Unannounced Secondary Care Inspection

Name of establishment:	**Cherry Tree House**
RQIA number:	**1433**
Date of inspection:	**27 November 2014**
Inspector's name:	**Donna Rogan and Karen Scarlett**
Inspection number:	**IN017188**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Home:	Cherry Tree House
Address:	79 North Road Carrickfergus BT37 8QZ
Telephone Number:	(028) 9336 5652
E mail Address:	cherrytreehouse1@btinternet.com
Registered Organisation/ Registered Provider:	Dr Dean W G Harron
Registered Manager:	Ms Cassie Philips, acting manager
Person in Charge of the Home at the Time of Inspection:	Ethel Colquhoun registered nurse in charge
Categories of Care:	Nursing – I, PH Residential – I, MP(E), PH (E), PH, LD Only one person to be accommodated in category LD
Number of Registered Places:	56
Number of Patients Accommodated on Day of Inspection:	34 patients 17 residents
Date and Type of Previous Inspection:	Monitoring Inspection 17 September 2014
Date and Time of Inspection:	27 November 2014 09.30 – 15.30
Name of Inspector:	Donna Rogan and Karen Scarlett

1.0 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 unannounced inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being met.

1.1 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 Residential 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.

1.2 Methods/Process

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

- Discussion with the registered nurse in charge of the home.
- Discussion with the independent nurse consultant.
- Discussion with the registered provider.
- Discussion with staff.
- Discussion with patients individually and to others in groups.
- Discussion with two relatives visiting at the time of inspection.
- Review of a sample of policies and procedures.
- Review of a sample of staff training records.
- Review of a sample of staff duty rotas.
- Review of a sample of care plans.
- Review of the accidents and incidents records.
- Review of the morning routine.
- Observation during a tour of the premises.
- Evaluation and feedback.

1.3 Consultation Process

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

Patients	**20 individually and others in small groups**
Staff	**11**
Relatives	**2**
Visiting Professionals	**0**

Questionnaires were provided, during the inspection, to patients, their representatives and staff seeking their views regarding the service. Matters raised from the questionnaires were addressed by the inspector either during the course of this inspection or within the following week.

Issued to	Number Issued	Number Returned
Patients	**5**	**5**
Relatives / Representatives	**2**	**2**
Staff	**5**	**5**

1.4 Inspection Focus

The 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.

RQIA brought forward the planned inspection on incontinence management in view of information following contact by a whistle blower expressing concerns that the recently appointed acting manager was no longer available in the home.

The following issues were also raised by the whistle blower:

- Staffing shortages.
- Patients not being appropriately supervised.
- Patients not having their continence needs appropriately attended to.
- Patients not receiving their breakfast in a timely way.

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

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.

2.0 Profile of Service

Cherry Tree House is a large purpose built nursing and residential home situated on the outskirts of Carrickfergus town centre. It is a two storey home; the first floor is accessed by stairs and by a passenger lift. Bedroom accommodation is provided in single and double bedrooms, seventeen beds are situated on the ground floor and thirty nine beds are on the first floor.

There is a range of communal lounge and dining facilities, the majority of which are located on the ground floor of the home with one small lounge/kitchen area and a small dining room on the first floor. There is also a range of bathroom, shower and toilet facilities.

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

Nursing Care (NH)

I	Old age not falling into any other category
PH	Physical disability other than sensory impairment – under 65 years

Residential Care (RC)

I	Old age not falling into any other category
MP (E)	Mental disorder excluding learning disability or dementia – over 65 years
PH (E)	Physical disability other than sensory impairment – over 65 years
PH	Physical disability other than sensory impairment – under 65 years
LD	Learning disability (Only one person to be accommodated in category LD)

The Home's RQIA 'Certificate of Registration' was appropriately displayed in the main entrance hall of the Home.

3.0 Summary of Inspection

This summary provides an overview of the services examined during an unannounced secondary care inspection to Cherry Tree House Nursing and Residential Home. The inspection was undertaken by Donna Rogan and Karen Scarlett on 27 November 2014 from 09.30 to 15.30.

