The Regulation and Quality Improvement Authority

Unannounced Primary Care Inspection

Name of establishment: Faith House Private Nursing Home

RQIA number: 1603

Date of inspection: 2 October 2014

Inspector's name: Carmel McKeegan

Inspection number: IN017172

The Regulation And Quality Improvement Authority
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1.0 General information

Name of establishment:	Faith House Eventide Home
Address:	25 Orpen Park Belfast BT10 0BN
Telephone number:	(028)9061 2318
Email address:	anne.acheson@faith-house.co.uk
Registered organisation/ Registered provider / Responsible individual	Board of Trustees-Faith House Mr Roland William McCahon
Registered manager:	Ms Jane Moore
Person in charge of the home at the time of inspection:	Ms Jane Moore
Categories of care:	NH - I, PH, TI RC - I
Number of registered places:	65 (34 Nursing and 31 Residential)
Number of patients / residents accommodated on day of inspection:	33 NH –I 29 RC-I
Scale of charges (per week):	£ 461.00 Residential £ 624.00 Nursing
Date and type of previous inspection:	5 July 2013 Primary Unannounced
Date and time of inspection:	2 October 2014 10:00 -17:00
Name of inspector:	Carmel McKeegan

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 an unannounced primary care 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/residents 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 the preliminary assessment of achievement by the Provider 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 inspection visit by the inspector.

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

- Review of any notifiable events submitted to RQIA, in accordance with Regulation 30 of the Nursing Homes Regulations (NI) 2005, since the previous inspection.
- Analysis of pre-inspection information submitted by the registered person/s.

- Discussion with the registered manager, Ms Jane Moore.
- Review of the returned quality improvement plan (QIP) from the previous care inspection conducted on 5 July 2013.
- Observation of care delivery and care practices.
- Discussion with staff on duty at the time of this inspection.
- Examination of records pertaining to the inspection focus.
- Consultation with patients individually and with others in groups.
- Tour of the premises.
- Evaluation and feedback.

5.0 Consultation process

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

Patients/Residents	**8**
Staff	**7**
Relatives	**4**
Visiting professionals	**0**

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

Issued to	**Number issued**	**Number returned**
Patients / residents	5	4
Relatives / representatives	5	4
Staff	10	0

6.0 Inspection focus

The theme for the inspection year April 2014 – March 2015 is: 'Nursing Care'

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 regular reviewed. (Standard 5).

Under the 'Nursing Care' theme, inspection will focus on three areas of practice:

- Management of wounds and pressure ulcers (Standard 11).
- Management of nutritional needs of patients and weight loss (Standard 8 & 12).
- Management of dehydration (Standard 12).

Only selected criteria from each of the four standards will be inspected across nine areas and incorporated into the Provider's Self-Assessment.

The inspector will also consider the management of patient's human rights during this inspection.

The inspection theme and focus for the 2014 – 2015 inspection year was outlined by RQIA at the annual Provider Roadshow in February 2014 and the self-assessment was made available on the RQIA website.

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

Faith House Eventide Nursing Home is situated in Orpen Park in the Finaghy area of Belfast.
The nursing home is owned and operated by the Board of Trustees – Faith House. Mr Mervyn Wishart is the responsible person.

The current registered manager is Ms Jane Moore who was appointed Director of Nursing in August 2014.

Faith House is a listed historical building which dates back to 1727. The main house is a two storey building which provides residential care, and the two storey purpose built extension is designated as a nursing home.

The main residential home has two ground floor sitting rooms that overlook the front of the house and a sitting area is available on the first floor. All the bedrooms in the residential home are single, and one double bedroom is also available.

There is a large lounge in the nursing home overlooking the garden and car park, and in addition there are smaller sitting rooms which are positioned throughout both floors. The bedroom provision within the nursing home consists of single bedrooms with en-suite toilet and hand washing facilities and a shower facility has also been provided in some rooms.

The home has two spacious dining rooms. Within the nursing home the dining room is situated next to the main lounge and in the residential home the dining room is positioned next to the kitchen.

Communal toilet/shower/bathrooms were also appropriately located throughout both homes.

The well-equipped laundry and kitchen provide a service to both the nursing and residential home.

A small shop, located close to the main reception areas is provided for patients and residents.

Faith House is set in spacious grounds surrounded by well-maintained gardens. Car parking spaces are available.

The home is registered to provide care for a maximum of 65 persons under the following categories of care:

Nursing care

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
TI	terminally ill

Residential care

I	old age not falling into any other category

8.0 Executive summary

The unannounced inspection of Faith House Nursing Home was undertaken by Carmel McKeegan on 2 October 2014 between the hours of 10:00 and 17:00.

