents in reminiscence work to stimulate group discussion and memory. Friends and family are also involved in this work.

Evidence

- Staff are trained to undertake life story work with residents.
- Staff understand that life stories are dynamic and do not stop once the resident moves into the home. Tastes, preferences and choices are regularly reviewed and changes recorded.
- Staff demonstrate that their engagement with residents is not confined to topics about the past.

- A conversational approach to reminiscence is demonstrated.
- Where staff are undertaking life story and reminiscence work with residents with dementia, they have been trained in this regard.

Standard 11 – Activities and Events

Activities are offered that are meaningful to the resident and reflect their life story. Activity and meaningful engagement is recognised by all staff as an integral part of the care process.

Criteria

1. The programme of events and activities provides positive and meaningful outcomes for residents⁸ and is based on their identified needs, life experiences and interests. The duration of each activity and the daily timetable takes into account the needs and abilities of the residents.
2. Staff discuss and observe residents' preferences for involvement in activity and respond accordingly.
3. Staff recognise every interaction as an opportunity for engagement with residents and demonstrate this understanding in their approach to care.
4. Activities are planned for times that are suited to the residents' preferences and needs.
5. There are opportunities for informal activity and interaction between staff and residents as well as opportunities for residents to be involved in the routines of the home. Residents who are unable or do not wish to participate in group activities are supported with one-to-one activities.
6. Staff demonstrate and understand the opportunities to actively engage with residents in activities through their approach to care and the chances to instigate conversation as a result of this approach – particularly where residents are unable to participate in more formal communal events.

⁸ Guidance on activities can be accessed at:
<http://www.cot.co.uk/living-well-care-homes>

7. The home makes best use of appropriate equipment, aids and technology in providing purposeful, enjoyable activities for residents.
8. The programme includes activities that are enjoyable, purposeful and age- and culturally-appropriate and takes account of residents' physical and emotional needs and interests. It promotes healthy living, is flexible and responsive to residents' changing needs and facilitates social inclusion in community events.
9. There are opportunities for relaxation and reflection either alone or as part of a larger group of residents.
10. There are opportunities for creative activity such as story-telling, music, song, dance and poetry.
11. Residents, including those who prefer to stay in their rooms, are given the opportunity to contribute suggestions and to be involved in the development of the programme of activities.
12. Staff understand how to deliver meaningful, appropriate and enjoyable activities and events for residents and demonstrate this understanding in their interactions with them.
13. Where an activity is provided by a person who is contracted in to do so, the Registered Manager either obtains evidence from the person or monitors the activity to ensure that those delivering or facilitating activities have the necessary skills to do so.
14. Cultural, religious and spiritual needs are met through the range of activities provided in the home. The home incorporates important dates and festivals into the calendar of activities.
15. The programme of activities is reviewed regularly (at least twice yearly) to ensure it meets residents' changing needs.

Evidence

- The programme of activities is displayed in a suitable format and in an appropriate location so residents know what is scheduled.
- There is evidence that residents are enabled to participate in the programme through the provision of equipment, aids and support from staff.
- There is evidence that the programme of activities is flexible enough to accommodate the daily preferences and choices of the residents.
- There is evidence that the programme and the individual activities therein are evaluated regularly to ensure they are enjoyable, appropriate and suitable for residents. This includes evidence of engagement with residents and those delivering the activity or event.
- A record is kept of all activities that take place, the names of persons leading each activity and the residents who participate.
- Where an activity is provided by a person contracted into the home to do so, there is evidence that staff inform them about the changing needs of any resident prior to the activity commencing. There is also a system in place to deliver and receive timely feedback.

Standard 12 – Nutrition, Meals and Mealtimes

Residents' nutritional needs are met in line with current best practice guidance.

Criteria

1. Residents are provided with a nutritious and varied diet, which meets their individual dietary needs, preferences and religious or cultural requirements.
2. There is a policy on meals and mealtimes in line with current best practice policy⁹ and guidance¹⁰.
3. Nutritional screening is carried out (with residents' consent) on admission, using a validated tool to identify patients who may be or are at risk of malnutrition. Patients who are at risk of malnutrition should have a nutritional care plan in place
4. Nutritional screening is repeated monthly, or more frequently depending on individual assessed need, and nutritional support is implemented according to the screening protocol as required.
5. There are up to date nutritional guidelines that are used by staff on a daily basis. These should address both underweight and overweight prevention and interventional measures and any other individual special dietary requirements including food intolerance or food allergy.
6. Staff regularly discuss with residents their preferences for food and drink and record any changes in their care plan. Residents are helped to make choices

⁹DHSSPS policy on nutrition can be found at:
http://www.dhsspsni.gov.uk/promoting_good_nutrition-2.pdf

¹⁰ Guidance on nutrition and menus for homes can be found at:
http://www.publichealth.hscni.net/sites/default/files/Nutritional_guidelines_and_menu_checklist_march_2014.pdf

about food and drink in ways that are accessible to and understood by them, such as through a pictorial menu.

7. There are referral arrangements for both Speech and Language Therapist (SALT) and Dietitian to assess individual residents' who have chewing or swallowing difficulties and any special nutritional requirements. The arrangement should include the development of individualised nutritional treatment or care plans if required.
8. Where residents have difficulties with oral health or chewing and swallowing, strategies are in place to avoid immediate transfer to a liquidised diet. Pureed food is served in the most appealing way, with foods pureed separately.
9. Nurses have up-to-date knowledge and skills in managing feeding techniques for residents who have swallowing difficulties.
10. Nurses have up-to-date knowledge and skills in the provision of enteral tube feeding.
11. There are adequate numbers of staff present when meals are served to ensure:
 - Risks when residents are eating and drinking are managed; and
 - Required assistance is provided.
12. Residents' weight is monitored and if weight loss or gain is noted, staff review the arrangements around eating and drinking to ensure nutritional needs are met. Significant changes in weight are notified to a medical professional for advice.
13. The menu either offers residents a choice of meal at each mealtime or, when the menu offers only one option and the resident does not want this, an equally nutritious alternative which reflects the resident's food preference is provided. This includes an alternative choice of hot meals and any special dietary requirements

14. Independent eating is maintained for as long as possible. Where residents require assistance with meals, this is given in a discreet, unhurried and sensitive manner.
15. Meals are served in suitable portion sizes, and presented in a way and in a consistency that meets each resident's needs. Food (including liquidised meals) is presented in a way that is attractive and appealing in terms of flavour, texture and appearance.
16. Where residents require aids for eating or drinking, such as specialist drinks holders, straws, coloured crockery or adapted cutlery, this is provided by the home.
17. Food and drink is visible and accessible to residents (and visitors) so they are able to help themselves; or have visitors prepare snacks and drinks for them; or may be provided on request.
18. Where residents are disordered regarding time, there is a selection of food and drink available at all times so as to ensure meals are available according to the residents' needs.
19. Food is served in such a way so that it is appealing to residents. Where residents have difficulty in using cutlery but are able to chew and swallow, finger food is offered.
20. Residents are enabled to have their meals served in the dining room or can choose to eat their meals in their rooms or another area of the home and in the company of their chosen friends or companions should they wish, subject to an appropriate risk assessment.
21. The dining experience is calm and relaxed and residents are allowed to take their meals where they feel comfortable. Where possible, residents are involved in the tasks around meals and mealtimes and food is used as part of the reminiscence work with them in conversation about food memories and likes and dislikes.

22. There are protected mealtimes to ensure that mealtimes are unhurried with residents given sufficient time to eat and drink without unnecessary interruptions or distractions. Families and carers wishing to provide assistance to their relative during mealtimes are facilitated and receive any additional support or information necessary to assist them in the process.
23. Residents are offered and assisted where necessary with use of toilet and hand washing facilities before and after meals.
24. Residents are positioned correctly and safely to avoid the risk of choking and to promote enhanced enjoyment of meals.
25. Residents are offered appropriate clothing protectors (including napkins) which respect their dignity and protect their clothing.
26. Takeaway food is available to residents in line with their choices and the care plan and is served and stored in accordance with guidance on food hygiene.
27. Where a resident's care plan requires, or when a resident is unable, or chooses not, to eat a meal, this is noted in the patients care plan and a record is kept of all food and drinks consumed. Where a resident is eating excessively, a similar record is kept. All such occurrences are discussed with the resident and reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.

Evidence

- The daily menu is displayed in a suitable format (including pictorial where necessary) and in an appropriate location, showing what is available at each mealtime. There is a process in place to update the menu to ensure it reflects what is being served and a means by which residents can request an alternative.

- Nutritional screening takes place to identify patients who may be at risk of malnutrition and underweight or overweight and each resident has an appropriate nutritional care plan in place.
- There is a system in place to monitor meals and food returned uneaten which supplements the monitoring of residents' weight.
- Where a resident loses their appetite or refuses food, staff understand to look for underlying causes such as not understanding the cues for mealtimes, difficulties recognising cutlery and food etc and respond sensitively and appropriately to ensure they do not go hungry.
- There is evidence that the home adopts strategies to enhance residents' appetites through means such as aroma and visually through using pictures of meals or packaging to prompt cues for mealtimes. Where a resident's sense of taste or smell has diminished, steps are taken to enhance the flavour of the food served such as additional seasoning or stronger flavours.
- There is evidence of patient and/ or carer input to the design of menus and the provision of appropriate food and meal choices for each resident and that there is an opportunity to provide feedback on issues such as choice and quality and quantity and frequency of meals and refreshments.
- Menus provide for special occasions and there is evidence of mealtimes as social events where important dates such as holidays or birthdays are celebrated.
- 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. Residents can have a snack or drink on request, or have access to a domestic style kitchen if this is deemed a suitable and safe option.
- Mealtimes are recognised and promoted as opportunities for social interaction and residents indicate that their preferred choices of where to eat and whom to eat with are observed.

- Mealtimes are organised to enable residents to receive adequate supervision which is specific to needs indicated on their care plan.
- There is evidence that residents have access to specialist crockery or cutlery as required and that mealtime assistance is provided in a timely manner and with regard to maintaining a resident's dignity.
- A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each resident is satisfactory.
- Menus are rotated over a three-week cycle and revised at least six-monthly, taking into account seasonal availability of foods and residents' views.
- Variations to the menu are recorded.

Standard 13 – Safeguarding

Residents feel safe and are safe in the care of the home. Arrangements are in place to safeguard them and to protect them from harm.

Criteria

1. Residents are safeguarded and their safety and welfare are promoted within the home. They are protected from all forms of abuse, neglect, exploitation, and serious harm – including online.
2. Staff actively promote the welfare of residents living in the home.
3. Staff develop positive relationships with residents in the home, generate a culture of openness and trust and are aware of and alert to any signs or symptoms that might indicate that a person is at risk of harm.
4. Residents and their relatives are informed and know how to make a complaint or allegation of abuse, neglect or exploitation.
5. There is a written protocol to be followed in the event of an allegation of abuse, neglect or exploitation made about a member of staff, any other resident or a member of the public. Residents and their relatives know how they will be supported in the event of an allegation being made.
6. All incidents of actual, alleged or suspected abuse, neglect or exploitation are promptly reported in line with Departmental policy on adult safeguarding. Reports are also made to families, if agreed with the resident.
7. There is a written policy and procedures on whistle blowing (including by relatives) in line with regional protocols. Staff know and understand the whistle blowing policy and know how to raise concerns with appropriate bodies outside the home and, if appropriate, wider organisation.

8. Staff, residents and relatives are assured of the Registered Manager's support if they express concerns about the care practices of staff and colleagues and are further assured of the support of the Registered Provider if there are concerns about the practice of the Registered Manager.
9. The Registered Person and Registered Manager understand and implement the regional procedures for notifying the relevant authorities of any staff (or former staff) believed to be unsuitable to work in a nursing home.
10. The Registered Person is trained and understands their specific role in relation to safeguarding.
11. Opportunities are provided regularly for staff to update their knowledge and skills as well as for more advanced and specialised training in safeguarding and protection. Training is appropriate to the role of staff. Refresher training is provided at a minimum of every three years.
12. Following an allegation of abuse, neglect or exploitation, the Registered Manager arranges a de-brief with staff to discuss the conclusion of the investigation and the learning arising.

Evidence

- There is a written policy and procedures in place for safeguarding consistent with Departmental Policy on Safeguarding and all suspected, alleged or actual incidents of abuse, neglect or exploitation (including those where another resident or a member of staff is the alleged abuser) are dealt with in accordance with policy and procedures.
- There are protocols in place to be followed in the event of an allegation of abuse, neglect or exploitation whether resident on resident or made about a member of staff.
- Incidents are recorded and reported appropriately to the HSCT and RQIA.

- Safeguarding procedures are included in the induction and continuing training programme for all staff.
- Within their probationary period of employment, staff complete training on and can demonstrate knowledge of:
 - Safe working practices with residents;
 - Human Rights;
 - Restrictive Practice and Deprivation of Liberty Safeguards;
 - Methods of preventing abuse, neglect and exploitation;
 - Indicators of abuse, neglect or exploitation and signs that residents may need help;
 - Their role in recognising and responding to suspected, alleged or actual abuse, neglect or exploitation; and
 - Reporting and recording suspected, alleged or actual abuse, neglect or exploitation.
- There is evidence of reflective practice including discussion and dissemination of lessons learned as a result of safeguarding incidents.

Standard 14 – Residents’ Money and Valuables

Residents’ money, valuables and financial interests are safeguarded in line with legislation, guidance and best practice.

Criteria

1. Residents’ rights to control their own money are respected and there are written policies and procedures in place for the safeguarding of residents’ money and valuables.
2. There is a policy and procedures in place in case of residents’ money or valuables going missing from the home. Residents and their relatives are made aware of requirements for individual insurance of valuables where required.
3. There is a transparent and accessible policy on the charges levied for any transport provided by or on behalf of the home.
4. Residents’ personal monies are not held in the home’s business bank account. Where a member of staff acts as an appointee or agent for a resident, there is written permission from the resident or their representative for their money to be paid into a business account. Personal monies belonging to the resident are withdrawn from the business account no later than four weeks following the monies being paid in.
5. Residents’ personal allowances are freely available to them at all times and are not added to any payments for board and lodgings or used for the upkeep of the home.
6. Where a home is responsible for managing a resident’s finances, the arrangements and records to be kept are specified in the individual agreement. Written authorisation is obtained from each resident or their

representative to spend the resident's personal monies to pre-agreed expenditure limits.

7. The written authorisation must be retained on the resident's records and updated as required. Where the resident or their representative is unable to, or chooses not to sign the agreement, this must be recorded. Where the resident is managed by a HSC Trust and does not have a family member or friend to act as their representative, the authorisation about their personal monies must be shared with the HSC Trust care manager.
8. When residents' money lodged for safekeeping is provided to staff or residents' representatives to make purchases, the purchases are verified and receipts are obtained or copied for the resident's own records.
9. There are accurate, up to date records maintained of:
 - Amounts paid by each resident in respect of itemised services and facilities as listed in the individual agreement;
 - Any monies or valuables (including bank cards and gift cards) handed over by the resident for safekeeping (this record is signed and dated by the resident and the member of staff on receipt and return of the items);
 - All allowances and income received on behalf of the resident and of the distribution of this money to the resident or their representative (with each transaction signed and dated by the resident and a member of staff); and
 - Receipted amounts of expenditure on behalf of the resident (with each transaction signed and dated by the resident and a member of staff). Receipts are held with the records.
10. A standard financial ledger format is used to clearly and accurately detail transactions for residents. The format captures the following information each time an entry is made on the ledger:
 - The date;

- A description of the entry;
 - Whether the entry is a lodgement or withdrawal;
 - The amount;
 - The running balance of the resident's cash total held; and
 - The signatures of two persons able to verify the entry on the ledger.
11. Records made on behalf of residents are legible and mistakes appropriately dealt with on the face of the ledger (ie a clear line crossed through the incorrect entry with an amendment on the line below and initialled by the member of staff recording the entry). Correcting fluid is never used to amend records.
12. Where residents or their representatives are unwilling or unable to sign these records, they are signed by two members of staff as an accurate account of proceedings.
13. Where any service is facilitated within the home (such as, but not limited to, hairdressing, chiropody or visiting retailers) the person providing the service and the resident or a member of staff of the home signs the treatment record or receipt to verify the treatment or goods provided and the associated cost to each resident.
14. Receipts are held for all purchases made on behalf of residents. Where it is not possible to obtain a receipt from a purchase, the record is annotated to reflect this.
15. Receipts from purchases made on behalf of residents are returned to the home immediately following the purchase. The policies and procedures in place in the home include a reasonable timeframe for the returning of receipts where it is not possible to do so immediately.
16. Where staff purchase items on behalf of residents, any store loyalty points earned are owned by the resident and this is documented on the receipt.