The inspectors were welcomed into the home by Ethel Colquhoun registered nurse in charge of the home. An independent nurse consultant has been employed to advise and support staff in the home in the maintenance of robust processes and systems to support the clinical governance framework. The consultant and Dr Dean Harron joined the inspection and were available throughout the day to facilitate the inspection. Both were available for feedback at the conclusion of the inspection.

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

The inspectors had been informed the day prior to the inspection by the registered provider that the recently appointed acting manager would not available as there was currently an investigation ongoing which involved a number of staff employed. RQIA cannot comment on the detail regarding the employment issues in this report as there is an investigation ongoing regarding several members of staff. These issues are being addressed in accordance with the homes employment policies and procedures. RQIA and the relevant Healthcare Trust have been made aware of the issues and are satisfied that they are being addressed by the registered provider. The registered provider has agreed to keep RQIA informed of any outcomes or action taken without delay.

A management plan has been received by RQIA and details of how the home will be managed whilst the investigation is on-going have been shared with RQIA. Ethel Colquhourn has been appointed by the registered provider as the acting deputy nurse manager, who will be supported on a daily basis by an independent nurse consultant.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. This self-assessment was received by the Authority on 28 April 2014. The inspectors have reviewed the responses provided however, due to a change in inspection focus they have been unable to validate the statements provided by the registered persons. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

As a result of the previous inspection conducted on 17 September 2014, one requirement and one recommendation were made. They were reviewed during this inspection. The inspectors evidenced that the requirement and recommendation were fully complied with. Details of the previous requirement and recommendation can be viewed in the section immediately following this summary.

Conclusion

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

In addition to the theme inspected, the inspectors also reviewed the following:

- Care practices.
- Supervision of patients.
- Management of patients incontinence.
- Mourning routine (breakfast).
- Patients' views.
- Staffing/staff views.
- Staffing levels.
- Environment.
- Wound/pressure ulcer care.

Requirements are made in relation to staff views, the environment and wound/pressure ulcer care. A total of, seven requirements are made following this inspection. These requirements are detailed throughout the report and in the quality improvement plan (QIP).

An urgent findings letter was forwarded to the registered person, Dr Harron, that the following three requirements are met within 28 days of the inspection;

- Regulation 15 (2)
  The registered person shall ensure that the identified patient's care record is updated in relation to wound/pressure ulcer care.

- Regulation 17 (1)
  The registered person shall ensure that there is an on-going audit of wounds completed at least weekly and that wounds/pressure ulcer care is monitored to ensure their management is in keeping with best practice guidelines.

- Regulation 12 (2) (b)
  The registered person shall ensure fluid balance and repositioning charts are appropriately completed and consolidated in keeping with best practice.

The inspectors would like to thank the patients, the independent nurse consultant, the registered person, the nurse in charge and staff for their assistance and co-operation throughout the inspection process.

4.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	20(1)(c)(i)	The registered provider must ensure that the newly appointed acting manager is provided with a robust induction programme. The induction must include the following: • the managerial and nursing responsibilities of the post • detail of the topics to be covered. • who will be responsibility for providing the induction of each individual area. • who will have overall responsibility for assessing the acting managers competency. It was agreed with the registered provider that a copy of the induction programme would be submitted to RQIA by Monday 22 September 2014. **Ref section 5, 5.4**	The inspectors can confirm that an induction programme was completed and a copy of the induction was submitted to RQIA within the set timescale. The content of the induction programme was assessed by the inspectors as being robust and relevant to the acting manager's role and responsibilities.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	Criterion 30.2	It is recommended that, the registered provider continues to closely monitor the staffing levels within the home to ensure that at all times there are sufficient number of staff to meet the needs of the patients and residents. **Ref section 5, 5.1**	Following discussion with the independent nurse consultant and the registered provider it was confirmed that there were a number of on-going employment issues in the home, which were being addressed in accordance with the homes' employment policies and procedures. A review of the staff duty rosters evidenced that there were sufficient staff on duty to meet the needs of the patients. The independent nurse consultant had recently carried out a dependency study on all patients and residents in the home in accordance with best guidelines. (Clifton Assessment Procedures for the Elderly) (CAPE). The nurse consultant informed the inspectors that the planned duty rosters reflect the dependencies of patients/residents in the home and RQIA minimum staffing guidelines in terms of numbers and skill mix. RQIA will continue to monitor staffing levels in the home and have requested that the worked duty rosters are forwarded to RQIA on a weekly basis until further notice.	Compliant