The inspector was welcomed into the home by Ms Jane Moore, registered manager who was available throughout the inspection.

The theme for the 2014 – 15 inspection year is 'Nursing Care' (Standard 5) and the inspection focused on three areas of practice related to:

- Management of wounds and pressure ulcers (Standard 11).
- Management of nutritional needs of patients and weight loss (Standard 8 & 12).
- Management of dehydration (Standard 12).

The inspector also considered the management of patient's human rights during this inspection. The requirements and recommendations made as a result of the previous inspection were also examined.

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. This self-assessment was received on 18 April 2014, which was within the time frame requested by RQIA.

The comments provided by the responsible individual/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

Review of pre-inspection information submitted by the registered person/registered manager indicated that notifiable events were provided to RQIA in accordance with legislation. Analysis of other documentation including the returned QIP from the previous care inspection on 5 July 2013, confirmed that sufficient information had been provided.

During the course of the inspection, the inspector met with patients, staff and relatives, who commented positively on the care and services provided by the nursing home. There were no concerns brought to the attention of the inspector.

Discussion with the registered manager, 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 guidelines for the number of patients currently in the home. An activity therapist is employed to provide additional hours for the provision of activities to patients, this is good practice.

The ancillary staffing levels were found to be satisfactory, the home was organised and tidy throughout. A requirement is made in relation to infection control which also applies to the home's cleaning regime. The registered manager stated that she intends to review the current work pattern for domestic services within the home to extend the existing domestic service to provide cover into the late afternoon and also to enhance domestic services at weekends.

Staff were provided with a variety of relevant training including mandatory training since the previous inspection.

During the inspection the inspector spoke individually and in private with seven staff which included two registered nurses, three care staff and a cook. Staff responses in discussions indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes. There were no issues of concern raised with the inspector, staff indicated they enjoyed working in the nursing home and felt supported and valued by management.

Comments made by staff members included;

"I am very happy working in this home and think the patients and residents are very well looked after."
"The quality of care provided is generally very good, we all do our best to make sure the patient's needs are met. The management of the home has improved."
"We all get on very well as a team and I think that is important for the sake of our patients and residents."
"We get a lot of training and it's been very good, I like learning new things."

The inspector observed the interactions between staff and patients throughout the home which were seen to be respectful and considerate of the patients' abilities and well-being. Patients were well presented, clothing was clean and fresh, and several patients had matching accessories of their choosing. Patients appeared comfortable and relaxed, and were seen to receive regular attention from a variety of staff members, which included, nursing and care staff, and also housekeeping and catering staff. The activity therapist was present throughout the day and provided activities as displayed on the patient's and relative's notice board.

The inspector can confirm that the home at the time of the inspection presented as clean, fresh and free from odour.

The inspector can also confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a satisfactory standard and patients were observed to be treated by staff with dignity and respect.

One requirement was made to ensure that the Tissue Viability Nurse's recommendations are accurately incorporated into the respective patient's care plan and followed until notified otherwise by the Tissue Viability Nurse.

The inspector observed that a choice of fluids to include fresh drinking water were available and refreshed regularly. Staff were observed offering patients fluids at regular intervals throughout the day. One recommendation was made to improve upon the recording of fluid management in place for patients.

There were systems and processes in place to ensure the effective management of the standards inspected. A recommendation was made to ensure that patient's care records show that there has been consultation and discussion with the patient and/or their

representative regarding the agreeing and planning of nursing interventions and/or following subsequent changes to the plans of care.

The inspector reviewed and validated the home's progress regarding the nine requirements and three recommendations made at the last inspection on 5 July 2013. The inspector was able to verify that all nine requirements and two recommendation had been fully complied. One recommendation relating to the provision of patient/relative meetings was not assessed due to the recent appointment of the registered manager. It was agreed that this recommendation would be reviewed at the next care inspection.

Verbal feedback of the issues identified during the inspection was given to Ms Moore at the conclusion of the inspection.

Conclusion

As a result of this inspection, two requirements and three recommendations were made and one recommendation is carried forward for review at the next care inspection.

Details can be found under Section 10.0 in the report and in the quality improvement plan (QIP).