Where a resident is not a member of a loyalty scheme, staff do not benefit from the transaction by using their personal loyalty cards. Receipts for such purchases are returned to the resident for their own records.

17. Written authorisation is obtained to use a resident's bank card and PIN. The PIN is stored securely and away from the card. A record is retained of the removal and return of a resident's bank card and all staff authorised to use it. Records are retained on all transactions made from the bank card on behalf of the resident.
18. If a resident has been assessed as incapable of managing their own affairs and a designated next of kin has been appointed, the amount of money or valuables held by the home on their behalf is reported in writing by the Registered Manager to the referring Trust and designated next of kin at least annually, or as specified in the individual agreement.
19. When there is evidence of a resident becoming incapable of managing their own affairs, the Registered Person reports the matter in writing to the local or referring Trust.
20. If a person within the home acts as an appointee, the arrangements for this are discussed and agreed with the resident and (if involved) the referring Trust. These arrangements are noted in the individual agreement and a record is kept of the name of the appointee, the resident on whose behalf they act and the date they were approved by the Social Security Agency.
21. Written authorisation from the Social Security Agency for the Registered Person or staff member to act as an appointee is retained with the resident's individual agreement.
22. Staff acting as appointees demonstrate awareness of their responsibilities as set out by the Social Security Agency.

23. Where the home has access to or management of a resident's bank account, there is compliance with the instructions as detailed in the certificate issued by the Office of Care & Protection.
24. If a member of staff acts as an agent, a written record is kept of the name of the member of staff, the date they acted in this capacity and the resident on whose behalf they acted. Written authorisation from the resident or their representative for a staff member to act as an agent is retained with the resident's individual agreement.
25. Reconciliation of money and valuables held and accounts managed on behalf of residents is carried out at least quarterly. The reconciliation is recorded and signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.
26. An inventory of property belonging to each resident is maintained throughout their stay in the home. The inventory record is reconciled at least quarterly. The record is signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.
27. There is a policy and procedures on staff receiving gifts from residents or their representatives.
28. Money donated to or collected for the home specifically for the benefit of residents is not used for routine expenditure and such money is accounted for separately from the home's other income and expenditure accounts.
29. There is evidence that any expenditure paid from the residents' comfort fund is used for the benefit of the body of residents at the home and does not fund any items which should be paid for by the home or by individual residents.
30. A policy and procedure is in place addressing the aims and objectives of the comfort fund and providing guidance for staff on the ethos and operation of the fund. The policy and procedure should include reference to and inclusion

of the resident and/or relative forum in the decision making process for expenditure from the comfort fund.

31. A separate bank account should be in place to hold resident comfort fund monies distinct from other monies. A reconciliation of the bank accounts managed on behalf of residents should be carried out at least quarterly. The reconciliation is recorded and signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.

32. In all cases where cash or valuables of a deceased resident have been deposited for safekeeping they are released only:

- Where the total value of the property is estimated at £5000 or less – when forms of indemnity are given to the Registered Person by the resident’s legal personal representative;
- Where the total property is estimated to be in excess of £5000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act (NI) 1967, as amended SR1085 No 9) – on production of Probate or Letters of Administration.

Evidence

- There are secure facilities and controlled access for the safekeeping of money and valuables on behalf of residents.
- There is a record of what has been personally purchased by and for each resident and this includes a property log detailing, for example, furniture purchased by the resident for their own use.
- Where third party or “top up” payments are made, there is evidence to show that these are received from a third party and not via the resident’s bank account or personal allowance.
- There is evidence that the Registered Person has taken steps to ensure that staff understand the requirements (as set out by the Social Security Agency) of their role should they act as an appointee – for example to ensure the

resident is not under- or over-claiming benefits and is receiving all eligible benefits etc.

- Where residents' money is pooled (in joint bank accounts or cash tins) there is a record detailing how much belongs to each resident.
- Where residents have significant amounts of personal money, this is not held in a pooled bank account, but where possible transferred to an interest-bearing account in the resident's name.

Standard 15 – Transport

Vehicles owned or managed by the home ensure the safety of residents, comply with legislation and are well maintained.

Criteria

1. Where the home provides a transport scheme, there is compliance with the RQIA guidance for transport¹¹.
2. The written procedure detailing the action to be taken in the event of a road traffic accident is kept in all vehicles owned or managed by the home.
3. Accurate and transparent information is made available to residents and their representatives on the annual running costs of maintaining vehicles.
4. Vehicles owned and managed by the home, and used for transporting residents, meet all current road traffic legislation and are maintained according to manufacturers' instructions.
5. Individual residents' needs while using transport are part of their overall needs assessment. Any risks involved are identified in the resident's risk assessment. The management of these risks is included within the care plan and is subject to periodic review as part of the review process.
6. Residents are not left unattended in a vehicle run by the home unless their risk assessment allows for this.
7. The Registered Person ensures that the appropriate hire and reward arrangements are reflected in the insurance policies.

¹¹The RQIA guidance can be accessed at:
http://www.rqia.org.uk/cms_resources/RQIA%20Guidance%20on%20Transport%20Schemes%2030%20May%2013.doc.pdf

8. When the home runs a scheme where the residents are charged for the running costs, and no profit is included in the charges, the insurance company provides written confirmation that the insurance policy covers the shared use of the vehicle.
9. Staff in the vehicle can make contact with the home by safe and legal use of a mobile phone or other means of communication.
10. Staff have the correct category of licence and insurance to drive the vehicles required and have received appropriate training in dealing with medical emergencies that may occur during outings.
11. A record is maintained of the journeys undertaken by each resident to include:
 - The resident's name;
 - Date of journey;
 - Destination;
 - Miles incurred; and
 - The name of the staff member accompanying the resident.
12. A record is maintained of the rate per mile and staff hourly rate (if applicable) charged to residents for undertaking the journey. A record of the rate per mile and how the staff hourly rate was ascertained is also maintained.

Evidence

- There are records detailing charges levied for transport schemes and these correspond to the amounts set out in individual agreements.
- Records are kept of the maintenance of vehicles, the reporting and repair of defects, and all required legislative documents.
- Where a vehicle is owned by a group of residents, records are kept of its use and running costs, and of the charges made to each resident.

- Each vehicle, and equipment in the vehicle, is clean, safe, well maintained and, when necessary, complies with guidance from the Medical Device Agency on Wheelchair Tiedown and Occupant Restraint Systems (WTORS).

Standard 16 – Complaints

All complaints are taken seriously and dealt with promptly and effectively.

Criteria

1. Homes should operate a complaints procedure that meets the requirements of the HSC Complaints Procedure and is in accordance with the relevant legislation and DHSSPS guidance on complaints handling in regulated establishments and agencies¹².
2. Arrangements for dealing with complaints including details of independent advocacy services are publicised.
3. A copy of the complaints procedure is provided on admission to every resident and to any person acting on their behalf, and this is available in a range of formats where required.
4. The complaints procedure includes a step-by-step guide to making a complaint; the timescales involved; how residents and relatives will be supported through the process; an outline of the role and function of the RQIA in dealing with regulated services; and contact details for the Authority.
5. The complaints procedure includes details of the PCC and an overview of their role in assisting with complaints and contact details¹³.
6. Staff are trained on dealing with complaints and know how to receive and deal initially with complaints. This training is recorded.

¹² The DHSSPS guidance can be accessed at:
http://www.dhsspsni.gov.uk/hsc_sqsd_23-2009.pdf

¹³ Information on the Patient and Client Council's role in complaints can be found at:
<http://www.patientclientcouncil.hscni.net/making-a-complaint>

7. Advice is provided to residents on how to make a complaint and who to contact outside the home if they remain dissatisfied or require support services.
8. Residents must, where appropriate, be made aware of the role of independent advocacy services and be assisted to access the support they need to articulate their concerns and successfully navigate the system. Homes facilitate arrangements for residents to speak to their advocates in private.
9. Staff directly involved in the management and investigation of complaints are trained and supervised in the application of the complaints procedure.
10. Complaints are investigated and responded to within 28 days and when this is not possible, complainants are kept informed of any delays.
11. Records are kept of all complaints and these include details of all communications with complainants; the result of any investigations; the action taken; whether or not the complainant was satisfied with the outcome; and how this level of satisfaction was determined.
12. The Registered Person co-operates with any complaints investigation carried out by the HSC Trust, PSNI or the NI Ombudsman.
13. Where a complaint relates to a Registered Person's failure to comply with the statutory regulations, then that complaint is referred directly to the RQIA for consideration¹⁴.
14. Where a complaint relates to abuse, neglect or exploitation, the appropriate guidance is followed in line with adult safeguarding policy.

¹⁴ The RQIA can be contacted via:
<http://www.rqia.org.uk/home/index.cfm>

15. When required, a summary of all complaints, outcomes and actions taken is made available to the RQIA.
16. The complainant is advised of their right to approach the NI Ombudsman if they remain dissatisfied with the outcome of the relevant complaints procedure.

Evidence

- There is evidence that staff understand that a complaint is any expression of dissatisfaction with the service provided in the home.
- Complaints are viewed as learning experiences and there is evidence that information from complaints is used to improve the quality of services. The Registered Manager considers and disseminates learning derived from analysis of complaints received.

Standard 17 – Responding to Residents’ Behaviour

The home ensures safe, effective and person-centred care for residents whose behaviour challenges others.

Criteria

1. Residents receive safe and appropriate care based on:
 - (a) A comprehensive person-centred assessment of their needs; and
 - (b) Agreed multi-disciplinary planning, delivery and evaluation of care (and, where appropriate, intervention) that:
 - (i) Meets the their individual needs and protects their rights;
 - (ii) Ensures their welfare and safety (and that of others); and
 - (iii) Is based on the most up to date research and/or evidence as defined by professional bodies and standard setting organisations such as NICE, SCIE or the RCN.
2. A specific documented behaviour support plan for the management of behaviour that challenges is drawn up and agreed with residents, their relatives and relevant professionals and are regularly reviewed for effectiveness. The plan identifies activities that can have a positive and preventative effect to minimise episodes of distress.
3. Residents with behaviours that challenge and their relatives have the support they need to ensure they can take an active part in these reviews.
4. Proactive and preventative strategies are always considered and evidenced within documentation as the first option - the intention being to reduce the frequency, intensity or duration of the challenging behaviour by:
 - Adjusting aspects of the environment in order that they are more supportive; and/or
 - Attempting to address individual factors such as skills/communication deficits; and/or

- Addressing physical health problems via medical intervention.
5. Restrictive interventions are evidence-based, proportionate and the least restrictive option required.
 6. The principles and good practice elements within the DHSSPS Guidance regarding Deprivation of Liberty¹⁵ are applied and documented, when people are at risk of or need to be restricted and/or deprived of their liberty.
 7. All staff receive regular training (and ongoing updates) that is appropriate to the level and type of behavioural challenges within the home. Training is delivered by a suitably competent professional or trainer. Induction covers initial information on behaviour that challenges.
 8. Appropriate reporting and recording of incidents (including reporting to relatives) takes place within the required timescales and format required by authorities.

Evidence

- Timely reviews and reflection of all behaviour management incidents and the interventions undertaken are held and used to review the current plan of care and to provide learning for all staff involved.
- Reviews or audits of incidents and interventions used are undertaken to ensure learning, reflection and amendments to the care plan if necessary.

¹⁵Deprivation of Liberty guidance can be found at:
<http://www.dhsspsni.gov.uk/revised-circular-deprivation-of-liberty-safeguards-october-2010.pdf>

Standard 18 – The Use of Restraint and/or Restrictive Practices

The philosophy and provision of care is the least restrictive and controlling possible for the individual resident. The level, nature and type of any restraint is proportionate to the risk it is attempting to address.

Criteria

1. When restraint and/or restrictive practices¹⁶ are used, they are done so as a last resort and in the least restrictive manner – promoting safety and person-centred care - and ensuring that:
 - The resident’s human rights are protected at all times;
 - Prevention strategies are evidenced and in place to minimise the need for the use of restraint/restrictive interventions;
 - Residents are treated with compassion and dignity at all times; and
 - Residents and their relatives are supported to be involved with and participate in the process.

2. There are policies and guidance for the use of restraint and restrictive practices that:
 - Are reflective of residents’ needs;
 - Are evidence-based; and
 - Reflect regional and professional guidance and policy including; DHSSPS Guidance regarding Deprivation of Liberty¹⁷ and DHSSPS Guidance on Restraint and Seclusion in Health and Personal Social Services¹⁸.

¹⁶ For the purposes of this document, restraint and restrictive practice includes, but is not limited to direct physical restraint on a single person (for example physical intervention, arrangement of furniture, bedrails, medication); restraint that limits an individual’s freedom (tagging, alarms, surveillance); and restraint that affects all residents (locks, rules, fences).

¹⁷ <http://www.dhsspsni.gov.uk/revised-circular-deprivation-of-liberty-safeguards-october-2010.pdf>

¹⁸ http://www.dhsspsni.gov.uk/restraint_and_seclusion_august_2005.pdf

3. Residents who may require restraint and/or restrictive interventions must have a behaviour support plan, identifying primary and secondary strategies which aim to reduce or prevent the need for restraint and/or restrictive practices. Behaviour support plans should be developed and reviewed with residents using a multi-disciplinary approach and including relatives where appropriate.
4. Full account is taken of the resident's capacity to consent to the proposed intervention. If the resident is assessed as not having capacity to consent, appropriate and documented best interests procedures must be followed.
5. Appropriate and accessible information is given to residents and relatives. This includes information about the purpose and reasons for the suggested intervention, proposals to review the behaviour support plan and the outcome of such reviews, and the ways in which they can be involved in decisions.
6. Wherever restraint or restrictive practices are used, it must be evident that:
 - There is a necessity to act to avoid harm to the resident or others;
 - The intervention is proportionate to the level of harm or risk to the resident or others;
 - The least restrictive approach is used;
 - The intervention is used for no longer than is absolutely necessary; and
 - What is done, for what reasons and the outcome and any consequences are recorded and reported as per local and regulatory requirements.
7. There are regular reviews or audits of incidences of restraint and/or restrictive practices. This informs the training strategy for the organisation and aids in monitoring progress made in reducing the use of such practice.
8. Where specific equipment is used as part of the restraint process, specialist knowledge is sought regarding the specific health and safety requirements associated with such equipment.

9. If medication is prescribed for the management of distressed reactions, the following points are addressed:

- The care plan identifies the parameters for the administration of these medicines in the management of the distressed reactions. The personal medication record identifies the reason for the administration;
- A record of the administration of any medicine for the management of distressed reactions is maintained. Staff record the symptoms of the distressed reaction and the effect of medication administered;
- There is multi-disciplinary involvement on the use of medication in the management of distressed reactions and full engagement with the resident and relatives where possible; and
- The Registered Manager regularly reviews the effectiveness and frequency of administration. If the medicine is administered regularly, systems should be in place to ensure this is reported to the prescriber and the reasons identified eg patterns of behaviour or triggers.

10. All staff receive appropriate training and updates that includes:

- An emphasis on preventative approaches, de-escalation and early intervention;
- A focus on physical intervention skills and skills in crisis management including alternatives to restraint and/or restrictive interventions;
- Promoting attitudinal and cultural change among staff; and
- Implementation of recognised and evidence based models of care.

11. Whenever restraint and/or restrictive practices have been used, relevant staff, the resident and their relatives are invited to take part in a supportive debriefing and post-incident review.

Standard 19 – Communicating Effectively

Staff communicate with residents in a manner that is sensitive and understanding of their needs.