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

Since the previous care inspection on 17 September 2014 RQIA have received two notifications of safeguarding of vulnerable adult (SOVA) incidents in respect of Cherry Tree House. RQIA have been appropriately informed of the issues and they are currently being investigated in accordance with the joint protocol. Appropriate protection plans have also been put in place in accordance with the relevant Health Care Trust.

6.0 Inspection Findings

Standard 19 - Continence Management Patients receive individual continence management and support.	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**Compliance Level**
Inspection Findings:	
Review of three patients' care records evidenced that bladder and bowel continence assessments were undertaken. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. There was evidence in all patients' care records examined that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. One patient with a urinary catheter was evidenced to require frequent bladder washouts. The care record did not detail the type of washout to be used, nor did it specify if a urinary PH level was required prior to the washout being carried out. A requirement is made that the care record is updated to reflect the care required. A requirement is also made that when short term care plans are no longer relevant that they should be discontinued. Review of three patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Substantially compliant

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 inspectors can confirm that the following policies and procedures were in place; • Continence management/incontinence management. • Stoma care. • Catheter care. However they are required to be reviewed and updated in keeping with best practice guidance. There were no up to date continence guidelines available for staff. The nurse consultant agreed to ensure that copies are provided to staff by 1 December 2014.	Moving towards compliance

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support.	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**Compliance Level**
Inspection Findings:	
Not applicable	Not applicable
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 and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the nurse in charge revealed that all the registered nurses in the home were deemed competent in male and female catheterisation and the management of stoma appliances. Continence training is maintained for all staff.	Compliant

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

7.0 Additional Areas Examined

7.1 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.

The morning routine was observed to be well organised. Patients spoken with stated that they had a choice of rising times and that they could choose where to have their breakfast. Patients also informed the inspectors that their continence needs were tended to in a timely way, they stated that when they sounded the nurse call system that their request was usually answered promptly.

There was a good atmosphere in the home the hairdresser was in attendance and some patients were enjoying having their hair done. There is a well organised activity programme ongoing in the home. Patients spoken with stated they enjoyed the activities organised and were looking forward to the social activities organised for Christmas.

7.2 Patients'/Relatives' Views

During the inspection the inspector spoke to approximately 20 patients individually and with others in groups. Patients spoken with expressed high levels of satisfaction with the standard of care, facilities and services provided in the home. A number of patients were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients' comments were as follows:

"I am very happy with, staff are kind and attentive."
"Staff answer the buzzers promptly."
"We are always offered choices at meal times."
"I have no complaints, it couldn't be any better."
"I am content living there is always somebody to talk to."
"We are all well looked after here."

The inspectors spoke with two relatives during the inspection. Both relatives were commendable regarding the care in the home and the care their relative was receiving. Both raised issues regarding the management of the home. The issues raised were discussed at length with the nurse consultant and the registered provider. There were no negative comments made by patients, residents or relatives to the inspectors during the inspection.

7.3 Staffing/Staff Views

Following discussion with the registered provider and staff spoken with on duty it was confirmed that there were a number of on-going employment issues in the home which are currently being investigated. It was confirmed that the acting nurse manager was currently not available in the home. RQIA cannot detail the issues raised in this report as there is an investigation ongoing regarding several members of staff. These issues are being addressed in accordance with the homes' employment policies and procedures.

