Announced Primary Inspection

Name of Establishment:	**Fairfields Care Centre**
Establishment ID No:	**1445**
Date of Inspection:	**04 August 2014**
Inspector's Name:	**Heather Moore**
Inspection No:	**16510**

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544

1.0 General Information

Name of Home:	Fairfields Care Centre
Address:	80a Fairhill Road Cookstown BT80 8DE
Telephone Number:	028 8676 6294
E mail Address:	Ciaran.Maynes@carecircle.co.uk
Registered Organisation/ Registered Provider:	Care Circle Ltd Mr Ciaran Sheehan
Registered Manager:	Mr Ciaran Patrick Maynes
Person in Charge of the Home at the time of Inspection:	Mr Ciaran Patrick Maynes
Registered Categories of Care and number of places:	NH-I, NH-DE, NH-PH, NH-MP (E) ,NH-LD (E), RC-I 70
Number of Patients/ Residents Accommodated on Day of Inspection **Scale of charges(per week)**	65 32 - NH-I 25 - NH-DE 8 - RC-I (2 residents in hospital on day of inspection) £581.00 - £624.00 Nursing £461.00 - Residential
Date and time of this inspection:	04 August 2014: 08.15 hours - 16.15 hours
Date and type of previous inspection:	15 January 2014 Primary Announced

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)

Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/Process

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

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

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

- Review of any notifiable events submitted to RQIA since the previous inspection
- Analysis of pre-inspection information
- Discussion with the registered manager

- Discussion with the registered provider.
- Discussion with patients/residents individually and with others in groups
- Consultation with patients'/residents/'relatives/representatives
- Consultation with staff
- Observation of care delivery and care records
- Examination of records
- Tour of the premises
- Evaluation and feedback.

Any other information received by RQIA about this registered provider has also been considered by the inspector in preparing for this inspection.

5.0 Consultation Process

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

Patients/residents	**10 individually and with others in groups**
Staff	**10**
Relatives	**2**
Visiting Professionals	**-**

Questionnaires were provided, during the inspection, to patients, their representatives and staff to seek their views regarding the service. Matters raised from the questionnaires were addressed by the inspector in the course of this inspection.

Issued To	**Number issued**	**Number returned**
Patients /residents	**6**	**6**
Relatives / Representatives	**2**	**1**
Staff	**10**	**10**

6.0 Inspection Focus

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

The criteria from the following standards are included;

- Management of Nursing Care – Standard 5
- Management of Wounds and Pressure Ulcers –Standard 11
- Management of Nutritional Needs and Weight Loss – Standard 8 and 12
- Management of Dehydration – Standard 12

An assessment on the progress of the issues raised during and since the previous inspection was also undertaken.

The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.
The table below sets out the definitions that RQIA has used to categorise the service's performance:

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

7.0 Profile of Service

Fairfields Care Centre is a two storey purpose built home situated in its own beautifully landscaped grounds off the Fairhill Road, Cookstown. The home was re-registered by the current owners on 30 July 2009.

The home is owned and operated by Care Circle Limited, Mr Ciaran Sheehan.

The current registered manager is Mr Ciaran Patrick Maynes.

The home is currently registered to provide nursing and residential care in the following categories:

NH - I Old and infirm not falling within any other category
NH - DE Dementia nursing
NH - PH Physical disability other than sensory impairment
NH - MP (E) Mental disorder excluding learning disability or dementia - over 65 years
NH - LD (E) Learning disability over 65 years
RC - I Old age not falling within any other category.

The administrator's office and nurses' station are located at the entrance to the home and an impressive reception area with space for relaxation is adjacent to this area.

Bedroom accommodation is provided on both floors with the majority of bedrooms having en-suite facilities which are completed to a high standard.