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

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

9.0 Follow-up on the requirements and recommendations issued as a result of the previous primary unannounced care inspection conducted on 5 July 2013

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
1	29 (4)	Ensure the regulation 29 report includes a section of the action taken on the issues raised from the previous inspection and a new action plan from the date of the inspection. The report should be dated and signed by the registered manager when received. The inspection report should include the start and finish time of the visit.	Review of the three most recent regulation 29 reports for June, July and August 2014 confirmed that reports were dated and signed by the registered manager on receipt. Reports provided the date, start and finish times of the visit and included details of the action taken on the issues raised at the previous inspection. This requirement is assessed as compliant.	Compliant
2	14 (4)	Ensure all staff in the home report suspicions of abuse in a timely manner and in keeping with regional guidelines.	Discussion with the registered manager and two registered nurses confirmed they were knowledgeable in their responsibility to report any suspicion of abuse in a timely manner. Training records were available to show that Safeguarding Vulnerable Adult training included the reporting procedures for all grades of staff. This requirement is assessed as compliant.	Compliant

3	14 (4)	Ensure the policy and procedures regarding 'whistleblowing' are reinforced with staff alongside timescales when incidents should be reported. Staff should also be reminded of their responsibility to report any incidents in keeping with best practice as outlined in the NMC (Nursing and Midwifery Council) and NISCC (Northern Ireland Social Care Council) codes of conduct.	Review of staff training records verified that staff had received further whistleblowing training. Discussion with seven staff members confirmed they were aware of their responsibility to report any incidents in keeping with best practice as outlined in the NMC and NISCC codes of conduct. This requirement is assessed as compliant.	Compliant
4	25 (c)	Ensure the outcome of the investigations by the local healthcare trusts and the programme of action and improvement by the management of the home if required is forwarded to the RQIA upon completion alongside timescales any actions are to be implemented.	The inspector can confirm that this requirement is compliant.	Compliant

5	12 (1)(b)	Ensure staff have a format where their views and suggestions have been taken into consideration. Minutes of discussions and the outcomes of discussions or actions agreed should be retained and where necessary actions should be implemented. Evidence should also be retained if deemed no action is necessary.	Discussion with two registered nurses, four care staff and the cook confirmed that regular staff meetings had taken place. Review of staff meeting records confirmed that records were kept in accordance with the Nursing Homes Minimum Standards (2008). This requirement is assessed as compliant.	Compliant

6	15 and 16	Ensure the following issues are addressed; • Pain assessments were not always completed or reviewed in a timely manner. • Care plans should be clearly discontinued when no longer relevant. • Ensure abbreviations are not used in the care records. • Ensure each wound/pressure ulcer has an individual plan of care in place. • Ensure the current state of wounds/pressure ulcer is recorded. • Ensure the date of when the wound/pressure ulcer is detected is recorded.	Review of care records at the time of the inspection evidenced that each of the areas identified for improvement had been addressed. The inspector was able to verify that registered nursing staff attended wound care training which included training on the legal and professional aspects of care planning and record keeping. Discussion with the registered manager confirmed that care plan audits have commenced and she intends to further develop the current system. Wound care records reviewed contained the information as stated in this requirement. However a further requirement is made as a result of this inspection in relation to the advice and recommendations made by the Tissue Viability Nurse. Further detail is provided in the main body of the report.	Compliant

		• Ensure each wound/pressure ulcer has the prescribed dressing recorded in the care records. • Ensure wound charts are properly completed each time the dressing is changed. • Photographs of wounds/pressure ulcers should be maintained in keeping with policy and best practice. • The care plan should be updated as changes in care occurs. Due to the short falls in the management of care records particularly in relation to the management of wounds/pressure ulcer care further training and development for staff		

		managing wound care/pressure ulcer care should be provided and attended. This should include training on the legal and professional aspects of care planning and record keeping. Care plan audits should be further developed in order to highlight common trends in the care planning process.		
7	12 (1) (b)	Ensure staff managing wounds/pressure ulcer care has a competency and capability assessment completed. Records should be maintained of the supervision and competency and capability assessments carried out.	Records were available to evidence that staff managing wounds/pressure ulcers had completed a competency and capability assessment in wound management. This requirement is assessed as compliant.	Compliant
8	13 (4)	Ensure medications are administered in keeping with best practice.	Observations made on the day of the inspection confirmed that medications were administered in keeping with best practice. This requirement is assessed as compliant.	Compliant

9	20 (1) (a)	Ensure at all times suitably qualified, competent and experienced persons are working in the nursing home in such numbers as are appropriate for the health and welfare of patients. Ensure there are two registered nurses are on duty daily from the hours of 14:00 to 20:00.	Review of the duty rota for three weeks from 15 September 2104 to 5 October 2014, confirmed that there are two registered nurses on duty from 14.00 to 20.00 daily. This requirement is assessed as compliant.	Compliant