RQIA have been made aware of the issues and are satisfied that they are being addressed by the registered provider. The registered provider has agreed to keep RQIA informed of any outcomes or action taken.

A management plan has been received by RQIA and details of how the home will be managed whilst the investigation is on-going have been shared with RQIA. Ethel Colquhourn has been appointed by the registered provider as the acting deputy nurse manager, who will be supported on a daily basis by an independent nurse consultant.

A review of the staff duty rosters evidenced that there were sufficient staff on duty to meet the needs of the patients. The independent nurse consultant has recently carried out a dependency study on all patients and residents in the home in accordance with best guidelines, (Clifton Assessment Procedures for the Elderly), (CAPE). The nurse consultant informed the inspectors that the planned duty rosters reflect the dependencies of patients/residents in the home and RQIA minimum staffing guidelines in terms of numbers and skill mix.

RQIA will continue to monitor staffing levels in the home and have requested that the worked duty rosters are forwarded to RQIA on a weekly basis until further notice.

During the inspection the inspector spoke with eleven staff. Staff spoken with expressed some negative comments regarding management in the home. These comments were discussed at length with the nurse consultant and the registered provider. The inspectors can confirm that a staff meeting has been arranged and staff will be given an opportunity to speak with the nurse consultant or the registered provider to express their concerns either in groups or individually. The nurse consultant informed the inspectors that it is the intention or have formal supervision with all staff members the week commencing 1 December 2014.

7.4 Environment

The inspectors undertook an inspection of the premises and viewed the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a high standard of hygiene. There were no malodours detected. The carpet on the corridors on the ground floor is required to be replaced as cleaning is no longer effective and there are signs of fraying and some areas are quite heavily stained. A requirement is made in this regard.

7.5 Wound/Pressure Ulcer Care

The inspectors reviewed the care of one patient who was identified as requiring regular dressings to wounds. The care record reviewed did not clearly set out the current state of their wounds/pressure ulcers. The wound care assessment and the ongoing wound chart was not updated. However, there was evidence in the desk diary that wounds were planned to be redressed. A requirement is made that this patient's care record is fully reviewed and updated to reflect best practice in wound/pressure ulcer care management. A further requirement is made that the acting home manager review all wounds/pressure ulcers in the home and to ensure that the records are up to date in accordance with best practice guidelines. RQIA received confirmation on 3 December 2014 that all that patients in the home with a wound/pressure ulcer have had their wounds/pressure ulcers reviewed and that care records have been updated and include an updated wound assessment, wound care chart and an ongoing wound chart.

Assurances have been provided that wound/pressure ulcer audits are conducted and that they are also reviewed in accordance with Regulation 29 visits conducted by the registered provider/nurse consultant.

A review of patients' fluid balance charts and repositioning charts evidenced that at times they were not consistently completed. The patients output was not always completed and the charts were not always consolidated. A requirement is made in this regard.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with the nurse consultant and 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**
Prior to admission to the home, the Home Manager or a designated representative from the home carries out a pre admission assessment. Information from the resident/representative (where possible), the nurse, the care records and information from the Care Management Team informs this assessment. Risk assessments such as the Braden Tool are documented in the pre admission documentation if available at this stage. Following a review of all information a decision is made in regard to the home's ability to meet the needs of the resident.	Compliant