Criteria

1. Staff understand residents' communication needs and ensure that they communicate in ways that are sensitive to these needs.
2. Where barriers to communication have been identified, appropriate and effective steps are put in place to address them¹⁹.
3. Staff understand and use a variety of communication methods (including gestures and non-verbal cues) according to each resident's assessed needs.
4. There is an environment in the home that supports effective communication.
5. There are arrangements in place for the use of a range of assistive technologies that support residents' communication needs.
6. The procedure for delivering bad news to residents and their families is developed in accordance with guidance, such as "Breaking Bad News" regional guidelines²⁰.

Evidence

- Staff are trained in communicating with residents according to their individual needs and demonstrate their understanding through every interaction with residents.

¹⁹ Guidance on communicating with people with dementia can be found at:
<http://www.publichealth.hscni.net/publications/communicating-effectively-person-living-dementia>

²⁰ Regional guidance on breaking bad news can be found at:
http://www.dhsspsni.gov.uk/breaking_bad_news.pdf

Standard 20 - Death and Dying

The dying and death of residents is handled with care and sensitivity; and relatives are supported in a sensitive and appropriate manner.

Criteria

1. Care and comfort are given to residents who are dying, and their death is handled with sensitivity²¹.
2. End of life care and after death arrangements are discussed with the resident and their relatives and documented in their personalised care plan as appropriate. This includes the resident's wishes to take account of their cultural and spiritual preferences as well as their preferred place of death.
3. The privacy and dignity of residents who are dying are maintained at all times, and their cultural and spiritual needs and rights are respected and observed.
4. There are arrangements in place for referral to specialist palliative care services to meet residents' palliative care needs should this be required.
5. Relatives of dying residents are offered support during this period and are informed sensitively of the death of their relative.
6. The home makes reasonable arrangements for relatives and friends to be with a resident who is very ill or dying.
7. The body of a resident who has died is handled with dignity, sensitivity and respect in accordance with their expressed social, cultural and religious preferences. Remains are removed in a sensitive and dignified way.

²¹ Regional guidelines for palliative care in nursing homes may be accessed at: http://www.gain-ni.org/images/Uploads/Guidelines/GAIN-UPDATED_Palliative_Care_Guidelines-20_November2013.doc

<http://www.dhsspsni.gov.uk/hss-md-21-2014.pdf> sets out five principles for the care of people in the last hours of life.

8. Residents are informed in a sensitive manner about any death in the home, have opportunity to pay their respects and are provided with appropriate support.
9. Deceased residents' belongings are handled with sensitivity and care and their relatives are consulted about the removal of these belongings.

Evidence

- Staff are trained to deal with death, dying and bereavement.
- Staff are proactive in identifying when a resident's condition is deteriorating or when they may be entering end of life so that effective communication pathways, medical and nursing care plans can be put in place.

Quality of Care

Care delivered in nursing homes must be of the highest quality. Care must be delivered by the right number of appropriately trained and qualified staff in line with the most recent, evidence-based practice guidance. Homes must have procedures in place to meet the recommendations of guidance issued by the variety of bodies such as NICE, SCIE and the RCN as well as local organisations such as GAIN and NISCC.

Increasing dependency levels of residents in homes, combined with fast-paced developments in health and personal care require staff to keep up to date with new medical technologies and medication.

Nutrition and hydration is vital for many aspects of health and wellbeing and all residents' nutritional and hydration needs and preferences should be met by the home.

Whilst recognising the increased healthcare needs of residents, homes must also support and facilitate residents' capacity for self-care and independence for as long as possible in order that they can maintain their quality of life. Regular health check-ups from a range of health professionals will ensure problems are detected and treated early. The home should have effective relationships with the range of health and social care professionals that can improve the quality of life for residents by delivering effective multi-disciplinary care.

Regular healthcare and medication reviews are essential in order to ensure appropriate prescribing for every resident in line with their identified needs.

Emotional wellbeing is also promoted, maintained and supported through the routines, policies and ethos of the home.

Standards 24-26 are specific to the needs of residents with dementia, in recognition of the high numbers of residents who present with some degree of the condition.

Standards 28-31 relate to medicines. For the purposes of these standards, medicines should be understood to include all medicines used within the home including for example tablets, liquids, ointments, eye drops, inhalers, dressings, nutritional feeds and thickeners. The evidence reflects what inspectors will expect in all homes.

Effective palliative and end of life care must be delivered to ensure the last stages of life are as comfortable as possible. Residents' preferences for this care must be discussed sensitively and supported; and relatives must also be given the information and support they need during this time.

Standard 21 – Health Care

Residents' health and wellbeing are promoted and maintained and they have access to health and social care services to meet their assessed needs.

Criteria

1. The general health and welfare of residents is monitored and recorded and timely referrals made to or advice sought from appropriate health and social care professionals as necessary and documented in resident records. With the agreement of the resident, their relatives are made aware of developments in their health and wellbeing.
2. The frequency of appointments for healthcare screening and community healthcare is monitored and recorded and referrals are made at least annually and as required individually (with the resident's consent). Where consent is refused, this is recorded.
3. Details of each resident's registration with health and social care professionals are recorded and arrangements are in place for residents to be provided with information and support when applying for re-registration or new registration to services.
4. Residents are facilitated and supported to receive all relevant immunisations and records of the immunisation status of all residents are kept.
5. Care staff maintain the personal and oral hygiene of each resident in line with best practice guidance²² and promote and facilitate each resident's own capacity for self-care.

²² Guidance for oral care for residents can be found at:
<http://www.gain-ni.org/index.php/audits/guidelines>

6. There are arrangements for health and wellbeing risk assessments for residents using validated or evidence-based tools. Care plans are reviewed in line with the outcomes of such risk assessments.
7. There are referral arrangements in place to obtain timely advice, treatment and support as required from relevant external health professionals and services.
8. Where residents require transport to and from medical appointments, there are clearly understood arrangements in place for residents and families or carers for such transport including timings, the responsibility for accompanying the resident and the information to accompany the resident.
9. When patients are being transferred from a nursing home to a hospital environment (including an emergency department) a Transfer Form must accompany the patient. When residents with confusion or dementia are transferred to hospital, documentation such as 'This is Me'²³ must accompany the patient. The appropriate Transfer Forms and documentation are also with the resident on their return to the home.
10. Information on personal healthcare is available to residents in a format accessible to them. This information should include:
 - Skin care and prevention of skin damage;
 - Promotion of continence;
 - Appropriate exercise and physical activity; and
 - Mental and emotional health and wellbeing.
11. Where residents require continence management and support, assessments are carried out by the home and care plans are reviewed to ensure individual needs are met.

²³ http://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=399

12. Residents' mental and emotional health and wellbeing are monitored regularly and preventative and restorative care provided in line with best practice guidance.

13. Opportunities are given for appropriate exercise and physical activity.

Evidence

- Best practice guidelines are available to staff for common conditions including, but not limited to:
 - Pressure damage;
 - Pain;
 - Wound care;
 - Continence management;
 - Falls prevention;
 - Nutritional screening;
 - Meeting residents' safety needs;
 - Dementia;
 - Diabetes; and
 - Palliative care.

- Aids or equipment necessary for continence management are provided.

- Residents have access to hearing and sight tests and appropriate aid according to need.

- Nurses have expertise and skill in wound care that includes the ability to carry out a wound assessment and apply wound care products and dressings.

- Nurses have up to date knowledge and expertise in the management of stoma appliances.

- There is evidence that residents are supported and facilitated to access external specialist services.

Standard 22 – Falls Prevention

Residents are appropriately assessed for the risk of falls and preventative measures are in place.

Criteria

1. There is a falls prevention policy in place within the home and this is reviewed regularly.
2. Homes have in place, sufficient equipment and staff with appropriate training, to manage residents who fall. Staff work in partnership with other agencies to ensure an ambulance is only requested for residents with a clinical need to attend hospital.
3. An assessment for the risk of falls is carried out, using an accepted risk assessment tool, no later than 24 hours after admission to the home.
4. The falls assessment and preventative measures are carried out in line with best practice guidance²⁴.
5. If the resident is deemed to be at risk of falls, following risk assessment, a detailed falls care plan is put in place, documented and communicated.
6. The falls risk assessment is reviewed in response to changes in the resident's condition and no less frequently than monthly and the care plan amended accordingly.

²⁴ Guidance on falls prevention in homes can be found at:
[http://www.publichealth.hscni.net/sites/default/files/Nursing%20Home%20Collaborative%20Falls%20Prevention%20Toolkit%20ver%201\(3\)%202013.pdf](http://www.publichealth.hscni.net/sites/default/files/Nursing%20Home%20Collaborative%20Falls%20Prevention%20Toolkit%20ver%201(3)%202013.pdf) and

<http://www.nice.org.uk/guidance/CG161>

7. Falls or fear of falls is not necessarily a barrier to allowing walking and the home takes all reasonable steps to accommodate this safely including securing floor coverings and rugs, ensuring suitable lighting and suitable placing of furniture to allow for free movement.
8. Residents' footwear is checked to ensure their safety when walking and they have any necessary equipment or aids and can use them safely.
9. A post-falls review is carried out within 24 hours of a resident sustaining a fall to determine reason for falling and any preventative action to be taken. This is in addition to existing mechanisms to record incidents within the home. The care plan is amended accordingly.
10. Falls are reviewed and analysed on a monthly basis to identify any patterns or trends and appropriate action is taken.

Standard 23 – Prevention of Pressure Damage

There are clear and documented processes for the prevention, detection and treatment of pressure damage or ulcers which are based on best practice guidelines²⁵.

Criteria

1. Pressure damage risk assessments and body mapping are carried out for all residents, where possible, prior to admission and, at the latest, on admission to the home as well as on leaving for any transfer to hospital and subsequent re-admission.
2. Where a resident is assessed as at risk of pressure damage, a documented pressure damage prevention and treatment programme is drawn up and agreed with relevant professionals and entered in to the resident's care plan.
3. A validated pressure damage grading tool is used to screen residents who have skin damage and an appropriate treatment plan implemented. Incidents of pressure damage, their treatment and outcome are recorded in the resident's records and reviewed on a regular basis.
4. Pressure sores assessed as Grade 2 or above are reported to RQIA and HSC Trusts in line with guidance and protocols.
5. The equipment necessary for the promotion of tissue viability and prevention or treatment of pressure damage is provided.

Evidence

- There is evidence of risk assessment and documentation of care planning for pressure ulcer prevention or treatment in the resident's care plan.

²⁵ NICE guidance on management and prevention of pressure damage can be accessed via: http://www.dhsspsni.gov.uk/circular_hsc_sqsd_nice_cg179_16_14_-_management_and_prevention_of_pressure_ulcers.pdf

Standard 24 - Recognising the Signs of Dementia and Responding to Need

Staff are aware of the signs, symptoms and disabilities associated with dementia and know how to seek further advice and assistance as necessary.

Criteria

1. Staff demonstrate awareness of the signs, symptoms and disabilities associated with dementia and know how to seek further advice and assistance on how to effectively support a resident who is experiencing difficulty with:
 - Memory;
 - Communication;
 - Delirium;
 - Recognition & co-ordination;
 - Orientation;
 - Changes in behaviour, judgement & moods;
 - Completion of daily life skills; and
 - Nutrition and hydration.

2. Where a resident displays the signs or symptoms of dementia, staff seek help in a timely way to obtain a thorough assessment and professional help and guidance on how to provide appropriate care and treatment.

3. Where a resident is diagnosed with dementia, this is handled sensitively and they and their relatives are offered access to timely and appropriate information, resources and support.

4. The home actively facilitates and maintains links with local resources that can provide support to individuals and groups. Residents and their relatives are made aware of such support and the steps to be taken to access it.

Evidence

- Staff demonstrate awareness of other conditions that may impact on a resident's memory, orientation and behaviour and seek appropriate medical support for investigation and diagnosis.
- Staff demonstrate awareness of the prevention, symptoms and treatment of delirium and follow best practice guidance.
- Staffing levels reflect the daily routines and behaviour patterns of the residents and allow for instances where behaviour may change at specific times of the day.

Standard 25 - Approach to Care for Residents with Dementia

It is recognised that the person with dementia may have fluctuating capacity and the care provided reflects a strength-based approach to assessment and care planning and promotes the right to self-determination.

Criteria

1. Residents with dementia are supported to make choices and decisions about their lives and how their personal care needs will be met in the home.
Residents' rights to make decisions and choices are respected and staff work to ensure the resident understands the consequences of decisions made, but do not undermine their right to make such choices.
2. Staff respect the resident's rights to decline or refuse a care intervention whilst considering the overall outcome for them and other residents.
3. The resident is provided with appropriate support to settle into the home, to promote orientation and feelings of safety and security, for example through the allocation of a "buddy" or similar system.
4. Staff work in partnership with relatives and representatives, sharing information as appropriate and recognising their valid feelings about the resident's move to the home and changing care needs as dementia progresses.
5. Staff understand and demonstrate knowledge of approaches to promote effective methods of communication with residents in various stages of dementia, including advanced stages. Alternative forms of communication such as music, song and touch are used as appropriate in communication with residents.
6. Advice is sought from HSC professionals on appropriate methods of and aids to communication.

7. Staff follow best practice guidance in the use of anti-psychotic medication for residents with dementia. They are aware of potential side effects and work with prescribers to ensure regular medication reviews with a view to reducing medication as per best practice guidance.
8. Additional attention is paid to the physical healthcare of residents taking anti-psychotic medication to ensure other issues including infection; constipation; hydration; poor hearing or eyesight and pain are not masked by the effects of the medication.

Evidence

- There is regular and up to date training for staff in caring for residents with dementia.
- Staff choose the most appropriate time of day to discuss choices and decisions with residents.
- Pictures or other means of communication are used to discuss and make decisions where appropriate.
- There is evidence that residents' daily routines are built around their preferences and choices as far as possible and accommodate instances where activity level or behaviour may change according to the time of day.
- There are accurate, contemporaneous records where residents are unable to make decisions for themselves. The record includes details of the choices available to the resident, the decisions made, who was consulted, who made the decisions and how those decisions were made.
- Staff induction includes training on communication and engagement with people with dementia.

Standard 26 - Understanding and Responding to Distressed Behaviour in Residents with Dementia

Behaviours displayed by a resident with dementia are recognised as communication of unmet need and strategies are put in place to respond to such behaviour in a caring and supportive manner.

Criteria

1. The home's policy and procedures for responding to distressed behaviour promote positive outcomes for the resident.
2. Staff have a knowledge and understanding of the range of distressed behaviour that residents with dementia may experience and the reasons why such behaviour may occur and how to respond (including but not limited to walking or pacing/activity disturbance; refusing help and assistance; being withdrawn; repetition; difficulties with continence; and sexual expression).
3. Staff recognise where behaviour may be caused by pain. Staff are trained to use a validated pain assessment tool to ascertain if residents with dementia are in pain and respond effectively to the need for pain relief. Pain-relieving medication (including over the counter remedies) is available in the home along with equipment such as specialist chairs and mattresses that can assist in pain management.
4. Staff understand and recognise patterns of behaviour and develop routines to accommodate rather than control behaviour which may challenge staff.
5. A record is kept of all distressed behaviours in order to identify triggers and patterns in order to support the analysis and understanding of the unmet need being communicated through the behaviour.
6. Strategies are put in place to respond to the behaviour in a caring and supportive manner and care plans and risk management plans are amended

to reflect the agreed strategy. The agreed strategy is communicated to all staff, residents, relatives and representatives and is regularly reviewed.

7. Where residents use walking or pacing/activity disturbance to communicate, a proportionate risk assessment is undertaken to allow residents to walk safely when they wish to.
8. Staff demonstrate a knowledge and understanding of individual residents' rights, preferences and routines so that a sudden refusal of care and assistance can be understood and responded to. The resident's individual right to refuse assistance or care is not over-ruled by staff's values and principles.
9. Where a resident demonstrates distressed behaviour during personal care, staff sensitively try to identify the potential factors that may be causing the behaviour such as personal choice; embarrassment; pain; or lack of understanding of the task.
10. Where a resident refuses medication, staff investigate possible underlying causes and respond appropriately. Where residents who lack capacity refuse their medication, this is reviewed in consultation with the prescriber.
11. Where residents become withdrawn, staff work with them to determine if a care need is unmet (e.g. the resident is depressed, bored or lonely or a side effect of medication). Staff make a conscious effort to engage with residents who have become withdrawn and use gentle, sensitive and clear explanations as to their actions.
12. Staff explore physical or emotional reasons behind sexualised or inappropriate behaviour and respond with empathy in a manner that respects the resident's feelings and dignity whilst managing the situation.

