Secondary Unannounced Care Inspection

Name of Establishment:	**Fruithill Nursing Home**
RQIA Number:	**1253**
Date of Inspection:	**13 January 2015**
Inspector's Name:	**Norma Munn**
Inspection ID:	**17019**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Fruithill Nursing Home
Address:	20 Fruithill Park Andersonstown Belfast BT11 8GD
Telephone Number:	02890 617717
Email Address:	manager@fruithill.com
Registered Organisation/ Registered Provider:	Ms Orla Frances Sheehan
Registered Manager:	Thresia Paily (Acting manager)
Person in Charge of the Home at the Time of Inspection:	Leanne Noble (Registered Nurse)
Categories of Care:	NH-LD, NH-I, NH-PH, NH-PH(E), NH-TI
Number of Registered Places:	35
Number of Patients Accommodated on Day of Inspection:	32 plus 1 day care
Scale of Charges (per week):	£611 - £669 (An additional third party top up charge ranges from £30 – 50 per week depending on the type of bedroom accommodation)
Date and Type of Previous Inspection:	6 June 2014, Secondary unannounced inspection
Date and Time of Inspection:	13 January 2015 10:40 – 17:00 hours
Name of Inspector:	Norma Munn

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

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

4.0 Methods/Process

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

- Discussion with the registered provider
- discussion with staff
- discussion with patients individually and to others in groups
- consultation with relatives
- review of a sample of policies and procedures
- review of a sample of staff training records
- review of a sample of staff duty rotas
- review of a sample of care plans
- review of a sample of staff induction records
- review of a sample of staff competency and capability records
- observation during a tour of the premises
- evaluation and feedback

5.0 Consultation Process

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

Patients/Residents	12 individually and to others in groups
Staff	10
Relatives	4
Visiting Professionals	0

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	5	5
Relatives/Representatives	0	0
Staff	7	7

6.0 Inspection Focus

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible person/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

However, due to workload pressures and contingency measures within the Regulation Directorate, the themes/standards within the self-assessment were not inspected on this occasion.

This inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

Standard 19 - Continence Management

Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

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

Guidance - Compliance Statements		
Compliance Statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Fruithill Nursing Home is situated in Fruithill Park, off the Andersonstown Road, Belfast. The home is convenient to public road transport, shopping areas and community services

The nursing home is owned and operated by Ms Orla Sheehan.

The acting manager is Ms Thresia Paily

Accommodation for patients is provided on both floors of the home. Bedrooms comprise a variety of single, shared and en-suite rooms. Two communal adjoining lounges and the dining room are located on the ground floor. Bath/shower rooms and a number of communal sanitary facilities are available throughout the home. Access to the first floor is via a passenger lift and stairs. The home also provides for catering and laundry services on the ground floor.

The home is surrounded by well-maintained mature gardens and there are car parking spaces to the side of the home.

The home is registered to provide care for a maximum of 35 persons under the following categories of care:

Nursing Care

I	Old age not falling into any other category
PH	Physical disability other than sensory impairment
PH (E)	Physical disability other than sensory impairment over 65 years
TI	Terminally ill
LD	Learning disability (not more than 2 patients at any one time)

8.0 Executive Summary

This unannounced inspection of Fruithill Nursing Home was undertaken by inspector Norma Munn on 13 January 2015 between 10 40 and 17 00 hours. The inspection was facilitated by Ms Leanne Noble, nurse in charge, who was available throughout the inspection. Ms Thresia Paily, newly appointed acting manager was not on duty on the day of the inspection. Verbal feedback was provided to Ms Orla Sheehan, registered provider at the conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection of 6 June 2014.

As a result of the previous inspection two requirements and five recommendations were issued. These were reviewed during this inspection and the inspector evidenced that one requirement in relation to infection prevention and control was not fully compliant and has been stated for a second time. All five recommendations were assessed as compliant. Details can be viewed in the section immediately following this summary.

The inspector reviewed assessments and care plans in regard to the management of continence in the home. Review of patients' care records evidenced that patients and/or their representatives were informed of changes to patients need and/or condition and the action taken. Areas for improvement were identified in the care records reviewed and one recommendation has been made.

Policies and procedures for continence management were available in the home. However, the policies reviewed were dated 2010 and did not refer to current best practice guidance. A recommendation has been made.

Nursing staff spoken with on the day of the inspection were knowledgeable regarding the management of urinary catheters and the frequency with which the catheters within the home required to be changed. Discussion with staff confirmed that staff had been trained and assessed as competent in urinary catheterisation.