If the admission is an emergency admission and a pre admission is not possible in the resident's current location then - a pre admission assessment is completed either over the telephone or immediately on admission with written comprehensive, multidisciplinary information regarding the resident being faxed or left into the home. On admission to the home an identified nurse completes initial assessments using a patient centred approach. The nurse communicates with the resident and/or representative, refers to the pre admission assessment and to information received from the care management team to assist her/him in this process. There are two documents completed within twelve hours of admission - an Admission Assessment which includes photography consent, record of personal effects and a Needs Assessment which includes 16 areas of need - the additional comments section within each of the 16 sections includes additional necessary information that is required to formulate a person centred plan of care for the Resident. In addition to these two documents, the nurse completes risk assessments immediately on admission. These include a skin assessment using the Braden Tool, a body map, an initial wound assessment (if required), a moving and handling assessment, a falls risk assessment, bed rail assessment (if required), a pain assessment and nutritional assessments including the MUST tool, FSHC nutritional and oral assessment. Other risk assessments that are completed within seven days of admission are a continence assessment and a bowel assessment unless there is evidence for immediate assessments requiring completion. Following discussion with the resident/representative, and using the nurse's clinical judgement, a plan of care is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations. This can be evidenced in the care plan and consent forms. The Home Manager and Regional Manager will complete audits on a regular basis to quality assure this process	

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**
A named nurse completes a comprehensive and holistic assessment of the resident's care needs using the assessment tools as cited in section A, between 7 and 11 days of admission. The named nurse devises care plans to meet identified needs and in consultation with the resident/representative.	Substantially compliant

The care plans demonstrate the promotion of maximum independence and focuses on what the resident can do for themselves as well as what assistance is required. Any recommendations made by other members of the mutidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable. Registered nurses in the home are fully aware of the process of referral to a TVN when necessary. The nurse makes a telephone call to call management who in turn contacts the nursing home support team to make them aware of the referral. Referrals are also made via this process in relation to residents who have lower limb or foot ulceration to either the TVN or a podiatrist from the relevant trust. If necessary, a further referral is made to a vascular surgeon by the G.P, TVN or podiatrist. Where a resident is assessed as being 'at risk' of developing pressure ulcers, a Pressure Ulcer Management and Treatment plan is commenced. A care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. The care plan will give due consideration to advice received from other multidisciplinary members. The treatment plan is agreed with the resident/representative, Care Management and relevant members of the MDT. The Registered Nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Referrals are made through call management or the GP. All advice, treatment or recommendations are recorded on the FSHC MDT form and advice sheet from the MDT member with a subsequent care plan being compiled or current care plan being updated to reflect the advice and recommendations. The care plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in the home and other members of the MDT are kept informed of any changes.	

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**
The Needs Assessment, risk assessments and care plans are reviewed and evaluated at a minimum of once a month or more often if there is a change in the resident's condition and are re written on a yearly basis. The plan of care dictates the frequency of review and re assessment. The resident is assessed on an on-going daily basis with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the Home Manager's attention. The Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.	Substantially compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to. The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading system. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an on-going wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime or if the condition of the pressure ulcer changes.	Substantially compliant

There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', ' PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff to refer to on an on-going basis. Staff also refer to FSHC policies and procedures in relation to nutritional care, diabetic care, care of subcutaneous fluids and care of percutaneous endoscopic gastrostomy (PEG) as required.	

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**
Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are comtemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines - Record keeping:Guidance for nurses and midwives. Records of the meals provided for each resident at each mealtime are recorded on a daily menu choice form. The Catering Manager also keeps records of the food served and include any specialist dietary needs.	Substantially compliant

All Residents have their food and fluids recorded in detail on a daily basis using a FSHC food record booklet or fluid record booklet. These charts are recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. The nurse utilises the information contained in these charts in their daily evaluation. Any deficits are identified with appropriate action being taken and with referrals made to the relevant MDT member as necessary. Any changes to the resident's plan of care is discussed with them and/or their representative. Care records are audited on a regular basis by the Manager/Deputy, these are given to the named nurse to addresss any deficits and are then reaudited.	

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care delivered is monitored and recorded on a daily basis on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed at least monthly or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their represenatatives are involved in the evaluation process.	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**
Care Management Reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the resident's file. The care manager is contacted if the minutes have not been received into the home. Any recommendations made are actioned by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The home follows FSHC policy and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs on admission and review on an on-going basis. The care plan reflects type of diet, any special dietary needs, and personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if necessary. The home has a 4 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives - residents meetings, one to one meetings and food questionnaires. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied. Copies of instructions and recommendations from the dietician and speech and language therapist are made available in the kitchen in the form of a diet notification form which informs the kitchen of each resident's specific dietary needs.	Compliant

Residents are offered a choice at each meal time, if the resident does not want anything from the daily menu an alternative meal of their choice is provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display on each dining room table.	