No	Minimum Standard Ref.	Recommendations	Action taken – as confirmed during this inspection	Inspector's validation of compliance
1	30.9	Ensure that the agreements made regarding staff meetings are implemented as follows; • Agenda for staff meetings should be clearly displayed prior to meetings being held. • There should be an opportunity for staff to contribute to the agenda. • There should be a clear action plan in place to address any issues raised alongside timelines. • The agenda for the staff meeting should include issues arising from previous meeting and the action taken to address	Discussion with two registered nurses, four care assistants and a cook confirmed that staff meetings had taken place regularly and staff were consulted regarding the meeting agenda. Staff spoken with confirmed they could contribute to the agenda prior to and during meeting. As previously stated staff meeting records reviewed were seen to be kept in accordance with the Nursing Homes Minimum Standards (2008). This recommendation is assessed as compliant.	Compliant

		the issues. • Staff should sign that they have read the minutes of the meetings held.		
2	1.2	Ensure a residents/relatives meeting is held as soon as possible.	The registered manager stated that she has not yet had the opportunity to arrange a residents/relatives meeting. This recommendation was not reviewed at this inspection and is carried forward to the next care inspection.	Not inspected
3	25.12	Ensure information is placed on the patient/relatives' notice board informing patients and their representatives that copies of the Regulation 29 unannounced visit reports and the annual quality reports are available on request.	Notice boards were seen to provide information of how patients/residents and their representatives may access a copy of the regulation 29 reports and the annual quality report. This recommendation is assessed as compliant.	Compliant

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

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if there is considered to be a breach of regulation as stated in the Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

Since the previous care inspection on 5 July 2013, RQIA have received nil notifications of safeguarding of vulnerable adult (SOVA) incidents, complaints or whistleblowing in respect of Faith House Nursing Home.

10.0 Inspection findings

Section A – On admission a registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Standard criterion 5.1, 5.2, 8.1 and 11.1 examined.
Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance. Review of three patients' care records evidenced that patients' individual needs were established on the day of admission to the nursing/residential home, through pre-admission assessments and information received from the care management team for the relevant Trust. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks. Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, Bristol stool chart and continence were also completed on admission. The inspector confirmed that pain and infection control assessments were undertaken for patients as appropriate to their condition. Information received from the care management team for the referring Trust confirmed if the patient to be admitted had a pressure ulcer/wound. Discussion with two registered nurses confirmed that should a prospective patient have a wound or skin condition, specific care plans regarding the management of the wound/ pressure ulcer/skin condition would be provided. Review of patients' care records evidenced that a comprehensive holistic assessment of the patients' care needs was completed within 11 days of the patient's admission to the home. Discussion with the registered manager and a senior nurse in the nursing unit, demonstrated they had a good awareness of patients who required wound management intervention and the also the number and progress of patients who were assessed as being at risk of weight loss and dehydration. At the time of this inspection there were no residents accommodated in the residential home with a wound or pressure ulcer.

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

Section B –A registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Care records evidence involvement of the patient and /or their representative and that care planning and delivery reflect the recommendation from relevant health professionals. Referrals to healthcare professionals are made as required and in a timely manner. Standard criterion 5.3, 11.2, 11.3, 11.8 and 8.3 examined.

The inspector observed that a named nurse and key worker system was operational in the home. The roles and responsibilities of named nurses and key workers were outlined in the patient's guide.

Review of three patient's care records did not evidence that either patients or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions or following subsequent changes to the plans of care. Discussions with two registered nurses indicated that consultation did take place with the patient and/or their representatives during the admission process and thereafter until the patient's care plan was fully established, nurses agreed that this was not always evidenced in the documentation.

Patient/representative consultation process was discussed with the registered manager who stated that this is an area of care planning that they are aware of and are currently reviewing different approaches to establish the most effective method for the home. A recommendation is made that there is written evidence to show that patients or their representatives have been involved in discussions regarding the agreeing and planning of nursing interventions and/or following subsequent changes to the plans of care.

It is also recommended that the Policy on Assessment, Care Planning and Evaluation is further developed to state the registered nurse's responsibility to evidence that patients or their representatives have been involved in discussions regarding the agreeing and planning of nursing interventions and/or following subsequent changes to the plans of care.

Discussion with the registered manager and two registered nurses and a review of three patients' care records, confirmed that where a patient was assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention plan and treatment programme.

The inspector reviewed two patient's care records who required wound management for a wound which showed the following;

- A body mapping chart was completed for each patient on admission. This chart was reviewed and updated when any changes occurred to the patient's skin condition.

- A care plan was in place which specified the pressure relieving equipment in place on the patient's bed and also when sitting out of bed

- The type of mattress in use was based on the outcome of the pressure risk assessment. The specialist mattresses in use were being safely used and records were available to reflect they were appropriately maintained.