Catering and laundry facilities are located on the ground floor and communal lounges and sanitary facilities are interspersed throughout the home. The laundry facilities had been extended to provide suitable space for the holding of soiled linen. En-suites facilities had been provided in four bedrooms since the previous inspection. Dining areas are available on both floors and hairdressing rooms and small kitchenettes for use by patients and residents and relatives are located on both floors.

The grounds around the home were well landscaped and enclosed garden areas are available for patients and residents use. There is adequate car parking facilities in the grounds of the home.

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) accurately reflected the categories of care and was appropriately displayed in a prominent position of the home.

8.0 Summary of Inspection

This summary provides an overview of the services examined during a primary inspection (announced) to Fairfields Care Centre. The inspection was undertaken by Heather Moore on 04 August 2014 from 08.15 hours to 16.15 hours.

The inspector was welcomed into the home by Mr Ciaran Maynes, Registered Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to Mr Ciaran Sheehan, Registered Provider and to the registered manager at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See Appendix one.

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

Questionnaires were issued to patients', residents', staff and two relatives during the inspection.

The inspector spent a number of extended periods observing staff and patient interaction. Discussions and questionnaires are unlikely to capture the true experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience.

These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool is designed to help evaluate the type and quality of communication which takes place in the nursing home. A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix two.

As a result of the previous inspection conducted on 15 January 2014, three requirements and seven recommendations were issued. These requirements and recommendations were reviewed during this inspection. The inspector evidenced that three requirements had been complied with; however two requirements were not addressed and have been restated for the second time. Three recommendations were addressed, one recommendation was substantially addressed and two recommendations were not addressed and were therefore restated. Details can be viewed in the section immediately following this summary.

Standards inspected:

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed. (Selected criteria)

Standard 8: Nutritional needs of patients are met. (Selected criteria)
Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)
Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria)

8.1 inspection Findings

- **8.1.1 Management of Nursing Care – Standard 5**

The inspector can confirm that at the time of the inspection there was evidence to validate that patients receive safe and effective care in Fairfields Care Centre.

The inspector examined four patients/residents care records.

There was evidence of comprehensive and detailed assessment of patient needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patients' needs was evidenced to inform the care planning process.

Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis plus as required.

There was also evidence that the referring HSC Trust maintained appropriate reviews of the patient's satisfaction with the placement in the home and the quality of care delivered.

The inspector can confirm that based on the evidence reviewed, presented and observed: that the level of compliance with this standard was assessed as Compliant

- **8.1.2 Management of Wounds and Pressure Ulcers –Standard 11 (Selected criteria)**

The inspector examined one patient's care record in regard to wound management. There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment.

A recommendation is made that the patients' pressure relieving equipment in use on patients' beds and when sitting out of bed be addressed in patients' care plans on pressure area care and prevention.

Examination of the patient's care record also confirmed the absence of a patient's pain assessment. A recommendation is made that this be addressed.

Discussion with relatives confirmed that registered nurses had undertaken discussions with them in regard to planning and agreeing nursing interventions however there was no written evidence in two patients care records that discussions with the patients/residents relatives had taken place. A recommendation is made in this regard.

The inspector can confirm that based on the evidence reviewed, presented and observed that the level of compliance with this standard was assessed as Substantially Compliant

- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12 (Selected criteria)**

The inspector reviewed the management of nutrition and weight loss within the home.

Robust systems were evidenced with risk assessments and appropriate referrals to GP's, speech and language therapists and or dieticians being made as required. The inspector also observed the serving of the lunch meal and can confirm that the patients were offered a choice of meal and that the meal service was well delivered. Patients were observed to be assisted with dignity and respect throughout the meal.

The inspector can confirm that based on the evidence reviewed, presented and observed: that the level of compliance with this standard was assessed as compliant.

- **Management of Dehydration – Standard 12 (Selected criteria)**

The inspector examined the management of dehydration during the inspection which evidenced that intake details for patients were recorded and maintained for those patients assessed at risk of dehydration however patients' daily fluid targets were not recorded in patients care records. A recommendation is made in this regard.