Standard 27 - Intermediate and “Step Up” or “Step Down” Care

Care is delivered for a time-limited period with the aim of promoting recovery from illness and premature admission to long-term residential care, by supporting timely discharge from hospital and return to independent living.

Criteria

1. Intermediate care is provided for a limited period of time and care is delivered on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active treatment and rehabilitation.
2. The assessment includes input from the range of HSC professionals involved in the delivery of the acute care and shows evidence of multi-disciplinary agreement regarding the suitability of placing the resident into an intermediate care setting.
3. Care is designed to promote recovery, maximise independence and to enable residents to return to living in their own home.
4. The care plan sets clear goals and milestones in relation to the treatment and interventions required. Discharge planning is included in the care plan. Responsibility for medical care and the supply and prescription of medication is clearly documented in the care plan.
5. Care is designed and delivered with support from an appropriate range of HSC professionals including acute practitioners, community services, Allied Health Professionals and General Practitioners.
6. There are clear and transparent arrangements setting out the medical responsibility for the resident receiving intermediate care. There is a named nurse responsible for delivering nursing care. There is a named social worker whose details are included in the care plan.

7. There is a programme of active rehabilitation involving the contribution of all necessary interventions such as (but not limited to) occupational therapy, speech and language therapy or physiotherapy to enable the resident to return home.
8. Staff working in intermediate care are trained and qualified to undertake the range of tasks and interventions required. Support from specialist nursing is available if required.
9. Staff are employed in adequate numbers to ensure the delivery of safe, high-quality care for residents requiring intermediate care.
10. Care and interventions are delivered in accordance with legislation, policy, best practice guidance and contracting arrangements.

Standard 28 - Management of Medicines

Medicines are managed in compliance with legislative requirements, professional standards and guidelines.

Criteria

1. Medicines²⁶ are administered in strict accordance with the prescriber's instructions.
2. Written policies and procedures for the management of medicines are up to date and cover all aspects of medicines management.
3. The management of medicines is undertaken by qualified, trained and competent staff and systems are in place to review staff competency in the management of medicines.
4. Concerns about the suitability of the medicine for the individual are raised with the prescriber and documented in the medical notes.
5. Destruction or disposal of medicines no longer required is undertaken by trained and competent staff.
6. There are suitable systems in place to manage drug alerts and safety warnings about medicines.
7. There are systems in place to report adverse drug reactions to the resident's prescriber.
8. There are robust incident reporting systems in place for identifying, recording, reporting, analysing and learning from adverse incidents and near misses involving medicines and medicinal products.

²⁶ Within these standards, "medicines" refers to all medicines used within the home including for example tablets, liquids, ointments, eye drops, inhalers, dressings, nutritional feeds and thickeners.

9. Staff have access to up to date information relating to relevant legislation, medicines reference sources and guidance with respect to the safe and secure handling of medicines.
10. There are robust arrangements in place to audit all aspects of the management of medicines.
11. Arrangements are in place to ensure the safe management of medicines during a resident's admission or readmission to the home and on their discharge or transfer from the home.
12. Systems are in place to manage the ordering of prescribed medicines to ensure adequate supplies are available and to prevent wastage.
13. Robust arrangements are in place for the management of self-administered medicines.
14. Medicines are prepared immediately prior to their administration from the container in which they are dispensed.
15. Compliance with prescribed medication regimens is monitored and any omissions or refusals likely to have an adverse effect on the resident's health are reported to the prescriber.
16. Suitable arrangements are in place for the administration of licensed medicines outside of the terms of the product licence.
17. The act of administering medication in disguised form is discouraged but, when necessary, it is undertaken in accordance with current professional standards and guidelines.
18. Non-prescribed medicines are administered in accordance with qualified medical or pharmaceutical advice.

Evidence

- All medicines are available for administration as prescribed.
- The process to ensure medicines information is regularly checked and verified for accuracy.
- Medicines are administered only to the resident for whom they are prescribed.
- Where necessary, protocols/care plans are in place for specific high risk medicines/residents.
- Written details of any communication with the prescriber about a concern or query relating to medicines are retained on the resident's notes.
- Patient Information Leaflets relating to all prescribed medicines are available to residents.
- Written policies and procedures cover each of the activities associated with the management of medicines.
- Written policies and procedures are subject to regular review and update.
- There is evidence that staff have read the policies and procedures.
- Appropriate arrangements are in place for the disposal of medicines. (Waste transfer note in place).
- There is evidence that a licensed agent is used to uplift medicines.
- All controlled drugs in Schedule 2, 3 and 4 (Part 1) are denatured and rendered irretrievable before being placed in waste containers.

- Written procedures are in place that outline the suitability, authorisation and record keeping relating to the administering of unlicensed medicines, including crushed medicines.
- Incidents are reported to RQIA and other relevant bodies as appropriate.
- Staff have access to medicines reference sources.
- Audits which cover all areas of medicines management are performed regularly, discrepancies investigated and records maintained.
- Evidence is available of any learning outcomes and resulting changes to practice.
- Written confirmation of current medication regimes is obtained from a health or social care professional for all new admissions.
- Resident's own medicines that are brought into the establishment on admission are assessed before use to ensure that they are in date, fully labelled and checked against the written confirmation of current medication regimes obtained from a health or social care professional. Where possible resident's own medicines should be used up before ordering new supplies.
- Medicines issued for temporary leave are supplied, labelled and packaged appropriately.
- On discharge or transfer, written confirmation of current medication regimens is sent with the resident.
- Systems are in place to prevent any over-ordering of medicines.
- Residents are in control of the storage and administration of their medicines

where risk assessment has deemed it appropriate. The review and monitoring of self administration are recorded in the care plan.

- Up to date protocols are in place.
- Medicines doses are prepared immediately prior to their administration from the container in which they are dispensed.
- There are policies and procedures in place to direct staff when to report adherence (compliance) problems.
- Written procedures are in place that outline the suitability, authorisation and record keeping relating to the administering of unlicensed medicines, including crushed medicines.
- Evidence of professional advice is in place for any crushing or disguising of medicines.
- The assessment process and outcomes are documented in the resident's records.
- Up to date protocols are in place and records are maintained for the use of non-prescribed medicines.

Standard 29 – Medicines Records

Medicines records comply with legislative requirements, professional standards and guidelines.

Criteria

1. Medicine records are legible and accurately maintained as to ensure that there is a clear audit trail.

2. The following medicine records are maintained:
 - Medicines requested and received;
 - Medicines prescribed;
 - Medicines administered;
 - Medicines refused;
 - Medicines doses omitted;
 - Medicines doses delayed;
 - Medicines transferred;
 - Medicines disposed of; and
 - Controlled drug record book.

3. Where medicines are prescribed on a 'when required' basis, parameters of use are clearly defined in the resident's records.

Evidence

- Medicine records are legible, accurate, up to date and signed and dated by the person(s) making the entry.

- A system is in place to manage recording errors.

- Prescription details are verified and signed by two designated members of staff.

- Medicine labels specify full dosage directions.
- Labelling enables staff to positively identify individual medicines.
- Records are in place where the administration of external preparations is delegated.
- Medicines Records include:
 - Medicines requested and received;
 - Personal Medication Record;
 - Medicine Administration Record;
 - Medicines refused;
 - Medicines doses omitted;
 - Medicines doses delayed;
 - Medicines transferred;
 - Medicines disposed of; and
 - Controlled drug record book
- Parameters for the administration of the medicine detail the rational for use, the minimum dosage frequency and maximum daily dose.
- There is evidence of review.

Standard 30 - Medicines Storage

Medicines are safely and securely stored in compliance with legislative requirements, professional standards and guidelines.

Criteria

1. Medicines are safely and securely stored.
2. Medicines are stored in accordance with the manufacturers' instructions.

Evidence

- Unauthorised access to medicines is prevented.
- There is sufficient storage space for medicines.
- Oxygen is stored securely and signage is in place.
- Medicines awaiting disposal are stored safely and securely.
- Medicines are stored under conditions that conform to the manufacturers' requirements.
- Dates of opening of medicines are routinely recorded.
- Procedures are in place to ensure that medicines are not used past the date of expiry.
- Robust arrangements are in place for the monitoring of medicine refrigerators.
- Temperatures of medicine storage areas are monitored regularly and records maintained.

Standard 31 - Controlled Drugs

The management of controlled drugs is in compliance with legislative requirements, professional standards and guidelines.

Criteria

1. Up to date Standard Operating Procedures (SOPs) are in place that cover all aspects of the management and use of controlled drugs.
2. The receipt, storage, administration and disposal of all controlled drugs subject to record keeping requirements are maintained in a controlled drug record book.
3. Controlled drugs are stored in accordance with the Misuse of Drugs (Safe Custody) (Northern Ireland) Regulations 1973 and published guidance.
4. The key of the controlled drugs cabinet is separate from other medicine cupboard keys.
5. Stock balances of Schedule 2 and Schedule 3 controlled drugs which are subject to safe custody requirements are reconciled on each occasion when the responsibility for safe custody is transferred.

Evidence

- SOPs are available and are signed by staff.
- There is a protocol in relation to the reporting, escalating, evaluating and investigating concerns in relation to the management and use of controlled drugs.
- The controlled drug record book is accurately maintained.

- The administration of a controlled drug subject to record keeping requirements is recorded and signed in the controlled drug record book by the nurse administering the drug and the witness who is present at its administration.
- Controlled drugs storage meets the Misuse of Drugs (Safe Custody) (Northern Ireland) Regulations 1973 (Nursing Homes).
- Key control prevents unauthorised access to controlled drugs.
- There is recorded evidence that Schedule 2 controlled drugs and Schedule 3 controlled drugs subject to safe custody requirements, are reconciled by two nurses or two authorised members of staff on each occasion when responsibility for safe custody is transferred and a record kept. Quantities of controlled drugs match the balances recorded in the record book.

Standard 32 – Palliative and End of Life Care

Residents' palliative and end of life care needs are met.

Criteria

1. A documented plan of care that meets the resident's assessed needs and comfort is drawn up and agreed with them, their relatives and relevant professionals. The care plan should follow the recommendation for palliative and end of life care as detailed in current guidance²⁷.
2. There are referral arrangements in place to obtain advice and support from relevant healthcare professionals who have the required expertise in palliative care.
3. Staff in the home, the GP and other members of the multidisciplinary and specialist palliative care teams work together as appropriate to plan the care. The resident (if appropriate) and their relatives are involved in the decision making processes, care planning and delivery and are kept up to date with developments.
4. The outcomes of symptom control and end of life care are monitored and are subject to review and re-assessment at agreed time intervals. The resident and their relatives are involved in the review and re-assessment together with the relevant healthcare professionals.
5. The resident is assessed regularly, including their hydration and nutrition needs, and interventions to promote comfort and dignity are initiated in a timely and responsive manner.
6. Pain management medications are prescribed and when administered, their effect monitored to ensure that they provide relief and that the resident is

²⁷ Current regional guidance can be accessed at:
[http://www.gain-ni.org/images/Uploads/Guidelines/GAIN-UPDATED Palliative Care Guidelines-20 November2013.doc](http://www.gain-ni.org/images/Uploads/Guidelines/GAIN-UPDATED_Palliative_Care_Guidelines-20_November2013.doc)

comfortable. This may involve anticipatory prescribing to ensure that medication is available in a timely fashion.

7. Pain relief medication is prescribed in line with current best practice guidelines and staff are aware of these²⁸.
8. Staff in the home ensure that the cultural, religious and spiritual needs of the resident and their relatives are identified and met in a sensitive manner through connections with members of the local faith community.
9. When the resident is believed to be imminently dying, their family and friends (including other residents) are facilitated as far as possible and in accordance with the person's wishes to spend as much time with them as they wish. This includes overnight stays if feasible.
10. There is a room or private space available where relatives talk privately.
11. In the event that relatives are unable to be present, the home makes arrangements to ensure someone is deployed to sit with the resident so that they are not left alone while dying.

Evidence

- Residents' needs for palliative and end of life care are assessed and reviewed on an ongoing basis and documented in their care plan.
- There is a mechanism for communicating both internally and with external care providers and organisations.
- A key worker is identified for each resident who is approaching end of life.

²⁸ Guidance can be accessed at:
<http://www.gain-ni.org/images/Uploads/Guidelines/Gain%20Pain%20Poster.pdf>

- Systems are in place for timely access to any specialist equipment or drugs which may be necessary to deliver end of life care including weekends and out of hours.
- Staff are appropriately trained to ensure they have the knowledge and skills to deliver high quality person centred end of life care.
- Privacy, dignity and respect is integrated throughout end of life care.
- An individual care plan is used to inform care delivery during the last days of life and this is updated regularly.
- Relevant support and information is provided to relatives during the last days of life and after death.
- Nurses have up-to-date knowledge and skills in providing symptom control and comfort and are able to ensure that instructions drawn up by relevant health professionals are adhered to.
- Staff work in partnership with the HSC to reduce the need for hospital attendance and admission and enable residents to be managed in the home.
- There are up-to-date palliative care guidelines for nursing staff that cover the management and use of syringe drivers.
- There is a readily available source of useful, educational information, in an accessible format, on the principles of palliative care for staff, residents and their relatives.

Standard 33 – Resuscitation

Resuscitation care is provided for residents in line with their expressed wishes.

Criteria

1. Where emergency resuscitation equipment is provided, it is readily accessible; checked according to manufacturer's instructions and in line with directives for medical devices; and restocked to ensure it remains in working order. Checks are recorded and signed.
2. The expressed wishes of residents regarding resuscitation are documented and recorded.
3. There is a resuscitation policy in line with the Resuscitation Council (UK) guidelines. The policy includes a section on ethical and legal issues; "do not attempt resuscitation" situations; and the review of resuscitation decisions.
4. There is a minimum of one member of staff on duty at all times who is trained in basic life support techniques.

Quality of Management

The quality of leadership and management within an organisation sets the culture and ethos of that organisation. Effective leaders recognise the skills and experiences of every member of staff and use these skills in developing the job roles for each person in the staff team.

Staff should be developed and trained to enhance existing skills and learn new ones that will enhance the quality of care and life for the residents of the home. Time spent in mentoring and supervising staff represents an investment in their continuing development.

Staff who feel involved and engaged by their managers and leaders are more likely to echo this involvement and engagement with residents.

Effective management systems support and facilitate good management and leadership.

Standard 34 – Ethos and Statement of Purpose

Residents and their representatives, staff and the referring Trust are clear about the aims and objectives of the home and what services and facilities it provides. The provider meets the aims and objectives of the Statement of Purpose.

Criteria

1. The home has a clear Statement of Purpose which conforms to the criteria set out in regulations and on pages 139 - 140.
2. The Statement of Purpose is available to and understood by residents, their relatives and staff and is reflected in all policies, procedures and guidance. It is available to the referring Trust, RQIA and any representative of the resident.
3. The aims and objectives of the Statement of Purpose are resident-focused and show how the home will meet outcomes for residents and demonstrate the culture and ethos of the home.
4. The Registered Person approves the Statement of Purpose and the Residents' Guide and reviews them at least annually and RQIA is informed of any revision within 28 days.

Evidence

- There is recorded evidence of the review process undertaken and the outcomes of the review.

Standard 35 – Governance

Management systems are in place that assure the safe delivery of quality care within nursing homes.

Criteria

1. Services are delivered in accordance with the Statement of Purpose as approved by the RQIA at the time of registration. The Statement of Purpose is kept under review and any change is only made with the approval of the RQIA.
2. The organisation has a coherent and integrated organisational and governance strategy in respect of adult nursing home services (and in exceptional circumstances, children, where appropriate). This is commensurate with the needs, size and complexity of the service. There are clearly identified lines of professional and corporate accountability which assure the effective safe delivery of the service.
3. The organisation has systems in place to discharge, monitor and report on the delivery of nursing and other services provided, in accordance with legislative requirements, DHSSPS Minimum Standards and other related standards for nursing homes.
4. There are structures and processes to support, review and action the organisation's governance arrangements for nursing homes services. This includes, but is not limited to, corporate; financial; health and safety; premises; social and clinical care; information management; and research governance arrangements.
5. The nursing home has business continuity management plans in place that can be activated in order to maintain essential services to a pre-defined level through a business disruption e.g. in the event of the home suffering a business continuity incident as a result of fire, flood, severe

weather, loss of power/IT/utilities, an infectious disease outbreak or high staff absence/ unavailability of key staff. These arrangements should be clearly outlined in contractual arrangements with individuals, organisations or other interested parties.