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

Additional Areas Examined

Care Practices
Staffing
Patients and Relatives Comments
Staff Comments
Environment

Details regarding the inspection findings for these areas are available in the main body of the report. Areas for improvement were identified in relation to care records for wound management and the environment. Three requirements have been made.

Conclusion

The inspector can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a good standard and patients were observed to be treated by staff with dignity and respect. Good relationships were evident between staff and patients. Patients were well groomed, appropriately dressed and appeared comfortable in their surroundings.

As a result of this inspection three requirements and two recommendations have been made and one requirement made during the previous care inspection has been stated for a second time.

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

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

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	15 (2) (a) & (b)	The registered person must ensure that the assessment of the patient's needs is kept under review and revised at any time when it is necessary to do so having regard to any change of circumstances by ensuring the following: • The fluid output should be recorded in respect of any patient with a urinary catheter in place • The Malnutrition Universal Screening Tool (MUST) should be re-assessed on at least a monthly basis or more frequently if deemed necessary.	Review of one patient's care records who had a catheter in place evidenced that fluid output had been recorded in the progress notes Review of three patients' care records evidenced that the MUST tool had been reassessed on a monthly basis	Compliant

2.	13 (7)	The registered person must make suitable arrangements to minimise the risk of infections and toxic conditions and the spread of infection between patients and staff by: • Ensuring a foot operated pedal bin is in place for the disposal of paper towels following hand-washing in order to prevent re-contamination of hands by touching the lid • Ensuring the laundry system is reviewed to separate laundered (clean) items from those which still require to be laundered • Equipment should not be stored in bathroom areas. In the event of a hoist being left in the bathroom, appropriate decontamination of that equipment should be undertaken in line with infection prevention and control evidence based practice and in accordance with the manufacturer's instructions. The advice of the	Observation of the environment and discussion with staff indicated that this requirement had not been fully addressed and has been stated for the second time. The inspector observed several bins to be foot operated. However, bins for disposal of clinical waste were observed in patients' rooms which were not foot operated. A review of the laundry arrangements revealed that clean laundry had not been segregated from items to be laundered. Pillows were lying on the floor, clothes were stored on top of the washing machines and a rail of clothing was being stored in the corridor outside the laundry area. Discussion with the laundry assistant confirmed that there was no system in place to separate clean laundry from dirty laundry. The registered provider informed the inspector that a meeting had been held with the architect to discuss plans to extend the laundry to address this issue. The inspector did not observed hoists in the bathroom however, weigh scales, pressure cushions, wheelchair cushions and a seat cushion were stored in the ground floor bathroom	Moving towards compliance

		lead infection control nurse at the Public Health Agency (PHA) should be sought in this regard.	Additional issues in relation to infection prevention and control were identified during this inspection and a further requirement to address them has been made.	

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	5.3	It is recommended: • care plans are developed in a person centred manner • daily progress recording reflects the patients response to planned care interventions	Review of three patients' care records and discussion with staff evidenced that care plans had been developed in a person centred manner and staff had attended training in person centred care planning. Review of one patient's care records and discussion with staff evidenced that patients response to the effect of prescribed analgesia had been recorded in the daily progress notes.	Compliant
2.	5.3	It is recommended nursing staff review their approach to pain management and ensure the management of pain is reviewed on a regular and/or at least monthly basis.	Review of one patient's care record evidenced that a pain assessment had been carried out, a care plan was in place and the management of the patient's pain had been reviewed.	Compliant
3.	28.4	It is recommended that all nursing staff undertake training in wound management.	Review of training records and discussion with staff evidenced that wound management training had taken place on 17 July 2014 and all nursing staff had attended.	Compliant

4.	28.1	It is recommended care staff receive training in relation to skin care and the prevention of pressure ulcers.	Review of training records and discussion with staff evidenced that pressure area care training had taken place on 2 September 2014 and 23 care staff had attended	Compliant
5.	28.4	It is recommended nursing staff undertake training/refresher training in relation to records and record keeping. **Ref - Section 4, Follow-up on Previous Issue**	Review of training records and discussion with staff evidenced that training in record keeping had taken place on 17 July 2014 and all nursing staff had attended.	Compliant