Patients were observed to be able to access fluids with ease throughout the inspection, staff were observed offering patients additional fluids throughout the inspection.

Fresh water /various cordials were available to patients and residents in lounges, dining rooms and bedrooms.

The inspector can confirm that based on the evidence reviewed, presented and observed: that the level of compliance with this standard was assessed as substantially compliant

Patients/residents / their representatives and staff questionnaires

Some comments received from patients and residents.

- "I enjoy the food that I am given in the home."
- "I would like to think that I am listened to."
- "My stay in the home is perfect, as regards to the care it couldn't be better. I am feeling much better now and I am happy for all the care given to me by the nurses."
- "My visitors are always made welcome."
- "I am fed up with the spicy food."
- "I am very happy with the standard of care in the home."
- "Staff are all first class I have no problems."

Some comments received from patients' and residents' representatives:

- "I have no complaints."
- "There is a lack of musical therapy and singsongs."
- "There is not enough staff and not enough physiotherapy."

Some comments received from staff

- "I feel this is a very well-run home staff endeavour to provide the best care possible to all the residents."
- "I feel that there is not enough staff to spend time with the individual residents."
- "Training is very good and patients are all well looked after."
- "Yes I have had training in the recording of food and fluid intake charts and the identification of patients at risk of malnutrition."
- "I have had training in wound management."
- "The home is well managed, and well-staffed."
- "Staff makes every effort to maintain a high standard of care."
- "I love my work there is good teamwork here."
- "Yes I have had training in nutrition."
- "Everyone works hard to ensure a good standard of care is provided."

- **8.3 A number of additional areas were also examined**

- Records required to be held in the nursing home
- Guardianship
- Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)
- Patient and staff quality of interactions (QUIS)
- Complaints
- Patient finance pre-inspection questionnaire
- NMC declaration
- Staffing and staff comments
- Comments from representatives/relatives
- Environment.

Full details of the findings of inspection are contained in section 11 of the report.

Conclusion

The inspector can confirm that at the time of inspection the delivery of care to patients and residents was evidenced to be of a good standard. There were processes in place to ensure the effective management of the themes inspected.

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

However areas for improvement are identified. Two restated requirements, four recommendations and three restated recommendations are made. These

requirements and recommendations are addressed throughout the report and in the Quality Improvement plan (QIP).

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

The inspector would also like to thank the patients, residents, relatives 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	20 (1)(c)(i)	It is required senior staff as appropriate be trained in supervision and appraisal. It is also required that staff as appropriate be trained in the management of restraint. This training should include the safe use of bedrails. The registered person shall ensure that the persons employed to work at the nursing home receive appraisal.	Inspection of staff training records confirmed that senior staff had not received training in supervision or appraisal. Examination of records also confirmed that a number of staff had not received annual appraisal. **Restated** Staff as appropriate had received training in the management of supervision including the safe use of bedrails.	**Moving Towards Compliance**
2	20 (2)	The registered person shall ensure that persons working at the nursing home are appropriately supervised.	Inspection of supervision records confirmed that systems were in place to ensure that staff receives supervision. **Restated**	**Moving Towards Compliance**
3	20 (3)	The registered person shall ensure that at all times a nurse is working at the nursing home and that the registered manager carries out a competency and capability assessment with any nurse who is given the responsibility of being in charge of the home for any period of	Inspection of eight registered nurses competency and capability records confirmed that a competency and capability assessment was in place.	**Compliant**

		time in his absence.		
4	17 (1)	The registered person shall introduce and ensure systems are maintained for reviewing at appropriate intervals the quality of nursing and other service provision in or for the purposes of the nursing home and that any such review is undertaken not less than annually. (A report on this review should be drawn up and a copy held in the home).	Examination of records confirmed that an Annual Quality Review report was available in the home.	**Compliant**
5	14 (2) (c)	The registered person shall ensure as far as reasonably practicable that unnecessary risks to the health or safety of patients are identified and so far as possible eliminated.	On the day of inspection the inspector inspected the home environment and it was confirmed that patients' toiletries in the nursing dementia unit were securely stored. The registered manager also informed the inspector that lockable cupboards had been provided in the newly refurbished bedrooms.	**Compliant**