6. The Registered Manager ensures that the nursing home delivers services effectively on a day-to-day basis in accordance with legislative requirements, DHSSPS Minimum Standards, and other standards set by professional bodies and standard setting organisations. Issues arising from deficits in services are reported to the Registered Person.
7. The Registered Person monitors the quality of services in accordance with the home's written procedures, and completes a monitoring report on a monthly basis. This report includes comments made by residents about the quality of the service provided and any actions taken by the Registered Person or the Registered Manager to ensure that the organisation is being managed in accordance with legislation and minimum standards.
8. There are risk management policies and procedures in place for each service provider/nursing home which enable an effective identification of escalating risks to the service provision and management structures are in place to effectively respond to identified risks. There are policies and procedures in place to prevent, identify, manage and review accidents and incidents to prevent reoccurrence and assure learning within the home and across the organisation (as appropriate).
9. All accidents, incidents, communicable diseases and deaths occurring in the nursing home are reported to the RQIA and other relevant organisations in accordance with legislation and procedures and a record is maintained.
10. There are policies and procedures in place to ensure the awareness, identification, reporting and learning from serious adverse incidents in line with legislation, policy and best practice guidance.

11. The organisation has policies and procedures in place to protect adults and to safeguard their rights and welfare in line with legislation and guidance.
12. The organisation has a workforce strategy that ensures clarity in respect of structure, function, roles and responsibilities of staff. Each person from the Registered Person to all staff in the nursing home is fully aware of, supported and trained to fulfil their responsibilities within the nursing home's governance arrangements.
13. There are robust human resource policies and procedures in place to ensure the workforce planning, skill mix, recruitment, training, supervision and development opportunities to deliver the service in compliance with DHSSPS policy and guidance, professional codes of practice and employment legislation.
14. The Registered Person has arrangements in place for the nursing home to confirm that staff supplied by an agency have been recruited, are appropriately trained and checked in accordance with the recruitment procedures used by the home. All international recruitment of nurses is carried out in accordance with inter-country arrangements and complies with legislative requirements and DHSSPS guidance.
15. There are arrangements in place to enable newly qualified registrants and internationally recruited nurses to have a period of supervised practice and experience until deemed competent and capable in providing safe and effective nursing care in accordance with NMC procedures. Records of this process must be maintained.
16. The organisation has systems in place to monitor, audit and review the quality of nursing and other services provided within their nursing homes on at least an annual basis. A report is prepared and includes follow-up action to be taken. Key stakeholders are involved in this process, which integrates the views of residents, their relatives, and staff into the

evaluation and review of the quality of care. A copy of the report is made available to residents, their relatives and RQIA.

17. There are systems and processes in place to ensure that urgent communications, safety alerts and notices, standards and good practice guidance are made available to key staff in a timely manner.
18. The registered person has arrangements in place for dealing with Chief Nursing Officer (CNO) Alerts, managing identified lack of competence and poor performance, and reporting incompetence in line with guidelines issued by DHSSPS and NMC.
19. The organisation provides regular reports to its senior management team, directors and management board (where appropriate) on governance arrangements and on-going continuous improvement within the organisation.
20. Any absence of the Registered Manager of more than one month is notified to the RQIA and arrangements for managing the home in the absence of the Registered Manager are approved by the RQIA.
21. There are written accounting and financial control procedures that meet professional standards of good practice and legislative requirements, and provide safeguards against errors or fraud.
22. The Registered Person has arrangements in place to ensure that before any research involving residents takes place, a research proposal is prepared and approval is obtained from the appropriate Research Ethics Committee.
23. For the independent sector, insurance cover is in place against loss or damage to the assets of the business. The level of cover should reflect the full replacement value of buildings, fixtures, fittings and equipment.

24. For the independent sector, insurance cover is held for employer's liability, public and third party liabilities and business interruption costs, including loss of earnings and costs to providers of meeting contract liabilities. This cover should be to limits commensurate with the level and extent of activities undertaken by the home, or to the minimum required by RQIA.

25. The home has systems in place for confirming that any medical device or equipment 'on loan' has been maintained and checked in accordance with the manufacturer's and installer's guidance, and records kept of the confirmation received.

26. All legally required certificates and licences are kept up to date, are displayed if required and are accessible for the purpose of inspection.

Standard 36 – Policies and Procedures

There are policies and procedures in place that direct the quality of care and services.

Criteria

1. The policies and procedures for all operational areas of the home are in accordance with statutory requirements and there is a process of systematic audit in place to ensure compliance with policies and procedures.
2. The policies and procedures for treatment and care are evidence-based and in line with current best practice as defined by professional bodies and national standard setting organisations.
3. There are arrangements to ensure that policies and procedures are reviewed with input from staff, residents and relatives where appropriate and are available and accessible to them as required.
4. Policies and procedures are subject to a systematic three yearly review at a minimum (and more frequently if required), and the Registered Person ratifies any revision to (or the introduction of new) policies and procedures.

Evidence

- Policies and procedures are centrally indexed and compiled into a policy manual.
- Policies and procedures are dated when issued, reviewed or revised.
- There is evidence that staff are trained in the policies and procedures of the home; that these are accessible to and understood by them; and they are embedded in to practice.

Standard 37 - Management of Records

Clear, documented systems are in place for the management of records in accordance with legislative requirements and best practice guidance.

Criteria

1. The home has a policy and procedures for the management of records detailing the arrangements for the creation, use, retention, storage, transfer, disposal of and access to those records. The policy and procedures are in line with legislation, DHSSPS policy procedures and guidance and best practice standards.
2. Residents have access to their records in accordance with the Data Protection Act 1998 and, where relevant, with the Freedom of Information Act 2000.
3. Records required under HPSS (Quality Improvement and Regulation) (NI) Order 2003 (Regulations) are up-to-date, accurate and available for inspection in the home at all times.
4. The information held on record is accurate, up-to-date and necessary.
5. Staff are trained to create, use, manage and dispose of records in line with good practice and legislative requirements.

Standard 38 - Recruitment of Staff

Staff are recruited and employed in accordance with relevant statutory employment legislation and mandatory requirements.

Criteria

1. The policy and procedures for staff recruitment detail the recruitment process and comply with legislative requirements and DHSSPS guidance.
2. The home uses interview techniques or other suitable tools to ascertain candidates' suitability to work in the home²⁹.
3. Before making an offer of employment:
 - The applicant's identity is confirmed;
 - Two written references linked to the requirements of the job are obtained, one of which is from the applicant's present or most recent employer. Reasons for leaving are requested. Where a candidate submits a reference from an agency, the home also receives a satisfactory reference from the last home (or relevant employer) in which the candidate worked;
 - Any gaps in an employment record are explored and explanations recorded;
 - Criminal history disclosure information, at the enhanced disclosure level (with barred list check where appropriate)³⁰, is sought from AccessNI for the preferred candidate (agencies that intend to employ applicants from overseas will need to have suitable complementary arrangements in place in this regard);
 - Criminal convictions are checked;
 - Professional and vocational qualifications are confirmed;

²⁹ <http://www.aquestionofcare.org.uk/> provides an online tool developed to help assess suitability for those applying for work in the sector

³⁰ For guidance on when barred list checks are required, see <http://www.dhsspsni.gov.uk/svg>

- Registration status with NMC, NISCC and any other relevant regulatory body is confirmed;
 - A pre-employment health assessment is obtained in line with guidance and best practice;
 - Where a home recruits staff from an employment agency or employs agency staff, the home must ensure that all relevant pre-employment assessments and checks have been carried out; and
 - Each individual's communication skills are assessed as appropriate for the job.
4. Job descriptions are issued to staff on appointment.
5. Residents, or where appropriate their representatives, are involved in the recruitment process where possible.

Evidence

- Records are kept of all the documentation relating to the recruitment process. Details of information obtained from an AccessNI Disclosure Application should be handled as per the AccessNI "Code of Practice and Explanatory Guide for Registered Persons and other Recipients of Disclosure Information".
- Staff are issued with a written statement of main terms and conditions of employment, no later than thirteen weeks after appointment.

Standard 39 - Staff Training and Development

Staff are trained for their roles and responsibilities.

Criteria

1. All staff who are newly appointed, agency staff and students are required to complete a structured orientation and induction and records are retained. An initial induction takes place within two days of employment commencing, with the full induction carried out within three months.
2. The Registered Manager allocates a mentor to each newly recruited staff member to guide and support them through their period of orientation and induction.
3. The Registered Manager requires newly appointed staff to provide evidence of training most recently undertaken that fulfills mandatory training requirements.
4. The training needs of individual staff for their roles and responsibilities are identified and arrangements are in place to meet them.
5. The Registered Manager encourages and supports care assistants to obtain the relevant vocational qualifications suitable to their role and function.
6. Newly qualified registered nurses undergo a comprehensive period of preceptorship in keeping with NMC guidance. The duration of preceptorship is determined by the competency and capability of each individual registered nurse.
7. The effect of training on practice and procedures is evaluated as part of quality improvement.

8. Staff are aware of their professional responsibilities and accountability for ensuring that their knowledge, skills and competence are up to date for safe and effective practice as per the NMC and NISCC codes.
9. The Registered Manager is responsible for ensuring that staff attend training and achieve and maintain competency as well as meeting requirements for ongoing professional development.

Evidence

- Mandatory training requirements are met.
- Records of preceptorship of newly qualified registered nurses are retained for inspection.
- A record is kept in the home of all training, including induction and professional development activities completed by staff. The record includes:
 - The names and signatures of those attending the training event;
 - The date(s) of the training;
 - The name and qualification of the trainer or the training agency; and
 - Content of the training programme.

In addition, for competency based training there is a record of when competency is achieved; supervisor details; signatures; and requirements for maintaining competency.

- There is a written training and development plan that is kept under review and is updated at least annually. It reflects the training needs of individual staff and the aims and objectives of the organisation.
- All staff who are required to use equipment and/or medical devices have attended training in their use and attend regular updates.

- Lists of training provided by Trusts or other organisations are displayed so staff are aware of the availability and opportunity to attend.

Standard 40 - Staff Supervision and Appraisal

Staff are supervised and their performance appraised to promote the delivery of quality care and services.

Criteria

1. There is a written policy and procedures that detail the arrangements for the supervision and appraisal of staff in accordance with relevant Departmental and professional guidelines, including Departmental guidelines for nurses working in mental health and learning disability settings. The policy includes the use of mentorship as part of the induction process and preceptorship of newly qualified registered nursing staff.
2. There is supervision and support for staff, student nurses/trainees and those who undertake specific contracted services that correspond to their roles and responsibilities and for achieving and maintaining competency.
3. Supervisory staff report any serious and/or recurring issues arising in supervision to the manager.

Evidence

- Managers and supervisory staff undergo training in supervision and performance appraisal and there is evidence of this training having taken place.
- Staff have recorded individual, formal supervision according to the home's procedures, and no less than every six months for staff who are performing satisfactorily. More frequent recorded supervision is held for new staff and staff who are not performing satisfactorily.

- A supervision schedule is in place, showing completion dates and the name of the supervisor.
- All staff have recorded annual appraisal meetings with line managers to review their performance against their job descriptions, and to agree personal development plans.
- A record is maintained of dates of appraisals undertaken and the name of the appraiser.
- There are opportunities for reflective practice, critical incident analysis and root cause analysis and subsequent learning for staff.

Standard 41 - Staffing

The number and ratio of staff on duty at all times meet the care needs of residents.

Criteria

1. At all times the staff on duty meet the assessed nursing care, social and recreational needs of all residents, taking into account the size and layout of the home, the Statement of Purpose and fire safety requirements.
2. The registered manager ensures that at all times suitably qualified, competent and experienced staff are working at the nursing home in such numbers as are appropriate for the health and welfare of the patients.
3. Student nurses on placement and volunteers working in the home are not taken into account in overall staffing numbers.
4. The registered manager ensures that a minimum skill mix of at least 35% registered nurses and up to 65% care assistants is maintained over 24 hours.
5. The duty roster is designed so as to best meet residents' choices and needs.
6. The duty roster is amended so that additional staff are in post during infection outbreaks so as to avoid cross-contamination where staff move between areas or floors of the home.
7. There is a competent and capable nurse in charge of the home at all times who has the knowledge, skill and experience necessary to care for the residents for which the home is registered.
8. The Registered Manager ensures arrangements are in place to support staff in day to day decision making.

9. All staff, including those contracted in to provide specific services, are clear about their roles and responsibilities. They are properly managed and understand to whom they are accountable.

10. Administrative and ancillary staff are employed to ensure that standards relating to food and meals, transport, laundry, cleaning and maintenance of the premises and administration are fully met.

Evidence

- Records are kept of all staff that include name, date of birth, previous experience and qualifications, starting and leaving dates, posts held and hours of employment.

- A record is kept of staff working over a 24-hour period and the capacity in which they were working.

- Duty rotas identify the name of the nurse in charge of the home on each shift. They also record the first name and surname of each member of staff, actual hours worked (which are verified) and signed by the nurse manager or designated representative.

- The nurse manager's hours worked are included on the duty rota and identify either management duty or working as lead nurse.

- A record is kept of the home's calculation to determine staffing requirements. Assessment of resident dependency levels informs the staffing requirements.

- Sufficient time is scheduled at all changes of shifts for handover reports to be given on resident care and other areas of accountability.

- Staff meetings take place on a regular basis and at a minimum quarterly. Records are kept which include:

- The date of all meetings;
- The names of those attending;
- Minutes of discussions; and
- Any actions agreed.

Standard 42 - Volunteers

Volunteers contribute to the home in the best interests of residents.

Criteria

1. The procedure for the involvement of volunteers details the arrangements for their recruitment, training and management.
2. Safeguarding checks are carried out on volunteers before they participate in a volunteering role.

Evidence

- Residents and staff are informed and understand individual volunteers' roles and responsibilities.
- The scope of activity and responsibilities of each volunteer is specified in writing.
- Records are kept of the recruitment, training, monitoring and support arrangements.
- A record is kept of volunteers deployed, the hours of service and the range of work undertaken.

Quality of the Physical Environment

The quality of the internal and external environment of the nursing home impacts directly on the quality of life for the residents and staff.

Safety is an obvious overriding consideration, but best practice also shows the importance of a thoughtfully-designed environment which addresses issues such as dementia care while maintaining a home from home person centred setting.

Additionally, the safe and effective use of medical devices and equipment is essential in maintaining high-quality care and likewise infection prevention and control must be maintained to ensure residents' safety from harm.

Standard 43 - Environment

The internal and external environment for the home is arranged so as to be suited to the needs of residents.

Criteria

1. Furniture is arranged with enough space so as not to impose barriers or obstacles to movement and encourages communication amongst residents. Effective signage, which is positioned appropriately, promotes way finding for residents.
2. All furniture and furnishings in the home are suited to the needs of residents. Furnishings and decorative accessories including items such as “rummage boxes” are placed so as to stimulate residents’ interest and attention.
3. Consideration is given to the use of mirrors in the home and, where necessary, mirrors can be covered to avoid confusion for residents and the design of the home avoids polished surfaces that can cause reflection and glare that can be confusing.
4. The environment is safe for residents with risks for falling and slipping minimised. The home engages with an Occupational Therapist as well as other members of the multi-disciplinary team to ensure the optimum design features for residents.
5. A noise management policy is in place in the home. There is evidence that steps are taken within the home to minimise noise. Areas of high noise levels should be located far from domestic and rest areas.
6. Bedrooms are personalised with the resident’s possessions to suit their needs and preferences. A variety of methods is used to promote the resident’s orientation to their bedroom – this may include their name, photographs, objects that the resident can make a connection with or the use of memory

boxes. The bed is visible and clearly demarked using, for example contrasting bed linen.