- A daily repositioning and skin inspection chart was in place for each patient with the wound and also for patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these charts revealed that patients' skin condition was inspected for evidence of change at each positional change. It was also verified that patients were repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention. A pain assessment had been undertaken for each patient and a pain management care plan was also in place for each patient.

- Patient A' s wound care record (identity known to the registered manager) – Tissue Viability Nurse (TVN) recommended that the patient's wound is redressed three times weekly however the patient's wound evaluation form states that the wound is to be redressed every 5 days.

- Patient B's wound care record (identity known to the registered manager) – Tissue Viability Nurse's assessment noted that a wound product had been applied to the wound that had not been recommended by the Tissue Viability Nurse.

It is required in accordance with the Nursing Home Regulations (Northern Ireland) 2005, Regulation 14 (1) (b) that the registered person shall make arrangements for patients to receive, where necessary, treatment, advice and other services from any other healthcare professional. The Tissue Viability Nurse's recommendations must be incorporated into the respective patient's care plan and followed until instructed otherwise. Any nursing treatment that deviates from the TVN's recommendations must show a decision making process by the registered nurse who will assume accountability for their decision.

Patients' moving and handling needs were assessed and addressed in their care plans. There was evidence that manual handling aids were used to minimise risk of friction. Staff consulted confirmed there was sufficient nursing equipment available to move and handle patients' appropriately.

The registered manager and registered nurses confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local healthcare Trust. Staff spoken with was knowledgeable regarding the referral process. Discussion with two registered nurses evidenced that they were knowledgeable of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

Discussion with the registered manager, registered nurses and review of the staff training records, revealed that since the previous inspection in 5 July 2013, all registered nursing staff have attended trained in wound management and pressure ulcer treatment.

Review of the records of incidents revealed that the incidence of pressure ulcers, grade 2 and above, were reported to RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

Review of care records verified that patients' weight was recorded on admission and on at least a monthly basis or more often if required. Discussion with two registered nurses showed they were knowledgeable on the patients who have been identified to have their weight recorded on a weekly basis, and explained the internal weight monitoring systems in place in the home.

Policies and procedures were in place for staff on making referrals to the dietician. These included indicators of the action to be taken and by whom. All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment.

The patient's nutritional status was also reviewed on at least a monthly basis or more often if required. The registered nurses confirmed that should they identify significant changes in patient's weight they would consult with the patient's dietician and make the appropriate referrals. Registered nurses confirmed that the registered manager is informed of all referrals made.

A daily food and fluid intake chart is maintained for patients who are nutritionally compromised and/or where a nursing decision has been made to monitor the patient's food and fluid intake. The inspector observed care staff completing these records after mid-morning beverages, the mid-day meal and following afternoon tea, this is good practice. The inspector selected a random sample of five patients' daily fluid intake charts, the fluid intake charts had all been totalled for the previous 24 hour period however the inspector was unable to evidence that patient's daily fluid intake was recorded in their respective daily progress records. It is recommended that where a patient is assessed as at risk of dehydration the patient's records should evidence that;

- A registered nurse verifies the patient's total fluid intake over the 24 hour period.
- An effective reconciliation of the total fluid intake against the patient's fluid target is established.
- Action to be taken if targets were not being achieved.
- A record of reconciliation of fluid intake is recorded in the patient's daily progress notes.

Review of care records reviewed evidenced that where appropriate, patients were referred to the speech and language therapist and/or dietetic assessment in a timely manner. Care plans reviewed showed that dietician's and speech and language therapist's recommendations had been addressed in the patient's respective care plan.

The inspector reviewed the record of staff training which included mandatory training for all staff members, records showed that training on the Malnutrition Universal Screening Tool (MUST) had been provided for registered nursing staff and care staff had attended training on the use of thickening agents.

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

Section C - Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans. Standard criteria 5.4 examined.
Review of three patients' care records evidenced that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care including wound care for each patient. Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required. Review of two patient's care records in relation to wound care indicated that these care records were reviewed each time the dressing was changed and also when the condition of the wound had deteriorated. As previously stated a requirement is made to ensure the Tissue Viability's recommendations are followed. Review of care records also evidenced that nutritional care plans for patients were reviewed monthly or more often as deemed appropriate. The evaluation process included the effectiveness of any prescribed treatments, for example prescribed analgesia. Discussion with two registered nurses and a review of governance documents evidenced that a number of care records were audited on a monthly basis. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process.

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

Section D – All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. Standard criterion 5.5, 8.4 and 11.4 examined.