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	25.12	It is recommended that the policy on unannounced visits undertaken in the home under Regulation 29 be reviewed to address The Residential Care Homes Regulations (Northern Ireland) 2005 and the Nursing Homes (2008) and Residential Care Homes (2011) DHSSPS Minimum Standards.	Inspection of the policies and procedures confirmed that the policy on unannounced visits was reviewed and updated.	**Compliant**
2	25.12	It is recommended that relatives' views on the quality of care and other service provision provided in the home be recorded as appropriate in reports of unannounced visits undertaken in the home under Regulation 29. It is also recommended that reports of these visits be signed by the person undertaking the visit.	Inspection of a sample of Regulation 29 visits confirmed that relatives' views were recorded in the reports however the reports of these visits were not signed by the person undertaking the visit. **Restated**	**Substantially Compliant**
3	25.12	It is recommended that details contained in reports of unannounced visits undertaken in the home under Regulation 29 be discussed during staff meetings / forums.	Discussion with the registered manager and staff confirmed that details contained in reports of unannounced visits undertaken in the home under Regulation 29 were discussed during staff meetings/forums.	**Compliant**
4	5.2	It is recommended that infection control assessments be undertaken for patients and residents with outcomes incorporated into care plans.	Inspection of four patients /residents care records confirmed that infection control assessments were not maintained. However the registered manager informed the inspector that systems were in place with the	**Moving Towards Compliance**

			Infection control Nurse NHSCT to commence this assessment. **Restated**	
5	28.1	It is recommended that the template used to undertake care staff induction programmes be reviewed to address pressure area care and prevention.	Inspection of a sample of care staff induction programmes confirmed that this template had not been reviewed to include pressure area care and prevention. **Restated**	**Not Compliant**
6	1.1	It is recommended that privacy blinds be provided on bedroom windows in consultation with patients and residents. These blinds should be washable and disinfectable. Suitable alternatives such as one way vision privacy film may be considered.	The inspector undertook a tour of the home and discussions with the registered provider registered manger and a number of patients /residents confirmed that currently privacy blinds are not required. To be reviewed at forthcoming inspections.	**Not Applicable**
7	1.1	It is recommended that systems are put in place for the appropriate individualisation of patients' and residents' clothing.	Discussions with the registered manager, patients and residents, and observation of the laundry facilities confirmed that currently patients and residents clothing was maintained and identified appropriately.	**Compliant**

11.0 Additional Areas Examined

11.1 Documents required to be held in the Nursing Home

Prior to the inspection a checklist of documents required to be held in the home under regulation 19(2) schedule 4 of The Nursing Homes Regulations (Northern Ireland) was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required documents were maintained in the home and were available for inspection. The inspector reviewed the following records:

- The home's statement of purpose
- The patient's guide
- Sample of reports of unannounced visits to the home under regulation 29
- Sample of staff duty rosters
- Record of complaints
- Sample of incident/accidents
- Record of food provided for patients
- Statement of the procedure to be followed in the event of a fire
- Sample of the minutes of patients/relatives and staff meetings.

11.2 Patients under guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) order 1986.

At the time of the inspection, and living in or using this service was sought as part of this inspection. During the inspection there were no patients in the home who were subject to a guardianship order.

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

The inspector discussed the Human Rights Act and the Human Rights Legislation with the registered manager. The inspector can confirm that copies of these documents were available in the home.

11.4 Quality of interaction schedule (QUIS)

The inspector undertook a number of periods of observation in the home which lasted approximately 20 minutes each.

The inspector observed the patients' and residents' lunch meal which was served in the dining rooms. The inspector also observed care practices in the sitting rooms following the lunch meal.