7. Assistive technology is used to promote non-intrusive monitoring at night where appropriate. There is a record of discussions and decisions made in respect of the human rights considerations in undertaking such monitoring.
8. In bathrooms, toilet seats, hand rails and towel rails are clearly identified and demarked (for example by using contrasting colours to the rest of the decor). Open shelving is available to display and allow easy access to toiletries. Appropriate equipment and aids are in place to prevent scalding, slipping and flooding.
9. Lighting in the home is designed to allow for increased light levels, good contrast, minimal glare and good colour definition. Motion sensor lighting may be used in bathrooms and corridors to assist patients at night. Blinds are used to keep residents comfortable in hot weather. There is appropriate lighting at bedtimes.
10. Sudden changes in light levels are avoided. Natural daylight is utilised wherever possible and windows are kept clean and free from obstruction that blocks light. Care is taken when choosing low-energy light bulbs that take some time to come to full brightness. Lighting should be controlled in such a way that residents are exposed to the 24-hour cycle of light and dark.
11. Garden space is safe and secure and easy to find from inside the home. Planting is used to soften hard features such as walls and fencing and to create points of interest for residents. Paths are wide enough to allow for two people to walk side by side. There are opportunities for resting and sitting throughout the garden and there is shelter available from the sun and wind. Consideration is given to using the garden to stimulate the senses through water features; planting and features that attract wildlife and birds; and fragrant plants and flowers.

Standard 44 - Premises

The premises are safe, well maintained and remain suitable for their stated purpose.

Criteria

1. The building is kept clean and hygienic at all times in accordance with infection control best practice and is decorated to a standard acceptable for residents. Residents are encouraged to personalise their rooms and, as far as practicable, are involved in discussions regarding re-decorating programmes.
2. The grounds are kept tidy, safe, suitable for and accessible to all residents.
3. The nursing home, including all spaces, is only used for the purposes for which it is registered.
4. Changes to allocated bedrooms are only undertaken in consultation with the resident and the care manager.
5. Security measures are operated that restrict unauthorised access to the home to protect residents and their valuables, the premises and their contents.
6. CCTV is used in compliance with legislation, guidance and best practice in information management and human rights³¹.
7. Catering areas comply with the Food Safety legislation at all times and reports from the Environmental Health Department are made available to the RQIA.

³¹ Guidance can be obtained from RQIA at: <https://www.rqia.org.uk/RQIA/files/a9/a902520c-ab06-460a-b80d-472f8f98165b.pdf>

8. The premises, engineering services, plant and care equipment are kept safe and suitable and maintained in line with the relevant statutory requirements, approved codes of practice and the manufacturers' and installers' instructions.
9. Waste is segregated appropriately and kept in a secure identified areas outside and all waste receptacles are kept locked at all times.
10. The procedures for maintaining the premises, grounds, engineering services and care equipment are in line with the relevant statutory requirements, approved codes of practice and the manufacturers' and installers' instructions.
11. All proposed changes to the use of any area, the use of any room or the layout of the premises are notified to RQIA in writing for consideration prior to the changes taking place.
12. Notification is submitted to RQIA of any mechanical or engineering failure or fault which impacts on the wellbeing of residents.
13. Any changes made to furniture and fittings in communal and residents' private accommodation meet the standards specified in the requirements for registration of the premises.
14. Provision is made, in accordance with legislation³² and guidance³³, for residents who smoke.

Evidence

- The temperature in areas occupied or used by residents is between 19°C - 22°C.

³² The relevant legislation is The Smoke-free (Exemptions, Vehicles, Penalties and Discounted Amounts) Regulations (NI) 2007 which can be accessed at:
<http://www.legislation.gov.uk/nisr/2007/138/contents/made>

³³ Guidance can be obtained from RQIA at:
http://www.rqia.org.uk/cms_resources/RQIA%20Guidance_Smoking_RCH_NH.pdf

- In extremes of weather, residents are provided with additional appropriate equipment for heating or cooling.
- Furniture, fittings and any equipment or mobility aids in areas accessed by residents are positioned to take into account the mobility and overall needs of the residents, including those with sensory impairments.
- The temperatures at all hot water outlets at wash hand basins, showers and baths accessible to residents are maintained in accordance with the Safe Hot Water and Surface Temperature Health Guidance Note.
- Records are kept of all maintenance and servicing work undertaken, and all required maintenance certificates and documents are available for inspection.
- There is evidence of a planned programme of continuous improvement to the environment.

Standard 45 - Medical Devices and Equipment

Medical devices and equipment provided for residents' treatment and care are used safely.

Criteria

1. There is a written policy and procedures for the use of medical devices and equipment in line with best practice guidance³⁴ - including policies for decontamination and disposal.
2. Staff have up to date knowledge and skills in using medical devices and equipment for the provision of treatment and care. There is a record of the training provided and competency demonstrated in the use of medical devices and equipment. Manuals are retained and are easily accessible by all staff.
3. Medical devices and equipment that are designated for single use are not re-used under any circumstances.
4. Any contaminated re-useable medical devices and equipment are handled, collected and prepared for transportation in a manner that avoids the risk of contamination to handlers, residents and staff.
5. Decontamination of re-useable medical devices is carried out in line with current best practice and standards and related records kept.
6. All medical devices and equipment 'on loan' are maintained in good condition and are returned promptly after use. All relevant records are retained for inspection.

³⁴ Guidance for the Management of Medical Devices can be accessed at: <http://www.dhsspsni.gov.uk/dbni-2014-02.pdf>

7. There are processes in place for the servicing; reporting of incidents; accidents; and near misses. There is evidence of staff learning from such incidents (such as staff meetings or safety briefings).

Standard 46 - Infection Prevention and Control

There is a managed environment that minimises the risk of infection for staff, residents and visitors.

Criteria

1. Responsibility for infection prevention and control is clearly defined; there are clear lines of accountability throughout the home; and key members of staff have responsibility for the implementation of infection prevention and control policies and procedures. These policies and procedures reflect DHSSPS policy and PHA best practice guidance in this area.
2. There is an established system to assure compliance with best practice in infection prevention and control within the home. This includes assurance of best practice in hand hygiene; personal care; use of devices; environmental cleaning; use of personal protective equipment; decontamination; and antimicrobial stewardship.
3. Findings of audit and assessment of best practice for infection prevention and control within the home are regularly reported to and discussed with the Registered Person and Registered Manager. Findings are also regularly shared with staff, visiting healthcare providers, residents (as appropriate) and relatives.
4. All staff, including those employed in support services, receive mandatory education and training in infection control that is commensurate with their work activities and responsibilities and is regularly updated.
5. There is an identified nurse with day-to-day responsibility for monitoring compliance with infection and prevention control procedures such as hand decontamination; the use of protective clothing; and the safe disposal of sharps.

6. There are written guidelines for staff on making referrals to infection control nurses and public health professionals, who have expertise in infection prevention and control, for expert advice and support.
7. There are clear processes and a documented contingency plan supporting the risk assessment and management of outbreaks of infection occurring within the home (including, but not limited to, influenza outbreaks).
8. Outbreaks of infection are managed in accordance with the home's procedures, and are promptly reported to the PHA Duty Room and RQIA. Accurate records are maintained for all activities relating to outbreak assessment and management.
9. The home provides information on infection prevention and control as requested by the RQIA and outlined in regulations.
10. There is information available on infection prevention and control for residents, their representatives and staff. This is accessible and available in a range of formats and includes any restrictions on visiting or movement within the home during an infection outbreak.
11. Hand hygiene is a priority for the home and every effort is applied to promoting high standards of hand hygiene among residents, staff and visitors. There are wash hand basins, supplies of liquid soap, alcohol hand gels and disposable towels and sharps containers wherever care is delivered.
12. There are arrangements in place for regular hand hygiene audits to ensure standards are being met and maintained.
13. All staff are encouraged to take up seasonal influenza immunisation annually.

Standard 47 - Safe and Healthy Working Practices

The home is maintained in a safe manner.

Criteria

1. There are health and safety procedures which comply with legislation and cover:
 - The maintenance of equipment;
 - Working practices that are safe and without risk to health or welfare;
 - The maintenance of a safe and healthy working environment; and
 - A safe and healthy place of work, with safe access to it and egress from it.

2. There are arrangements in place to ensure the person in charge of the home, at any given time, receives the relevant information to fulfil their health and safety responsibilities.

3. The Registered Person promotes safe and healthy working practices through the provision of information, training, supervision and monitoring of all staff in the following areas:
 - Fire safety;
 - Carbon monoxide levels;
 - Infection prevention and control;
 - Moving and handling;
 - First aid;
 - Accident and incident prevention;
 - Food hygiene;
 - Control of Substances Hazardous to Health (COSHH);
 - Maintenance and use of all equipment and machinery;
 - A safe and healthy work environment and safe systems of work; and
 - A safe place of work, with safe access to it and egress from it.

4. There is a designated member of staff to receive and act on health and safety information, and information from the Northern Ireland Adverse Incident Centre (NIAIC). Adverse incidents involving medical devices and equipment are reported to the NIAIC and any required action is managed appropriately.
5. The Registered Person ensures that risk assessments are carried out for every area of work (in liaison with relevant others). The findings of the risk assessments are recorded and action taken to manage identified risks. Risk assessments must be made easily accessible to all staff.
6. Publicly displayed health and safety procedures are in formats that are easily understood and take account of the special communication needs of people using the building.
7. Staff are provided with appropriate protective clothing and equipment suitable for the job, to prevent risk of harm, injury or infection to themselves or others.
8. The home has arrangements in place to provide staff with access to occupational health services when necessary.
9. All records pertaining to health and safety issues are maintained and available for inspection.

Standard 48 - Fire Safety

Precautions are in place that minimise the risk of fire and protect residents, staff and visitors in the event of fire.

Criteria

1. There is a current fire risk assessment and fire management plan that is revised and actioned when necessary or whenever the fire risk has changed.
2. The organisation's premises meet the minimum physical statutory requirements laid down in the Fire and Rescue Services (NI) Order 2006, the Fire Safety Regulations (NI) 2010 and the Health and Safety (Safety Signs and Signals) Regulations (Northern Ireland) 1996 and the organisation has access to up-to-date fire safety legislation, Approved Codes of Practice, the NI Firecode, British Standards and other guidance relating to fire safety.
3. The organisation's physical fire safety infrastructure is maintained and tested in accordance with legislation, Approved Codes of Practice, British Standards and/or manufacturer's guidelines.
4. Actions recommended following fire inspections are undertaken. The Registered Person sends any report made by inspectors that highlights areas for action following an inspection by them to the RQIA as well as evidence that actions have been completed.
5. There are measures in place to avoid/minimise false alarms being generated from their Automatic Fire Alarm Systems which result in disruption within the home and the unnecessary mobilisation of Fire and Rescue service resources.
6. All staff have training in the fire precautions to be taken or observed in the home, including the action to be taken in case of fire. This training is provided

by a competent person at the start of employment and is repeated at least twice every year.

7. There is an identified competent person who is responsible for fire safety in the home. There are arrangements in place to ensure that the nurse in charge of the home at any given time has relevant information to fulfil his or her fire safety responsibilities.
8. All staff participate in a fire evacuation drill at least once a year. Action taken on problems or defects is recorded.
9. All records with respect to fire safety are maintained and available for inspection

SECTION 2

REQUIREMENTS FOR REGISTRATION

Registration

This section sets out the requirements that must be met by providers of nursing homes to obtain registration. Articles 12 to 22 of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003 deal with registration and should be read in conjunction with this section.

The home must have a Statement of Purpose and an Operational Policy. The Statement of Purpose defines what services and facilities the home will provide whilst the Operational Policy describes how they will be provided.

An individual who intends to carry on a home must be registered with the RQIA, and is referred to as the “Registered Person”. An organisation that intends to carry on a nursing home is required to nominate one person to be registered on behalf of the organisation.

The manager of the home must be registered and is referred to as the “Registered Manager”. The Registered Person may also be the Registered Manager. Those applying for registration as the Registered Person and/or the Registered Manager must meet the relevant criteria for fitness of these positions.

The design and construction of the home and grounds must be suitable for their stated purpose and provide a comfortable, safe and enabling environment.

The environmental requirements are separated into:

1. **Standards for new buildings.** These will apply to new buildings that require to be registered as nursing homes and to new extensions to any existing registered home; and
2. **Standards for existing buildings.** These will apply to buildings that already operate and are registered as nursing homes. These standards also apply to existing registered nursing homes seeking re-registration after changing ownership.

There must be evidence that the following requirements are met prior to homes and persons being registered.

Statement of Purpose

Part 1

The written Statement of Purpose for the home includes the following information:

- Details of the person or organisation with overall responsibility for the home;
- The status and constitution of the home;
- The organisational structure of the home;
- The aims and objectives of the home;
- The philosophy of care;
- The services and facilities provided by the home; and
- The number of residents and the categories of care to be accommodated or provided with services.

Part 2

The Operational Policy for the home which includes the following:

- The arrangements in place to ensure the fitness of persons to work at the home;
- The arrangements in place to ensure the adequacy of numbers of persons working in the home;
- Admission arrangements for residents, including the residents' guide;
- The arrangements for safeguarding;
- The arrangements in place for promoting the health and well-being, and spiritual needs of the resident;
- The arrangements for the training and development of people who work in the home;
- The care planning process;
- The arrangements for securing health and social care services;
- The arrangements for the management and control of the home;

- The accounting and financial control arrangements for the home;
- The insurance arrangements (Independent sector only);
- The arrangements for the keeping of documents and records;
- The arrangements for the notification of reportable events;
- The arrangements for dealing with complaints and the steps for publicising the arrangements;
- The arrangements for the management of medicines;
- A fire safety management plan that demonstrates compliance with 'fire code' and The Fire Precautions (Workplace) Regulations (Northern Ireland) 2001, based on the findings from a risk assessment carried out against HTM 84 or an equivalent;
- A written agreement or contract detailing the responsibilities of each party involved for the maintenance, safety and fire precautions for the property where the Registered Person does not own the building; and
- The policies and procedures listed in Appendix 2.

Fitness of the Registered Person

To determine the fitness of the person applying for registration, the following are required:

- Two satisfactory written references;
- A pre-employment health assessment;
- AccessNI checks (where applicants come from countries outside the United Kingdom, pre-employment checks are carried out with the national agency in the country of origin);
- Documentary evidence of qualifications (if any) and registration with any professional regulatory body;
- Confirmation of identity;
- Financial / business plan; and
- Adequate insurance arrangements.

In addition, the RQIA is assured through the registration process that the person or organisation:

- Has knowledge and understanding of his or her legal responsibilities;
- Intends to carry on the establishment in accordance with legislative requirements, DHSSPS Minimum Standards, and other standards set by professional bodies and standard setting organisations;
- Intends to undertake update training to ensure he or she has the necessary knowledge and skills; and
- Will adhere to the professional codes of conduct / practice of relevant regulatory bodies.

Fitness of the Registered Manager

To determine the fitness of the person applying for registration as the Registered Manager, the RQIA is assured through the registration process that the person:

- Is a first level nurse with current registration on Part 1 of the NMC Register;
- Has at least 5 years' post-qualification experience, 2 of which have been in a similar care setting within the last 5 years;
- Has at least 2 years' experience, within the last 5 years, in a similar care setting providing nursing care to the main client group accommodated within the home; and
- Has a management qualification or 2 years' relevant managerial experience at Band 6 level (or suitable equivalent), gained within the last 5 years.

The following are also required:

- Confirmation of identity;
- Two written references linked to the requirements of the job, one of which is from the applicant's present or most recent employer. Where the last employer has been via an agency, the substantive employer (ie the last home) must also be asked for a reference;
- A full employment history, including history of management experience within health and social care together with a written explanation of any gaps in employment;
- Satisfactory AccessNI checks (where applicants come from countries outside the United Kingdom, pre-employment checks are carried out with the national agency in the country of origin);
- Documentary evidence of professional and vocational qualifications;
- Confirmation of registration with NMC;
- A pre-employment health assessment; and
- Confirmation of current status of work permit / employment visa.

In addition, the RQIA is assured through the registration process that the person:

- Has knowledge and understanding of his or her legal responsibilities;
- Intends to carry on the establishment in accordance with legislative requirements, DHSSPS Minimum Standards, and other standards set by professional bodies and standard setting organisations;
- Intends to undertake update training to ensure he or she has the necessary knowledge and skills; and
- Will maintain registration with NMC and adhere to the Code of Professional Conduct.