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All instructions from speech and language therapy and other members of the multi disciplinary team, are transcribed in a care plan for all staff to adhere to. Dietary requirements for these residents are also forwarded to the Catering team for reference. Breakfast is served in a patient cantered manner in Resident bedrooms and is available when the residents request. Lunch is served at 12.45pm, evening meal at 5pm and supper at 8.30pm, however if the resident chooses not to eat at these times a meal is provided at a time of their choice.	Substantially compliant

Hot and cold drinks and snacks are available on request and at customary intervals and fresh drinking water is available at all times. Each resident has an eating and drinking care plan and a diet notification sheet. Food questionnaires detailing likes and dislikes are completed periodically throughout the year. Allocation of staff is done on a daily basis to ensure that there are adequate numbers of staff in the dining room and also for assisting those in their bedrooms at meal times. Any required special aids are provided. Nurses have completed the E Learning module on pressure area care. They also complete a wound competency and supervision practice. The home has good support from the nursing home support team with regards to wound care.	

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

Cherry Tree House

27 November 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Hilary Fleming, independent nurse consultant, and Dr Dean Harron registered provider during the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	15 (2)	The registered person shall ensure that the identified patient's care record is updated in relation to wound/pressure ulcer care. **Ref 6.5**	One	The identified patients care record is updated in relation to wound/pressure ulcer care	By 25 December 2014
2	17 (1)	The registered person shall ensure that there is an on-going audit of wounds completed at least weekly and that wounds/pressure ulcer care is monitored to ensure their management is in keeping with best practice guidelines. **Ref 6.5**	One	There is an ongoing wounds/pressure ulcer audit which is monitored to ensure their management is in keeping best practise.	By 25 December 2014
3	12 (2) (b)	The registered person shall ensure fluid balance and repositioning charts are appropriately completed and consolidated in keeping with best practice. **Ref 6.5**	One	Fluid balance and repositioning charts are completed and a weekly audit ascertains if residents fluid target is met and if not appropriate action taken.	By 25 December 2014
4	16 (2)	The registered person shall ensure that the identified care record is updated to reflect the care required in regards to catheter care. The registered person shall ensure that when short term care plan is no longer relevant that they should be discontinued. **Ref 19.1**	One	Identified care record is updated and reflects the policy. The short term care plan has been discontinued in accordance with good practise.	Three months

5	15 (2)	Ensure the identified patient's care record is updated in relation to wound/pressure ulcer care. The registered person shall ensure that there is an ongoing audit of wounds completed at least weekly and that they are monitored to ensure their management is in keeping with best practice guidelines. **Ref 6.5**	One	Duplication of Regulation 1&2 (See previous page)	From the date of inspection
6	12 (1) (b)	The registered person shall ensure that the policies and procedures are updated in relation to; • Continence care. • Stoma care. • Catheter care. The registered manager shall ensure up to date guidelines are made available to staff regarding their continence care. **Ref 6.5**	One	The named policies have been devised in keeping with best practice guidelines. - Improving continence care for patients (RCN) - Continence care in residential and nursing homes (BGS) Are available to all staff.	From the date of inspection
7	27 (2) (d)	The registered person shall make arrangements to have the identified areas of the carpet replaced in the corridors. **Ref 6.4**	One	Work has commenced and is ongoing to refurbish the corridors	Within four months of inspection

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

NAME OF REGISTERED MANAGER COMPLETING QIP	Mrs Hilary Fleming Nurse Consultant
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Dr DWG Harron Proprietor

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Donna Rogan	27/01/15
Further information requested from provider			