The inspector examined three patients' care records which evidenced the completion of validated assessment tools such as:

- The Roper, Logan and Tierney assessment of activities of daily living.
- Braden pressure risk assessment tool.
- Nutritional risk assessment such as Malnutrition Universal Screening Tool (MUST)
-

The inspector confirmed the following research and guidance documents were available in the home:

- DHSSPS 'Promoting Good Nutrition' A Strategy for good nutritional care in adults in all care settings in Northern Ireland 2011-16
- The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.
- The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care
- The European Pressure Ulcer Advisory Panel (EPUAP)
- RCN/NMC guidance for practitioners.

Discussion with the registered manager and registered nurses confirmed that they had a good awareness of these guidelines.

Discussion with the registered manager, registered nurses and a review of governance documents evidenced that the quality of pressure ulcer/wound management was audited each time dressings were changed and discussed at each hand over report. There was also evidence to confirm that action was taken to address any deficits or areas for improvement identified through the audit process. Registered nursing staff were found to be knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care.

Eight staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held in the dining room for staff reference.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Moving towards compliance**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**

Section E – 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. Standard criterion 5.6, 12.11 and 12.12 examined.

A policy and procedure relating to nursing records management was available in the home. Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance.

Registered nurses spoken with were aware of their accountability and responsibility regarding record keeping.

A review of the training records confirmed that since the previous inspection staff had received training on the importance of care planning and record keeping commensurate with their roles and responsibilities in the home.

Review of three patients' care records revealed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient. These statements reflected wound and nutritional management intervention for patients as required.

Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patients' status or to indicate communication with other professionals/representatives concerning the patients.

Entries were noted to be timed and signed with the signature accompanied by the designation of the signatory.

The inspector reviewed a record of the meals provided for patients. Records were maintained in sufficient detail to enable the inspector to judge that the diet for each patient was satisfactory.

The inspector reviewed the care records of three patients identified of being at risk of inadequate or excessive food and fluid intake. This review confirmed that:

- Daily records of food intake were being maintained.
- The nurse in charge had discussed with the patient/representative their dietary needs.
- Where necessary a referral had been made to the relevant specialist healthcare professional.
- A record was made of any discussion and action taken by the registered nurse.

- Care plans had been devised to manage the patient's nutritional needs and were reviewed on a monthly or more often basis.

There was evidence that the patients were offered fluids on a regular basis throughout the day, as previously stated fluid intake monitoring charts were in place for patients assessed as 'at risk' of dehydration, a recommendation was made.

Staff spoken with were evidenced to be knowledgeable regarding patients' nutritional needs.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Moving towards compliance**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**

Section F – 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. Standard criteria 5.7 examined.
Please refer to criterion examined in Section E. As previously stated in Section B, review of three patients' care records did not evidence that consultation with the patient and/or their representative had taken place in relation to the planning of the patient's care. A recommendation is made in this regard to ensure best practice in keeping with the DHSSPS Minimum Standards and the Human Rights Act 1998.

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

Section G – The management and involvement of patients and/or their representatives in review of care. Standard criterion 5.8 and 5.9 examined.
Prior to the inspection, a patients' care review questionnaire was forwarded to the home for completion by staff. The information provided in this questionnaire revealed that all the patients in the home had been subject to a care review by the care management team of the referring HSC Trust between 01 April 2013 and 31 March 2014. The registered manager informed the inspector that patients' care reviews were held post admission and annually thereafter. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff preferably the patient's named nurse attends each care review. A copy of the minutes of the most recent care review was held in the patient's care record file. The inspector viewed the minutes of three care management care reviews which evidenced that, where appropriate, patients and their representatives had been invited to attend. Minutes of the care review included the names of those who had attended, an updated assessment of the patient's needs and a record of issues discussed. Care plans were evidenced to be updated post care review to reflect recommendations made where applicable.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Moving towards compliance**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**

Section H – Management of nutrition including menu choice for all patients. Standard criterion 12.1 and 12.3 examined.
A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance. There was a three weekly menu planner in place. The inspector spoke with the cook who informed the inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home. The cook stated that patients and their families are always consulted and encouraged to have input when reviewing menus for patients. The inspector discussed the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients with the registered manager, two registered nurses, four care assistants and the cook. A Nutritional Folder is available for staff reference which provides a copy of the three week menu, results of the 2014 menu satisfaction survey and relevant best practice guidance. Staff spoken with were knowledgeable regarding the individual dietary needs of patients and to include their likes and dislikes. Discussion with staff and review of the record of the patient's meals confirmed that patients were offered choice prior to their meals. Staff spoken with were knowledgeable regarding the indicators for onward referrals to the relevant professionals. e.g. speech and language therapist or dieticians. As previously stated under Section D relevant guidance documents were in place. From a review of the menu planner, records of patients' choices and discussion with a number of patients, registered nurses and care staff, it was confirmed that choices were available at each meal time and also between meal snacks, for all patients including patients who were on therapeutic diet.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Moving towards compliance**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**

Section I – Knowledge and skills of staff employed by the nursing home in relation to the management of nutrition, weight loss, dehydration, pressure area care and wounds. Standard criterion 8.6, 11.7, 12.5 and 12.10 examined.