Fitness of the premises – New homes and those registered since February 2008

The following set of requirements (N1 – N65) applies to **new buildings and to those registered since February 2008**.

Premises and grounds

- N1. The building and grounds are designed to comply with all current relevant legislation and guidance documents. Certificates and commissioning documents with regard to engineering services and plant, and approval letters and letters certifying completion of works from other agencies and authorities confirm this.
- N2. There are car parking spaces for residents, visitors and staff consistent with the number of residents that the home will be registered for and the number of people employed in the home.
- N3. There is clear access to and egress from the home for emergency and other vehicles, and there are suitably sized turning spaces for service vehicles using the site.
- N4. There are areas for residents to get on and off transport safely that are illuminated and offer some protection against the elements.
- N5. There is safe outdoor space with seating, accessible to all residents including those with physical disability or sensory impairment. The outdoor environment promotes leisure and therapeutic opportunities and stimulates sociable activity for all residents. In homes registered to accommodate people with dementia, there is a secure perimeter.
- N6. The doorways in areas accessed by residents have a clear opening width of at least 800mm, but where residents need assistance when walking or use wheelchairs, wider doorways need to be considered.

Corridor doors have vision panels and in homes where residents need assistance when walking or use wheelchairs, there are level access thresholds at all doors.

- N7. The minimum corridor width in areas accessed by residents is 1.2m unobstructed between handrails, but where residents need assistance when walking or use wheelchairs, a minimum width of between 1.5m and 1.8m is recommended.
- N8. All areas occupied or used by residents are accessible to them through the provision, where necessary, of ramps, lifts (large enough to accommodate a stretcher), other facilities and signage.
- N9. There are suitably positioned hand and grab rails, moving and handling equipment, ambulatory aids, communication aids and other equipment including assistive technology, which meet the general needs of the resident group and promote independence in all the areas occupied or used by residents.
- N10. Resident/staff call points, accessible to residents, are provided in every room used by residents and linked to a system that alerts staff a call is being made or assistance is required.
- N11. There is both natural and good quality artificial lighting in all areas suitable for the needs of residents and any activities planned for each room. The artificial lighting in areas used by residents is domestic in character, sufficiently bright and positioned to facilitate reading and other activities. The recommended lighting level in toilets is between 100-200 lux, and in bedrooms it is recommended that dimmable lighting is installed that provides levels between 0-400 lux. Motion sensor lighting may be considered in bathroom and corridor areas.
- N12. All areas used by residents are naturally ventilated, have opening windows with safety glazing and guarding where necessary. The height

of the windowsill affords an unobstructed view when the residents are seated. Window openings are controlled to a safe point of opening of no more than 100mm and cannot be overridden by residents. Frosted or obscured glass is fitted as required to ensure privacy. The effects of light pollution should be considered when positioning external lighting.

- N13. The heating system can be controlled within safe limits for the residents' comfort in areas accessed and used by them, and is able to provide a range of temperatures throughout the home. Each room accessed or used by residents has a wall-mounted thermometer. Pipework and radiators are guarded or have guaranteed low temperature systems.
- N14. Furniture and fittings in communal rooms are domestic in character, are suitably designed for both the activities that take place in the room and the client group who will use them. They must incorporate ergonomic design principles that promote user independence and safe moving and handling procedures. Any moving and handling equipment or mobility aids should be positioned or stored in an appropriate area and take account of the collective and individual mobility needs of the residents, including those with sensory impairments.
- N15. Floor coverings, wall finishes and soft furnishings are suitable for the purpose of each room and meet health and safety and infection control requirements. Finishes that produce glare, dazzle and optical illusions are avoided, and where residents use wheelchairs, floor coverings have non-directional pull. According to the statement of purpose and needs of residents, for example those with a visual impairment, changes in the texture of floor coverings or other indicators should be considered to identify key areas in the home, for example doorways, or the top or bottom of stairs.
- N16. There are arrangements in place to ensure the home can operate in the event of a utility service failure.

Communal space

- N17. There is communal space (excluding corridors and circulation areas) amounting to at least 4.00m² for each resident. This allows for dining space of at least 1.5 m²/person and sitting space of approximately 2.5m²/person.
- N18. The communal space includes a range of rooms that can be used for a variety of activities, and where the varied needs of residents can be met. This includes:
- A room where meetings can take place in private;
 - Dining rooms to cater at any one time for all residents;
 - A facility for residents to make or get drinks and snacks; and
 - A room where telephone calls can be made or received in private.
- N19. Where residents cannot access a local hairdresser or barber, there is a hairdressing facility in the home.

Residents' bedrooms /private accommodation

- N20. All accommodation is provided in single bedrooms. However, to accommodate persons wishing to share bedrooms, two adjoining bedrooms with a connecting half hour fire resistant soundproofed door or movable partition can be provided. Furniture is suitable for the size of the room and allows all equipment to be used safely.
- N21. The minimum useable floor space (excluding ensuite facilities) is 12m², except in homes that are registered specifically for residents with physical disability, where the minimum useable floor space (excluding ensuite facilities) is 20m².

- N22. There is a minimum ceiling height of 2.4m, and room dimensions allow for a minimum space of 2.00ms on one side and 0.8 ms on the other side of the bed to promote when necessary, safe handling of residents, and access for any equipment needed.
- N23. The installation of ensuite facilities is in addition to the minimum useable floor space standard in any resident's bedroom.
- N24. The height of the windowsill affords a view when the resident is seated or in bed.
- N25. Where the home provides furniture in residents' private accommodation, these rooms contain all of the following unless the resident wishes otherwise:
- A suitable bed at a height for safe handling of residents with mattress and accessories suitable for the assessed needs of residents;
 - A mirror of suitable size at an appropriate height;
 - Overhead and bedside or wall lighting;
 - Suitable seating for the resident's use with seating available for visitors;
 - Drawers or built in shelving;
 - An enclosed space for hanging clothes;
 - A tabletop facility;
 - A lockable storage space; and
 - A bedside cabinet.
- N26. Furniture and fittings are safely secured and positioned to take into account the mobility and overall needs of the residents. Wardrobes are secured to walls for safety.
- N27. The positioning of telephone, television aerial points and light switches are considered so that they are suitable for the resident to control. A

minimum of 4 double electrical socket outlets is recommended for each bedroom.

- N28. Doors are fitted with appropriate master key locks, with an easy opening (thumb-turn) device fitted to the inside of the door.

Toilet and washing facilities

- N29. A range of toilet, washing, bath and shower facilities (including assisted facilities) are provided to meet the needs of residents and a toilet facility is available for use by visitors.

- N30. Ensuite facilities (minimum of a toilet and wash hand basin) are provided in all residents' private accommodation.

- N31. There is a minimum of 2 separate toilets and 1 assisted toilet to 5 residents, with a minimum of 1 facility per floor. Each toilet facility, including en-suite facilities:

- Is clearly marked and conveniently located to communal rooms;
- Is fully and separately enclosed;
- Has suitable hand washing and drying facilities to meet infection control guidelines;
- Has an accessible call system; and
- Has a door that opens outwards.

Toilets for ambulant, semi and assisted-ambulant people are a minimum of 3m². Toilets for people who use a wheelchair independently or require the assistance of one person are a minimum of 4.5m² and at least 2m long. Toilets for people who use a wheelchair and require the assistance of two people are a minimum of 5.5m² and at least 2m long.

- N32. Where suitably adapted ensuite bathing or shower facilities are provided in residents' private accommodation, there is 1 assisted bathroom or

shower room per floor. Where there are no suitably adapted ensuite bathing or showering facilities, there is a ratio of 1 assisted bathroom or shower room to 8 residents. Bathrooms for ambulant people, people who require assistance and people who use a wheelchair independently are a minimum of 8.5m². Bathrooms for people who require the use of a hoist are a minimum of 16m². Shower rooms for ambulant people, people who require assistance and people who use a wheelchair independently are 7m² (non-linear layout) and 7.5 m² (linear layout), and are level access.

N33. Locks and handles on toilets, bathroom and shower room doors are easy to operate and allow staff immediate access in an emergency. Hand rails are in place in toilets and bathrooms.

Medicines

N34. There is an identified area where medicines can be stored in accordance with the manufacturers' instructions. This has:

- Cupboards conforming to British Standards for the storage of medicines;
- Space to safely store, access and administer medicines and medicinal products in accordance with current policy and legislation;
- Sufficient work surfaces for the tasks required;
- Hand washing facilities in close proximity that meet infection prevention and control guidelines; and
- Facilities for disposal of medication should be available in accordance with current policy and legislation.

N35. There is a controlled drug cabinet that complies with the Misuse of Drugs (Safe Custody) (Northern Ireland) Regulations 1973 for the storage of any Schedule 2 and Schedule 3 controlled drugs subject to safe custody requirements.

N36. Where necessary, there is a lockable trolley or trolleys for administration of medicines.

Clinical or treatment room

N37. There is a clinical or treatment room with facilities in place so that procedures such as application of dressings, health checks or podiatry treatments can be carried out. Certain procedures can be undertaken in the resident's single room.

N38. The clinical room is fully equipped with appropriate diagnostic and clinical equipment to meet the home's statement of purpose and residents' care needs. (See Appendix 3)

N39. The clinical or treatment room has a clinical hand washing facility. There is a range of high and low level lockable cupboards for the safe, secure storage of clinical equipment, and approved containers for the collection, storage and disposal of clinical waste including sharps.

Infection prevention and control

N40. There is hand-washing equipment (wash hand basins, liquid soap dispensers, disposable paper towels and pedal operated bins) in all areas where care is provided. Hand sanitizers are in place throughout the home.

N41. Approved containers that are suitable for the type of waste generated are provided in all areas of the home. Waste audit data is recorded and available for inspection.

N42. Wheeled bins for clinical waste are provided that allow for 'single handling' of the waste in a secure outside area.

Sluice rooms - Dirty Utility

- N43. Sluice rooms are located away from communal areas, residents' private accommodation and areas where food is stored, prepared, cooked or eaten.
- N44. Sluice rooms are ventilated, lockable and equipped with facilities for disposal of clinical waste including disposable continence products, and for cleaning and disinfecting soiled items in accordance with relevant guidelines. A lockable COSHH cupboard should be located in this room
- N45. Separate hand-washing facilities that meet infection prevention and control guidelines are provided in sluice rooms.
- N46. There is adequate storage in sluice rooms for bedpans, urinals and disposable continence products.

Laundry

- N47. The laundry is located away from communal areas, residents' private accommodation and areas where food is stored, prepared, cooked or eaten. The location of the laundry ensures that dirty laundry is not transported through day or dining areas. The laundry is suitably ventilated and allows for the separation of soiled items from clean clothes and linen.
- N48. Laundry equipment includes a sink with drainer, washing machine with a sluicing facility and a specified programme to meet disinfection standards, and a tumble drier that is vented externally.
- N49. There are facilities for ironing and separately stacking individual resident's personal laundry prior to distribution.

N50. Separate hand-washing facilities that meet infection prevention and control guidelines are provided in laundries. The laundry operates a dirty-clean workflow.

Catering areas

N51. The catering facilities and equipment are adequate for the method of food provision and for the number of residents the home will be registered to accommodate. Consideration is given to the provision of separate cooking areas to accommodate specific cultural or religious catering needs.

N52. Catering areas comply with the Food Hygiene legislation. All relevant records are maintained and available for inspection.

Storage

N53. There is provision for the secure storage of all required records.

N54. Secure facilities are provided for the safekeeping of money and valuables held on behalf of residents.

N55. There are separate recessed areas designated as storage space for wheelchairs on every floor and in close proximity to communal areas and residents' private accommodation.

N56. Storage space is provided for residents' belongings that cannot be kept in their rooms. Personal items must be easily identifiable as belonging to one particular resident.

N57. There is storage space for reserve linen and bedding.

N58. There is storage space for cleaning materials and equipment that is ventilated and lockable. In large facilities, there is a cleaner's store with

separate hand-washing facilities that meet infection prevention and control guidelines. (An average size for a storeroom for cleaning materials is between 5.5m² and 7.5 m²).

- N59. Gas and other fuel storage facilities comply with any relevant legislative requirements and good practice guidance.
- N60. There is external storage space for garden furniture, equipment and other items.
- N61. Where necessary, there is an area for charging batteries for equipment.

Staff facilities

- N62. There are staff facilities, including at least one office, consistent with the required number of people employed in the home.
- N63. Nurses' stations are provided on each floor in close proximity to resident areas. The number of nurses' stations is dependent on the number of residents to be accommodated, category of care and the layout of the Home.
- N64. Staff rest with lockable lockers consistent with the required number of people on duty at any time
- N65. Staff WCs and shower should be available.

Fitness of the premises – Homes registered prior to February 2008

The following set of requirements (E1 – E57) applies to **homes registered prior to 2008**.

General premises and grounds

- E1. The building and grounds comply with relevant legislation and to a reasonable degree with guidance documents. Certificates and commissioning documents with regard to engineering services and plant, and approval letters and, if appropriate, letters certifying completion of works from other agencies and authorities confirm this.
- E2. Car parking spaces are available unless the location and site prevent this.
- E3. Emergency vehicles and other vehicles have access to and egress from the home.
- E4. There are illuminated areas for residents to get on and off transport safely that, where possible, provide protection against the elements.
- E5. Where possible, there is safe outdoor space with seating, accessible to all residents. In homes that accommodate people with dementia, there is a secure perimeter.
- E6. The RQIA approve the width of doorways and corridors so that all areas occupied or used by residents are accessible to them through the provision of (where necessary) ramps, passenger lifts, other facilities and signage.
- E7. There are suitably positioned hand and grab rails, moving and handling equipment, ambulatory aids, communication aids and other equipment including assistive technology, which meet the general needs of the

resident group and promote independence in all the areas occupied or used by residents.

- E8. Resident/staff call points, accessible to residents, are provided in every room used by residents and linked to a system that alerts staff a call is being made or assistance is required.
- E9. There is both natural and good quality artificial lighting in all areas suitable for the needs of residents and any activities planned for each room. The artificial lighting in areas used by residents is domestic in character, sufficiently bright and positioned to facilitate reading and other activities. The recommended lighting level in toilets is between 100-200 lux.
- E10. All areas used by residents are naturally ventilated, have opening windows with safety glazing and guarding where necessary. Areas not naturally ventilated have mechanical ventilation. Window openings are controlled to a safe point of opening of not more than 100mm and cannot be overridden by residents. Frosted or obscured glass is fitted as required to ensure privacy.
- E11. The heating system can be controlled within safe limits for the residents' comfort in areas accessed and used by them, and is able to provide a range of temperatures throughout the home. Each room accessed or used by residents has a wall-mounted thermometer. Pipework and radiators are guarded or have guaranteed low temperature systems.
- E12. Furniture and fittings in communal rooms are domestic in character, are suitably designed for the activities that take place in the room and incorporate ergonomic design principles that promote user independence and safe handling. They, and any equipment or mobility aids, are positioned to take into account the mobility and overall needs of the residents, including those with sensory impairments. Mobility aids have washable coverings.

- E13. Floor coverings, wall finishes and soft furnishings are suitable for the purpose of each room and meet health and safety and infection control requirements. Finishes that produce glare, dazzle and optical illusions are avoided and, where reasonably possible, when residents use wheelchairs, floor coverings have non-directional pull. According to the statement of purpose and the needs of residents, for example, those with a visual impairment, changes in the texture of floor coverings or other indicators should be considered to identify key areas in the home, for example doorways or the top or bottom of stairs.
- E14. There are business continuity arrangements in place to ensure the home can operate in the event of an unplanned event.

Communal space

- E15. The RQIA approve the amount of communal space, which, where reasonably possible, amounts to at least 3.7m² for each resident (excluding corridors and circulation areas). This allows for dining space of approximately 1.4m²/person and sitting space of approximately 2.3m²/person.
- E16. The communal space includes rooms that can be used for a variety of activities and where the varied needs of residents can be met. This includes:
- A room where meetings can take place in private;
 - Dining room/rooms; and
 - A place where telephone calls can be made or received in private.
- E17. Where reasonably possible and risk assessed, a facility for residents to make drinks or snacks is provided.