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

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

Since the previous inspection on 6 June 2014, RQIA have not been notified by the home of any investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of three patients' care records evidenced that bladder and bowel continence assessments had not been fully completed as part of the assessment process within the home. A recommendation has been made to ensure that bladder and bowel continence assessments are completed for all patients. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. However, in one care record reviewed there was one overarching care plan in place for catheter, bowel and elimination needs. A recommendation has been made to ensure that separate care plans are in place for each individual assessed need. Review of patient's care records evidenced that patients and/or their representatives were informed of changes to patient need and/or condition and the action taken. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place; • continence management / incontinence management • management of constipation However, the policies reviewed were dated 2010 and did not refer to current best practice guidance. A recommendation has been made to ensure that policies and procedures in relation to continence management are reviewed in line with current best practice as defined by professional bodies and national standard setting organisations The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not assessed.	Not assessed
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the nurse in charge confirmed that staff were assessed as competent in continence care. Discussion with staff revealed that identified registered nurses in the home were deemed competent in catheterisation and all registered nurses in the home were deemed competent in the management of stoma appliances. Staff informed the inspector that advice and support for continence management can be sourced from the continence nurse in the local Trust.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

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

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

11.2 Care Records

Nursing staff informed the inspector that one patient required wound management. Review of the patient's care record evidenced that an initial assessment of the wound had been carried out and an ongoing wound assessment record had been completed following each dressing change. However, a care plan had not been developed to direct staff in the management of the wound. A requirement has been made to ensure a care plan is in place to address needs identified through the assessment process in relation to wound management.

During a tour of the environment the inspector observed several patients' night time care records displayed on clip boards hanging on handrails in the corridors of the home. This practice is not respecting patients' confidentiality and a requirement has been made to ensure patient's records are stored securely.

11.3 Staffing

Duty rotas for weeks commencing 29 December 2014 and 5 January 2015 were reviewed and evidenced that staffing numbers were in keeping with RQIA's recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection

11.4 Questionnaire Findings/Staff Comments

During the inspection the inspector spoke with 10 staff which included the nurses, care staff and ancillary staff. The inspector was able to speak to a number of these staff individually and in private. Seven staff completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes. No issues or concerns were raised from staff about the home.

Examples of staff comments were as follows;

"It is like one big family"
"The residents' needs are met"

11.5 Patients/Relatives Comments

During the inspection the inspector spoke with 12 patients individually and with the majority of others in smaller groups. Five patients completed questionnaires. Patients spoken with and the questionnaire responses confirmed that patients were treated with dignity and respect, that staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home. No issues or concerns were raised from patients or relatives about the home.

Examples of patients' comments were as follows:

"If I had all the money in the world I wouldn't change this place"
"It's just like home"
"I get good care and have no complaints"
"I like the company and I like the staff"

11.6 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and fresh smelling.

As discussed in section 9.0 issues identified during the previous care inspection on 6 June 2014 in relation to infection prevention and control have not been fully addressed and have been stated for a second time.

Additional areas in relation to infection prevention and control were identified during this inspection as follows:

- the fridge in the dining room needed cleaned
- the dining room was being used as a storage area to store various items of equipment
- the floor of the incontinence products store needed cleaned
- commode buckets were stored on the floor in the sluices and not on the racks provided

A further requirement has been made.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Orla Sheehan, registered provider as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
5.1 This is in line with current admission policy. A pre-admission assessment visit also ensures that the needs of the client are identified and resources are available upon admission. 5.2 Assessments of care needs are completed within 11 days of admission using validated assessment tools e.g. MUST, BRADEN, RHYS HEARN DEPENDENCY and EPUAP. 8.1 MUST assessments are carried out with patients on admission and any concerns raised regarding nutritional status are referred to the dietician, speech and language therapist (SALT); supplements/thickeners are requested from the client's G.P. until a formal review is held. 11.1 A pressure ulcer risk assessment is carried out during the pre-admission visit. This is further assessed on admission using EPUAP assessment tools/body mapping and appropriate referrals made to the tissue viability nurse (TVN) team.	Substantially compliant