The inspector discussed the needs of the patients with the registered manager and two registered nurses. It was determined that a number of patients had swallowing difficulties.

As stated in Section B staff training records showed that training on the Malnutrition Universal Screening Tool (MUST) had been provided for registered nursing staff and care staff had attended training on the use of thickening agents. Staff also had attended First Aid training which included guidance on the care of a patient when choking.

Discussion with registered manager confirmed that meals were served at appropriate intervals throughout the day and in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.
Discussion with the cook confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning afternoon and at supper times.

The inspector observed that a choice of fluids to include fresh drinking water were available and refreshed regularly. Staff were observed offering patients fluids at regular intervals throughout the day.

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Eight staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was available for staff.

On the day of the inspection, the inspector observed the lunch meal. Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely manner.

Staff were observed preparing and seating the patients for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients with their meal and patients were offered a choice of fluids. The tables were well presented with condiments appropriate for the meal served.

Discussion with the registered manager, registered nurses, care staff and review of the staff training records, revealed that since the previous inspection in 5 July 2013, all registered nursing staff have attended trained in wound management and pressure ulcer treatment.

Review of two patient's wound care in a patient's care plan evidenced that the dressing regime all care interventions was recorded for each patient. As previously stated a requirement is made to ensure that recommendations made by the Tissue Viability Nurse are followed.

Discussion with registered manager and senior nurse confirmed that wound care is monitored and audited on a regular and timely manner.

The registered manager and registered nurses informed the inspector that pressure ulcers were graded using an evidenced based classification system.

Discussion with the registered nurses clearly evidenced their knowledge in the assessment, management and treatment of wounds. Review of the template used to undertake competency and capability assessments for the registered nurses revealed that pressure ulcer/wound care was addressed.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Moving towards compliance**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**

11.0 Additional areas examined

11.1 Records required to be held in the nursing home

Prior to the inspection a check list of records required to be held in the home under Regulation 19(2) Schedule 4 of The Nursing Homes Regulations (Northern Ireland) 2005 was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required records were maintained in the home and were available for inspection. The inspector reviewed the following records:

- The patient's guide.
- Sample of staff duty rosters.
- Record of complaints.
- Record of food and fluid provided for patients.
- Staff training records.
- Sample of incident/accident records.
- Three week menu planner.

11.2 Patients/residents 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.

There were no patients or residents accommodated at the time of inspection in the home who were subject to guardianship arrangements.

11.3 Quality of Interaction Schedule (QUIS)

The inspector observed the mid-day meal being served in the nursing home dining room and the afternoon tea being served in the residential home. Each period of observation lasted for approximately twenty minutes each.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area. A description of the coding categories of the Quality of Interaction Tool is appended to this report.

Total number of observations	10
Positive interactions	10
Basic care interactions	
Neutral interactions	
Negative interactions	

The inspector evidenced that the quality of interactions between staff and patients was positive, staff were courteous, considerate and compassionate in their approach to providing direct assistance and also when offering encouragement and guidance with patients.

Staff were observed preparing and seating patients for their meal in a caring, sensitive and unhurried manner. Staff were seen to speak directly to each patient, making eye contact and actively communicating with each person. Care staff were also noted assisting patients with their meals, staff sat down beside the patient they were assisting and were fully engaged in the activity of providing the patient's meal, offering encouragement and prompting as appropriate.

During the serving of afternoon tea, the inspector evidenced that the quality of interactions between staff and patients was positive. Staff were polite and courteous when speaking with patients, conversation was relaxed and respectful. Staff were observed to offer a variety of drinks and different choice of snacks it was evident the staff in attendance were familiar with patient's individual preferences.

11.4 Complaints

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

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

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

11.5 Patient finance questionnaire

Prior to the inspection a patient financial questionnaire was forwarded by RQIA to the home for completion. The evidence provided in the returned questionnaire indicated that patients' monies were being managed in accordance with legislation and best practice guidance. The inspector discussed one aspect of the returned questionnaire which indicated that the home did not keep a record of furniture and personal possessions brought into the home. The registered manager stated that there must have been a typing error and provided a sample of patient's personal belongings records which verified that patient's personal belongings, including items of furniture is recorded and kept.