Residents' bedrooms /private accommodation

- E.18 At least 80% of residents are accommodated in single bedrooms. Where a home did not provide this proportion of its places in single bed accommodation (at the date of its registration with the RQIA), it must, at the least, continue to provide the same percentage of places in single bedrooms as it provided at the date of its registration. These homes should work towards achieving the 80% standard for places in single bedrooms. Shared rooms are occupied by residents who have made a positive choice to share with each other. Residents sharing double/twin bedrooms are given the opportunity to move to a single room when one becomes available. Rooms accommodating more than two residents are not acceptable.
- E19. The minimum useable floor space in residents' private accommodation is at least 16m² in a double room. Where provided, ensuite facilities are additional to the minimum useable floor space standard in any resident's room. Where 11.5m² or more of useable floorspace was provided in residents' private single bedroom accommodation (at the date of the home's registration with the RQIA), that amount of space is continued to be provided. Where less than 11.5m² was provided at the date of registration, the home, at the least, continues to provide the same useable floorspace in these rooms as it provided at the date of registration with the RQIA. In bedrooms accommodating wheelchair users, the minimum useable floorspace is 12m². Information on room size is set out in the "Residents' Guide."
- E20. Where the home provides furniture in residents' private accommodation, these rooms contain all of the following unless the resident wishes otherwise:
- A suitable bed at a height for safe handling of residents with mattress and accessories suitable for the assessed needs of residents;

- A mirror of suitable size at an appropriate height;
- Overhead and bedside lighting;
- Suitable and comfortable seating for the resident's use with seating available for visitors;
- Drawers or built in shelving;
- An enclosed space for hanging clothes;
- A tabletop facility;
- A lockable storage space;
- A bedside cabinet; and
- A wash hand basin if no ensuite is provided.

E21. Furniture and fittings are safely secured and positioned to take into account the mobility and overall needs of the residents. Wardrobes are fixed to walls for safety.

E22. The layout of the furniture in the room ensures, when necessary, there is room on each side of the bed to promote safe handling of residents and access for any equipment needed.

E23. The RQIA approves the arrangements for existing and replacement locks on doors.

Toilet and washing facilities

E24. A range of toilet, washing, bath and shower facilities (including assisted facilities) are provided to meet the needs of residents so that, where reasonably possible, there is a ratio of 1 assisted bathroom or shower room to 8 residents and 1 assisted toilet to 5 residents, with a minimum of 1 of each of these facilities per floor. Where suitably adapted ensuite bathing or shower facilities are provided in residents' private accommodation, these facilities will be taken into consideration in the calculation of the overall requirements, however these facilities continue

to be for the sole use of that resident. A toilet facility is identified for use by visitors.

E25. Each toilet facility has provision for suitable hand washing and drying facilities to meet infection control guidelines, an accessible call system and, where reasonably possible, is self-contained. Hand rails are in place for safety and independence.

E26. Locks and handles on toilets, bathroom and shower room doors are easy to operate and allow staff immediate access in an emergency.

Medicines

E27. There is an identified area where medicines can be stored in accordance with the manufacturers' instructions. This has:

- Lockable cupboards for the storage of medicines;
- Space to safely store, access and administer medicines and medicinal products in accordance with current policy and legislation;
- Sufficient work surfaces for the tasks required;
- Hand washing facilities in close proximity, which meet infection prevention and control guidelines; and
- Facilities for disposal of medication should be available in accordance with current policy and legislation.

E28. Where necessary, there is a controlled drug cabinet that complies with the Misuse of Drugs (Safe Custody) (Northern Ireland) Regulations 1973 for the storage of any Schedule 2 and Schedule 3 controlled drugs subject to safe custody requirements.

E29. Where necessary, there is a lockable trolley or trolleys for administration of medicines.

Clinical or treatment room

- E30. There is a clinical or treatment room with facilities in place so that procedures such as application of dressings, health checks or podiatry treatments can be carried out. Where a resident has a single room, the majority of treatments can be undertaken in that room.
- E31. The clinical room is fully equipped with appropriate diagnostic and clinical equipment to meet the home's statement of purpose and residents' care needs. (See Appendix 3)
- E32. The clinical or treatment room has a clinical hand washing facility. There is a range of high and low level lockable cupboards for the safe, secure storage of clinical equipment, and approved containers for the collection, storage and disposal of clinical waste including sharps.

Infection prevention and control

- E33. There is hand-washing equipment (wash hand basins, liquid soap dispensers, paper towels and pedal operated bins) in areas where care is provided. Hand sanitizers are available throughout the home.
- E34. Approved containers are provided in all areas of the home that are suitable for the type of waste generated. Waste audit data is recorded and available for inspection.
- E35. Wheeled bins for clinical waste are provided that allow for 'single handling' of the waste in a secure outside area.

Sluice rooms – Dirty Utility

- E36. Sluice rooms are located away from communal areas, residents' private accommodation and areas where food is stored, prepared, cooked or eaten.

- E37. Sluice rooms are ventilated, lockable and equipped with facilities for disposal of clinical waste including disposable continence products, and for cleaning and disinfecting soiled items in accordance with relevant guidelines. A lockable COSHH Cupboard is located within this room.
- E38. Separate hand-washing facilities that meet infection prevention and control guidelines are provided in sluice rooms.

Laundry

- E39. The laundry is located away from areas where food is stored, prepared, cooked or eaten. It is suitably ventilated and the space allows for separation of soiled articles from clean clothes and linen.
- E40. Laundry equipment includes a sink with drainer, washing machine with a sluicing facility and a specified programme to meet disinfection standards, and a tumble drier that is vented externally.
- E41. There are facilities for ironing and separately stacking individual resident's personal laundry prior to distribution.
- E42. Separate hand-washing facilities that meet infection prevention and control guidelines are provided in close proximity to the laundry.

Catering areas

- E43. The catering facilities and equipment are adequate for the method of food provision and for the number of residents the home accommodates. Consideration is given to the provision of separate cooking areas to accommodate specific cultural or religious catering needs.
- E44. Catering areas comply with the Food Hygiene legislation. All relevant records are maintained and available for inspection.

Storage

- E45. There is provision for the secure storage of all required records.
- E46. Secure facilities are provided for the safekeeping of money and valuables held on behalf of residents.
- E47. Where possible, storage space for wheelchairs is in close proximity to communal areas and residents' private accommodation.
- E48. Where possible, there is secure storage space for residents' belongings that cannot be kept in their rooms. Personal items must be easily identifiable as belonging to one particular resident.
- E49. There is storage space for reserve linen and bedding.
- E50. There is storage space for cleaning materials and equipment that is ventilated and lockable. Where possible, it has a bucket sink.
- E51. Gas and other fuel storage facilities comply with any relevant legislative requirements and good practice guidance.
- E52. Where possible, and if necessary, there is external storage space for garden furniture and equipment.
- E53. Where possible, and if necessary, there is an area for charging batteries for equipment.

Staff facilities

- E54. There are staff facilities, including at least one office, consistent with the required number of people employed in the home.

- E55. Nurses' stations are provided on each floor in close proximity to resident areas. The number of nurses' stations is dependent on the number of residents accommodated, category of care and the layout of the Home.
- E56. Staff rest with lockable lockers consistent with the required number of people on duty at any time.
- E57. Staff WCs and shower should be available.

APPENDICES

APPENDIX 1: Register of Residents

The register of residents will include the following information in respect of each person accommodated in the home:

1. The name, address, date of birth and marital status of each resident and whether he or she is the subject of a court order or any other process.
2. The name, address and telephone number of the resident's next of kin or of any person authorised to act on their behalf.
3. The name, address and telephone number of the resident's general practitioner and of any officer of a HSC Trust whose duty it is to supervise the welfare of the resident.
4. The date on which the resident was admitted to the home.
5. The date on which the resident was discharged from the home.
6. If the resident is transferred to a hospital or other establishment, the date of, and the reasons for, the transfer and the name of the hospital or establishment to which the resident is transferred.
7. If the resident died in the home, the date, time and cause of death and the name of the medical practitioner who certified the cause of death.
8. If the resident has been received into guardianship under Article 18 or 44 of the Mental Health (NI) Order 1986 (a), the name, address and telephone number of the guardian, the name, address and telephone number of any officer of a Trust required to supervise the welfare of the resident and, if the guardian is a Trust, the officer of a Trust nominated to carry out its duties as guardian.
9. The name and address of any Trust, organisation or individual who arranged the resident's admission to the home.

APPENDIX 2: Policies and Procedures

The following policies and procedures are associated with the minimum standards and are required to be in place in nursing homes:

Absence of the Registered Manager
Accounting and financial control arrangements
Accidents and adverse incidents
Advance directives
Alcohol in the home
Arrangements for admission, acceptance, transfer and discharge of residents
Clinical nursing procedures
Comfort fund
Communication
Competency and capability assessment for nurse in charge
Complaints
Completion of case records
Confidentiality
Consent
Continence management
Dealing with alert letters issued by DHSSPS and NMC
Decontamination
Delivering bad news
Deprivation of liberty
Dying and death
Emergency or unplanned admissions
Falls prevention
Fire precautions
First aid
Food hygiene
Gifts to staff and donations to the home
Human Rights
Infection prevention and control
International recruitment of nurses

Inspections of the home
Insurance arrangements
Involvement
Keys for residents' accommodation/bedrooms
Maintenance of equipment, plant, premises and grounds
Management, control and monitoring of the home
Management of keys
Management of medicines
Management of records and information
Management of risks associated with care of individual residents
Meals and mealtimes
Medical devices and equipment including disposal
Meeting residents' safety needs
Missing items
Missing residents
Moving and handling
Noise management
Nutrition
Occupational health arrangements
Operational policy
Prevention and treatment of pressure ulcers
Provision of nursing care – assessment, planning, implementing and reviewing
Programme of activities and events
Promoting residents' health and welfare
Provision for residents' personal furniture
Quality improvement
Referral arrangements to relevant health and social care professionals
Reporting, recording and notifying accidents, incidents, infectious diseases and deaths
Research
Residents' agreement
Residents' guide
Residents' clothing and personal laundry arrangements
Residents' meetings and forums

Residents' money and valuables
Residents' referral arrangements
Responding to residents' behaviour
Restrictive practice
Resuscitation
Review and revision of policies and procedures
Reviewing resident placements
Risk assessment and management
Safe and healthy working practices
Safeguarding
Scheme for the Issue of Alert Notices as per DHSSPS circular HSC JNF (1) 2010
Security of the home
Smoking
Spiritual care for residents
Staffing
Staff handover
Staff induction
Staff discipline and grievance
Staff meetings
Staff performance review
Staff records
Staff uniform
Staff recruitment
Staff supervision and appraisal
Staff training and development
Supervised practice experience for international nurses
Transport and administration of blood and blood products
Transfer and transportation of specimens
Transport arrangements for residents
The organisational structure
Using agency staff
Using and operating medical devices and equipment
Use of restraint
Visits by community groups

Volunteers

Waste management

Whistle blowing

APPENDIX 3: Equipment Requirements for Clinical Rooms

The following items should be provided in a fully equipped clinical room:

General equipment

Oxygen with fittings and safety notice

Basic resuscitation equipment

Anaphylactic kits and current guidelines

Suction machine and catheters

Sterile and non-sterile disposable gloves

Nebulisers, tubing and masks

Drip stands

Medicines fridge - Lockable and record of temperatures available for inspection

Diagnostic equipment

Clinical thermometers

Pencil torch

Blood pressure monitoring equipment

Syringes and needles

Tape measure

Tongue depressors

Scales

Glucose testing equipment

Blood and urine testing equipment

Items and equipment for dressings

Dressing trolley and dressing trays

Clinical waste containers

Sterile dressing packs

Gauze swabs

Scissors

Sterile absorbent dressings

Sodium Chloride 0.9% for irrigation

Adhesive tapes and strapping

Bandages

Promotion of continence and management of incontinence

Continence management products

Urinary catheterisation equipment

Measuring jugs

Urine collection bags etc

APPENDIX 4: Glossary

Agency staff

Staff contracted from a regulated agency to work in the home.

Assessment

Collection and measurement of data to determine a resident's need for health, personal and social care and support services, undertaken with the individual, his/her relatives/representatives, and relevant professionals.

Audit

Systematic review of the procedures that examines how associated resources are used and investigates the effect that care has on the outcome and quality of life for the resident.

Bad news

Any information which adversely and seriously affects an individual's view of his or her future or in situations where there is either a feeling of no hope, a threat to a person's mental or physical well-being, risk of upsetting an established lifestyle, or where a message is given which conveys to an individual fewer choices in his or her life. Bad news situations can include disease recurrence, spread of disease, failure of treatment to affect disease progression, the presence of irreversible side effects, results of genetic tests, or raising the issue of palliative care and resuscitation.

Case records

Records or documents containing information which has been created or maintained as evidence of resident/client care, treatment given, treatment planned.

Controlled drugs

Schedule 2 and 3 controlled drugs are as defined in the Misuse of Drugs Regulations (Northern Ireland) 2002.

Evidence-based (care/practices)

An approach to decision making where a nurse uses the best evidence available, in consultation with residents, their representatives and relevant health care professionals to decide upon the option which suits each resident best.

Holistic care

Care that meets social, psychological, cognitive, emotional, physical and spiritual needs.

Independent Advocacy

Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side.

Advocacy promotes social inclusion, equality and justice. Independent advocacy is used when the advocate is operationally independent from the service provider.

(Advocacy Charter produced by Action for Advocacy)

Life Story Work

Life story work is a loose term used to describe a practical way – based on reminiscence – of assisting an individual to look back, reflect upon their life and to make a record of their experiences. Life story work embraces the idea that each person is unique and is therefore at the heart of person-centred care. The process is as important as the product – promoting communication and providing a means of building confidence and self-esteem; if feeling valued; and preserving and retaining a sense of identity. It offers an opportunity to focus on positive aspects of the person's lifetime achievements rather than current illness, frailty or disability. Having relatives and friends involved in the process is strongly recommended.

Mandatory training

Training that is required by legislation.

Northern Ireland Social Care Council (NISCC)

The regulatory body for the social care workforce in Northern Ireland.

Nursing and Midwifery Council (NMC)

The UK regulatory body that is responsible for education, practice and conduct of nurses and midwives.

Nursing Care Plan (Care Plan)

A written, structured plan of action for care of residents based on holistic assessment of resident care needs, identification of specific care problems and the development of a plan of action for their resolution.

Outcome

The end result of the care provided to a resident. Evaluation of the outcomes of the nursing care plan can be used to measure the effectiveness of the service.

Records

Books, papers, maps, photographs, machine readable materials or other documentation created or maintained as evidence of a business activity, resident/client care, treatment given, treatment planned.

Reminiscence

Reminiscence, “the act or process of recalling the past” (Butler 1963), in this document generally means when a group of people remember and share their past experiences, through some opportunistic or planned process. It is a sociable activity and may occur freely or as a result of using triggers, such as familiar items, or multi-sensory stimulation, which encourage fully people to remember their past, and as a consequence enables them to reflect on and possibly better understand the influences in their lives.

Representative

A person acting on behalf of a resident, who may be a relative or friend.

Restrictive Practice

Interventions that may infringe a person's human rights and freedom of movement, including locking doors, preventing a person from entering certain areas of the living space, seclusion, manual and mechanical restraint, rapid tranquillisation and long-term sedation.

Safeguarding

Adult safeguarding is about the promotion of fundamental human rights, treating all adults with dignity and respecting their right to choose. It includes a range of actions including practical help, care, support and interventions designed to promote the safety and well being of adults that reduce opportunities for harm to occur. The term safeguarding is used to encompass both activity that prevents harm from occurring in the first place and activity that protects adults at risk where harm has occurred.

Screening tool

Aid to assess residents' health status e.g. nutritional screening tool is an aid to assess the nutritional status of residents.

Self-referred resident

A resident who purchases services directly from a nursing home and has not been referred through the HSC Trust care management or other statutory arrangements.

Supervised practice

Process of clinical assessment designed to provide evidence of competence to practise so that the individual's qualification that has been gained abroad is recognised by the NMC after the specified period.

Symptom control

The management of any/all symptoms a resident may experience in order to promote comfort and enhance the quality of life. Symptom control is much more than simply pain relief, although this is an important feature of symptom control.

Trusts (Local and Referring)

Local: The HSC Trust area in which the home is located.

Referring: The HSC Trust responsible for referring the resident to the nursing home.