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

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
5.3 All clients are allocated a primary carer (named nurse) who is responsible for agreeing and implementing a plan of care with the client and/or their representative based on the nursing assessment which promotes independence towards achievable goals. 11.2 Staff are aware and make use of the referral process to involve healthcare professionals in the agreed plan of care. 11.3 A body map is used to highlight the area. The wound care plan contains the grade of wound, dressing choice and frequency of review. The TVN link nurse will use her clinical judgement regarding dressing choice in line with the dressing formulary until formal review by tissue viability. 11.8 Referrals are made to the podiatrist for lower limb or foot ulceration. 8.3 Referral for any patient made to dietician via their G.P. based on B.M.I., weight gain/loss. In the interim, catering provision will supplement diet as necessary with full fat milk, extra butter or provide low fat spreads, milk and healthy option meals, as necessary.	Substantially compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.4 Re-assessment of each patient is ongoing and carried out daily. Care needs are recorded in the computerised care plans, which also have been updated to prompt nurses to view care plans that may need to be altered to meet any new needs the patient may have. Care plans are re-assessed to address the needs of the client, as they arise, and monthly, to ensure care is accurate and meets the patients needs.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.5, Roper Logan & Tierney is the nursing model of choice used in the home, this is useful in care planning and identifies areas at risk, e.g. continence, pressure damage, nutritional status 11.4, The EPUAP (pressure ulcer definitions & guidelines) & NICE guidelines on the management of pressure ulcers in secondary care provide guidance on grading of pressure ulcers, dressing choices and the importance of a holistic assessment of patients deemed to be at risk of pressure ulcer development. 8.4 MUST tool & Braden scores help to identify nutritional deficits in patients, ; NICE guidelines; the Dept of Health 'Adult Social Care Outcomes framework 2013/2014; NPC 'Prescribing of adult Oral Nutritional Supplement (ONS), help support and inform the clinical judgement of the NMC registered practitioner, on the correct action to take should the residents intake not meet their requirements. ie referral to SALT, dietetics and how best to supplement intake until formal review.	Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
5.6 Nursing staff maintain contemporaneous daily progress notes which reflect the individuality, personality and choices of the client. Care plans are updated in response to any change in client needs or wishes as they occur or, minimally, on a monthly basis. All care plans contain agreed, achievable outcomes. 12.11 Intake of each resident is recorded after each meal and snack, including the amount taken at each meal eg: half, 3/4 or nil. (refusals are also recorded) at midnight the nurse/carer will record the total intake for the day.. Food questionnaires are distributed in advance of the seasonal menu change to include patients' particular likes in menu planning. Resident forums provide an opportunity to comment on the quality of meals and snacks provided and to express wishes for any changes/additions to menus. Theme days are popular with many of the residents who like to get involved in preparing food on these occasions. e.g. Italian day when they help to make their own pizzas. 12.12 All residents' daily food and fluid intake, (or refusal), is recorded throughout the day and totalled at midnight; total inputs are recorded in the each patient's progress notes in comuterised care plans. The nurse will, explore with the client, any organic reasons for abnormal dietary intake e.g. dental caries, constipation or food choices prior to referral. The chef will meet with the patient and discuss possible changes that could be made to meals or discuss particular likes or dislikes and plan together with the patient a diet that is palatable. BMI, body weight, appetite, swallowing ability and general health (e.g. skin integrity) will, in conjunction with clinical judgement and guidelines, determine if and when a referral is made to G.P for dietetic referral and/or SALT.	Substantially compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.7 Daily progress notes are monitored by the primary carer to ensure stated outcomes have been met. When patients' needs change, eg on return from hospital, treatment for infection,insertion of urinary catheter or change in swallowing ability, the care plan is updated to reflect the patients change in needs.This is also incorporated into the daily notes, and, as a reminder to the nurse, a prompt to" review care plan "is present on the daily progress screen. All care plans are updated at least monthly to ensure each patient's needs are accurately assessed planned, and delivered. The resident and/or their representative are included in planning of care Formal annual care reviews are held with the client, (if appropriate), the named nurse, the key worker, the care manager, relatives and any other professionals involved in the client's care. The plan of care is reviewed at this time and agreed with the resident and their representative and documented.	Substantially compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
5.8 Patients are encouraged to take an active role in their care and to attend and contribute to annual care reviews where possible. Each patient is given two weeks notice of their annual care review and their input is encouraged. A relative/representative is also encouraged to contribute.Residents' forums are useful in encouraging input into aspects of care provided and for making holistic care decisions e.g. at the last forum meeting (17.05.14) some funding was available to benefit all clients and the forum decided on quarterly chiropody for each resident. Other decisions agreed at the forum included: day trip to Newcastle, 4th July Bar-be-que and some residents wished to start a gardening project. Skype is a more recent introduction to the home to facilitate residents keeping in touch with family overseas. Recently, the manager introduced a weight loss programme for overweight residents that several clients (and staff members) were keen to join in, incentivised by a weekly weigh-in. One lady, who needed to lose weight, lost 6 kg; this made her very happy and she is now more aware of making healthy food choices. At all stages of each patient's residency in the home, the resident, relatives and friends are encouraged to take an active part in suggesting ideas to supplement activities to add to improving overall quality of care and life at Fruithill. 5.9 The care manager, nursing team and relatives are given a copy of care reviews. Discussed and agreed outcomes are recorded in the client's care plan. Feedback on progress is given both formally and informally to all interested parties and contacts documented.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
12.1 A four weekly seasonal menu is compiled by the catering manager that incorporates the likes and dislikes of the clientele, as stated both verbally and in writing i.e. food questionnaires. The menu caters for individual dietary needs and catering staff are informed of specific nutritional needs and food consistencies for all clients. 12.3 A menu choice is offered at every mealtime for both normal and specialised diets. Should a client choose to have something different from the menu choice, the cook will discuss with the patient what they would prefer and ensure the request is catered for. G.P. consent has been sought for those patients who wish to enjoy a glass of sherry before their Sunday lunch.	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
8.6 Nurses use observation, clinical skills and professional knowledge to ensure safe feeding techniques for clients with swallowing/suspected swallowing difficulties. Nursing staff liaise with catering and care staff during the service of meals to ensure clients receive appropriate quantities and consistencies of food as assessed. 12.5 Breakfast, lunch, afternoon tea, evening meal and supper are served at conventional times. Fresh fruit, hot and cold drinks and snacks are made available throughout the day. 12.10 We have a dedicated dining room attendant to assist during meals and one-to-one attention given to clients who require assistance. At least one nurse is present in the dining room during service. All care staff have access to nutritional information contained in care plans and written instructions from SALT and dietician. Staff are trained in basic first aid (choking and burns) and dysphagia and use of thickeners. Further training on pressure relief, skin care and nutrition is organised for care staff (02.09.2014) All necessary catering aids and equipment are available on site. 11.7 Recent in-house training (17.07.2014) on wound management and wound care was well attended by nursing staff.	Substantially compliant