The observation tool used to record these observations uses a simple coding system to record interactions between staff, patients' residents and visitors.

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

A description of the coding categories of the Quality of Interaction Tool is appended to the report at Appendix 2.

The staff were observed seating the patients in preparation for their lunch in an unhurried manner.

The staff explained to the patients their menu choice and provided adequate support and supervision. Staff were also noted assisting patients with their meal and patients were offered a choice of fluids.

Observation of care practices during these periods of observation revealed that staff were respectful in their interactions with the patients.

Overall the periods of observations were positive.

11.5 Complaints

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

11.6 Patient Finance Questionnaire

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

11.7 NMC declaration

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

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

11.8 Staffing /Staff Comments

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

The inspector spoke to 10 staff members during the inspection process and 10 staff completed questionnaires.

Examples of staff comments were for as follows:

- “I feel this is a very well-run home staff endeavour to provide the best care possible to all the residents.”
- “I feel that there is not enough staff to spend time with the individual residents.”
- “Training is very good and patients are all well looked after.”
- “Yes I have had training in the recording of food and fluid intake charts and the identification of patients at risk of malnutrition.”
- “I have had training in wound management.”
- “The home is well managed, and well-staffed.”
- “Staff makes every effort to maintain a high standard of care.”
- “I love my work there is good teamwork here.”
- “Yes I have had training in nutrition.”
- “Everyone works hard to ensure a good standard of care is provided.”

11.9 Patients’/Residents Comments

The inspector spoke to ten patients /residents individually and with others in groups. Six patients/residents completed questionnaires.

Examples of their comments were as follows:

- “I enjoy the food that I am given in the home.”
- “I would like to think that I am listened to.”
- “My stay in the home is perfect, as regards to the care it couldn’t be better. I am feeling much better now and I am happy for all the care given to me by the nurses.”
- “My visitors are always made welcome.”
- “I am fed up with the spicy food.”
- “I am very happy with the standard of care in the home.”
- “Staff are all first class I have no problems.”

11.10 Relatives’ Comments

The inspector spoke to relatives and these relatives completed questionnaires.

An example of the relative’s comments is:

- “I have no complaints.”
- “There is a lack of musical therapy and singsongs.”
- “There is not enough staff and not enough physiotherapy.”

11.11 Environment

The inspector undertook an inspection of the home and viewed a number of patients'/residents' bedrooms, communal facilities, toilet and bathroom areas.

The premises presented as warm, lean and comfortable with a friendly and relaxed ambience.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr Ciaran Sheehan, Registered Provider and Mr Ciaran Maynes, Registered Manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

Heather Moore
The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS

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**
All residents have a pre admission completed prior to being admitted to the home. Only under extreme emergency situations is this rule not adhered too,(extremely rare), however a full range of assessments from the referrer would be received by email or sent with the patient, and a detailed verbal handover taken from the appropriately qualified referrer prior to the resident being admitted. A full care plan is completed within the allotted timeframe of 11 days post admission for All residents. All resident have a MUST assessment carried out as part of the admission and care planning process. A Braden scoring is carried out on all residents who are admitted to the home as part of the admission process.	Compliant

All of the above assessments are updated on a monthly basis and more frequently if required.	
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**
We operate a named nursing system in Fairfields Care Centre, and the care plan will reflect the residents requirements and goals, and any advice or recommendations from PAM's will be incorporated also. We work closely with our TVN's in this area and a clear referral system is in place to obtain advice and support in this	Compliant

area of care. Should as resident require specialist treatment for any pressure area they may have, this will be incorporated into the patients care plan after consultation with the TVN. Podiatry services are available for all residents who require specialist intervention re; lower limb or foot ulceration, and a referral process is in place to access these services. We work very closely with our dieticians and can refer to them at any time and are an important resource to avail of for the betterment of our residents. Should a resident require a nutritional treatment plan then a referral will be completed for a dietetic review and a care plan subsequently drawn up to try and meet the resident requirements.	
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**
Assessment of our residents is done on a daily basis and on top of this a monthly update of the residents care plan is compelted as a minimium.Each resident has a yearly care management review also with the residents care manager, trust representative, and themselves and/or a family representative to discuss the residents cureent status and should any recommendations arise from such reviews they are incorporated into the residents care plan also.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All procedures are carried out and verified using uo to date information and evidence based practice. Expert knowledge is used also to back up staff when carrying out these procedures and education training and support is provided to staff to ensure these procedures are carried out in the correct and safe manner. We use the Euopean Pressure Ulcer Advisory Panel (EPUAP) & National Pressure Ulcer Advisory Panel (NPUAP) pressure ulcer grading tools to screen pateint who have skin damaged areas and liase with tour colleagues in TVN team to devlop a plan of treatment to help to heal these wounds. The catering team use the Nutritional Guidelines for Residents living in Residential and Nursing Homes, RQIA verified, to help develop their menus for the residents so that they are getting a balanced healthly and wholesome diet.	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**
Nursing records are kept on a daily basis of all nursing activites and procedures that comply with the NMC guidelines. Records are kept of the meals providied to our residents and they are available for inspection at any time. Where a resident requires that food and fluid charts are kept to record their daily food and fluid intake, these records are maintained and should an individual resident require the input of a dietician to asses the need for dietary supplements to be added to a diet or, as can be the case, a reduction diet requires to be implemented then this is done and a record kept of all interventions and the residents care plan will be updated to relflect these changes.	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**
All care provided to our residents is documented on a daily basis and as previously stated is subject to review at least on an annual basis and can be reviewed more frequently as and when required. The care manager from the trust, the resident and/or their representative and the residents named nurse will be in attendance at these reviews.	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**
As previously stated, residents are actively involved in reviewing their own care and were possible attend their own care management reviews. If this is not possible the residents care manager will attempt to ascertain the residents wishes by meeting the resident on their own, and their thoughts wishes and feelings on topics relevant to their care are taken on board and implemented if at all possible to do so. The results of the reviews are documented and a record is kept by both the care manager of the trust and in the residents own care records in the home. A residents representative can also request a copy of the review	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**
I feel that our 3 weekly menus which are reviewed regularly offer a varied and nutritious diet for our residents. Each resident has a dietary profile that is regularly reviewed by our catering team and hospitality staff. We try to achieve all the requirements of residents dietary wishes and i fell that we are successful in this area.As already stated the Nutritional Guidelines for residents living in residential and nursing homes is used along with support and advice from the dieticians who work with us to provide the residents witht adiet that will meet their individual needs.	Compliant

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

here at Fairfields, the catering staff will often go over and above to provide meals for family gatherings and couples for special events such as anniveraries, birthdays etc. Staff are aware of the ever present dangers that can be involved with residents who have swallowing difficulties and can access help and assistance if and when required in an emergency situation. Our nurses are gaining knowledge all the time in the management of sometime complex wounds and i'm confident in their ability to carry wound assessment in the appropriate method. This will include a combination of the varying degrees of experience they have and the liasing with specialist TVN's to formulate the appropriate wound management plan. Also here at Fairfields we are part of the NHSCT TYC initiative for pressure area care and wound management in the nursing home setting, and training for nursing and care staff is in the rolling out process for same. I feel this will have a huge impact on wound management in the hospital and nursing home setting.	

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	**COMPLIANCE LEVEL**
	Compliant

Appendix 2

Explanation of coding categories as referenced in the Quality of Interaction Schedule (QUIS)

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic Care: (BC) –** basic physical care e.g. bathing or use if toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc. (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away • Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others	**Examples include:** Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (NS) –** communication which is disregarding of the residents' dignity and respect.
Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions • Not showing interest in what the patient or visitor is saying	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness') • Seeking choice but then ignoring or over ruling it • Being angry with or scolding older patients • Being rude and unfriendly • Bedside hand over not including the patient

References

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.