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

Quality Improvement Plan

Secondary Unannounced Care Inspection

Fruithill Nursing Home

13 January 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with Ms Orla Sheehan, registered provider, either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	13(7)	The registered person must make suitable arrangements to minimise the risk of infections and toxic conditions and the spread of infection between patients and staff by: • Ensuring a foot operated pedal bin is in place for the disposal of paper towels following hand-washing in order to prevent re-contamination of hands by touching the lid • Ensuring the laundry system is reviewed to separate laundered (clean) items from those which still require to be laundered • Equipment should not be stored in bathroom areas. **Ref: Section 9.0**	Two	Colour coded foot-operated pedal bin in place in the specified handwashing facility to prevent re-contamination of hands. All other areas already have foot-operated pedal bins in situ. Separation of laundry requires an extension of the existing laundry. Plans received from an architect submitted as requested in Feb 2015. This is a major project requiring extension into the outdoor area. Temporary arrangements are being progressed to separate laundry areas. Plans for extension include a dedicated storage area for equipment. The registered person contacted the Public Health Agency who advised to clean hoist between usage as is current practice. Slings are washed and hanged outside the bathroom area. There is are separate slings for residents	Ongoing

				with an infecion.	
2.	13 (7)	The registered person must ensure that • The fridge in the dining room is kept clean • the dining room is not used as a storage area • the floor of identified store is kept clean • commode buckets in the sluices are stored off the floor **Ref: Section 11.6**	One	The fridge in the dining room is being cleaned regularly and a cleaning schedule in place. Instruction given to night staff to defrost the fridge every month. Cartons from dining room removed and stored appropriately Domestic asked to clean floor immediately. Commode buckets from sluice room removed and instructions given to staff not to repeat.	By 10 February 2015
3.	16 (1)	The registered person must ensure that a care plan is in place to address needs identified through the assessment process in relation to wound care. **Ref: Section 11.2**	One	A dedicated nurse who has completed wound care training is allocated to complete care plan and assessment process. Further training will be arranged for all staff nurses.	By 10 February 2015
4.	19 (1) (b)	The registered person must ensure that patients' records are kept securely to ensure confidentiality is maintained **Ref: Section 11.2**	One	Sleeping charts have been removed from bedrooms and stored in a dedicated folder in the nurses station.	By 10 February 2015

Recommendations

These recommendations are based on The Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	19.1	The registered person must ensure that • Bowel and bladder assessments are completed for all patients • separate care plans to manage continence are in place for each individual assessed need. **Ref: Section 10.0, criterion 19.1**	One	Bowel and bladder assessments are completed for all patients. Separate care plans are in place to manage continence. Also dedicated care plans for catheter care and stoma care. A new template is on the computerised care system.	By 10 February 2015
2.	26	The registered person must ensure that policies and procedures in relation to continence management are reviewed in line with current best practice as defined by professional bodies and national standard setting organisations **Ref: Section 10.0, criterion 19.2**	One	Policy and procedures for continence management according to NICE guidelines are in the nurses station for all staff to read and sign.	By 10 February 2015

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

NAME OF REGISTERED MANAGER COMPLETING QIP	Thresia Paily
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Orla Sheehan

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Norma Munn	27 March 2015
Further information requested from provider			