Quality Improvement Plan

Announced Primary Inspection

Fairfields Care Centre

04 August 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 **Mr Ciaran Sheehan, Registered Provider and Mr Ciaran Maynes, Registered Manager** 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	20(1)(c)(i)	It is required that Senior staff as appropriate be trained in supervision and appraisal. The registered person shall ensure that the persons employed to work at the nursing home receive appraisal. **Follow up to previous issues**	Two	Training is in the process of being organised for senior staff within the home to ensure they are capable of performing appraisals and supervisions on nursing, care and ancilary staff in Fairfields.	Two months and ongoing
2	20(2)	The registered person shall ensure that patients working at the nursing home are Appropriately supervised. **Follow up to previous issues**	Two	When the above training has been fully completed the supervision of staff will be rolled out among all disciplines in the home.	Two months and ongoing

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	5.3	It is recommended that the patients' pressure relieving equipment in use on patients' beds and when sitting out of bed be addressed in patients' care plans on pressure area care and prevention. **Ref: Management of wounds and pressure ulcers**	One	All nursing staff have been educated regarding the importance of documenting all pressure relieving equipment in the residents care plan on pressure area care and prevention.	From the date of this inspection
2	5.2	It is recommended that written evidence is maintained in patients' and residents' care records to indicate that discussions had taken place with patients, residents, and their representatives in regard to planning and agreeing nursing interventions. **Ref: Management of wounds and pressure ulcers**	One	All residents have a letter in front of there care records that is signed by the nurse, resident/representative and home manager to give evidence to the fact that a discussion has taken place with regard to a plan of care to meet the reswidents needs.	One week
3	5.3	It is recommended that a pain assessment be maintained in patients' and residents' care records. (if applicable) **Ref: Management of wounds and pressure ulcers**	One	All residents who require a pain assessment to be carried out will have one in place and this will be reviewed regularly to ensure the residents pain, if any, is being appropriately managed.	From the date of this inspection

4	12.10	It is recommended that patients' recommended daily fluid targets and the action to be taken if these targets are not achieved be recorded in patients' care plans on eating and drinking. **Ref: Management of dehydration**	One	The care plans of all residents who require daily fluid targets to be met will have the targets documented in the their care plan and also will have the actions to be taken should the target not be met recorded in the care plan.	From the date of this inspection
5	5.2	It is recommended that infection control assessments be undertaken for patients and residents with outcomes incorporated into care plans. **Ref : Follow up to previous issues**	Two	We are looking into an appropriate infection control tool and the appropriateness of one being carried out on each resident as this would not be the general recommendation of the HPA. Their advice would be just to carry out infection control tools on those residents with an identified infection and carry out standard precautions which are being done on each resident anyway, however on speaking to the lead infection control nurse from the HPA, Caroline McGeary, a new infection control risk assessment tool is almost complete and will start to be rolled out across the trusts and the private care sector before the end of the year and we will be keen to initiate this in Fairfields.	Two months

6	28.1	It is recommended that the template used to undertake care staff induction programmes be reviewed to address pressure area care and prevention. **Ref : Follow up to previous issues**	Two	Our care staff induction templates have been reviewed and do incorporate pressure area care and prevention as part of the induction process and staff are receiving regular updates and training on pressure area care and prevention through in house and outsources services.	Two months
7	25.12	It is recommended that reports of the Regulation 29 reports be signed by the person undertaking the visit. **Ref: Follow up to previous issues**	Two	This point has been highlighted to the directors of care circle and they are aware to ensure that this is remedied should it arise.	From the date of this 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	Ciaran Maynes
Name of Responsible Person / Identified Responsible Person Approving Qip	Ciaran Sheehan

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Heather Moore	08 October 2014
Further information requested from provider			