11.6 NMC declaration

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

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

11.7 Questionnaire findings

11.7.1 Staffing levels and staff comments

Discussion with the registered manager and review of the nursing and care staff duty roster for weeks commencing 15 September 2104, 22 September 2014 and 29 September 2014, evidenced that the registered nursing and care staffing levels were in accordance with the RQIA's recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection.

The registered manager informed the inspector that the home did have staff vacancies and management were actively recruiting to fill these positions.

During the inspection the inspector spoke with seven staff which included two registered nurses, four care staff and a cook. The inspector was able to speak to a number of staff individually and in private. Staff responses in discussion indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes. There were no issues of concern raised with the inspector, staff indicated they enjoyed working in the nursing home and felt supported and valued by management.

Comments made by staff members included;

"I am very happy working in this home and think the patients and residents are very well looked after."
" The quality of care provided is generally very good, we all do our best to make sure the patient's needs are met. The management of the home has improved."
" We all get on very well as a team and I think that is important for the sake of our patients and residents".
" We get a lot of training and it's been very good, I like learning new things".

11.7.2 Patients/residents and relatives comments

During the inspection the inspector spoke with eight patients individually and with the majority of others in smaller groups.

Patients spoken with and the questionnaire responses confirmed that patients were treated with dignity and respect, that staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home. There were no concerns or issues raised with the inspector during the inspection.
Patients' responses included;

"The staff are all very good, they look after us all very well, I have no complaints at all "
"I have been very well cared for and looked after since coming into the home. The staff are very pleasant and helpful. Those who serve the meals are very attentive and lake sure we get what we want. "
"The meals are very good, and the staff are very kind "

The inspector can reflect that the patients and their representatives indicated they were very satisfied with the standard of care and support provided to their relatives and to family members, and praised the professionalism, empathy and kindness shown by all staff members.

The inspector spoke with four relatives during the inspection and four questionnaires were returned at the end of the inspection. Relatives' responses included;

"We have always found the staff in the home very helpful. Mum has settled into the home very well and is extremely happy."
"The staff are all wonderful, they all do their best for the patients."
"As a family we have no complaints, the nurses and carers always make us feel very welcome into the home."

11.8 Environment

The inspector undertook a general inspection of the home and examined a number of patients' bedrooms, lounges, bathrooms and toilets at random.

Communal lounge areas provided a variety of seating and accommodated the needs of patients and visitors to the home. Fluids were available in lounges and bedrooms.

Bedrooms presented as homely and comfortable, some patients had added some small items of furnishings which contribute to a domestic homely ambience.

In general bathroom facilities, sluice rooms and toilets were maintained to a good standard of cleanliness and hygiene, as stated below, some areas were identified for improvement.

In the interest of infection prevention and control, and in accordance with the Nursing Home Regulations (Northern Ireland) 2005,Regulation 13(7) the following issues are required to be addressed;

- The carpet on the ground floor corridor running up the ramp area leading to the upper bedrooms was observed to be stained in several places. This carpet should be deep cleaned to remove the stains or replaced.
- One patient's bedroom armchair had food and drink spillages and needs cleaned.
- One patient's bedroom carpet was notably stained around the vicinity of the patient's armchair, this carpet should be deep cleaned to remove the stains or replaced.
- The underneath of a bath hoist seat and a raised toilet seat in an identified bathroom, need to be cleaned. These items should be included in the cleaning schedule, and
- The hole in a cupboard door in one identified patient's bedroom should be repaired, in order to facilitate a surface that can be effectively cleaned.

12.0 Quality Improvement Plan

The details of the quality improvement plan appended to this report were discussed with Ms Jane Moore, 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:

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The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
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PP C Brown

Carmel McKeegan
Inspector/Quality Reviewer

11/11/2014

Date

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**
On admission to the Nursing Wing the nurse in charge completes the Homes admission documentation. This includes a full nursing history using Roper, Logan and Tierney. The Residential Wing use an adaptation of NHSCT Permanent Care Review Team Residential Review for their admission documents. The information gained in this initial assessment forms the basis of the patient's / resident's care plan. If a Trust care plan is received prior to admission the information enclosed is also used to inform the care plan. Core Risk Assessments including MUST, Braden, Continence, Bristol Stool, Falls, Nutrition and Hydration are completed within 48 hours of admission. All risk assessments use validated tools.	Substantially compliant

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Each resident is allocated a named nurse or a named carer depending on which wing they are admitted to. The named nurse / carer is responsible for using the information gathered to form a care plan. It is the responsibilty of the named nurse / carer to ensure each resident has an up to date care plan in place, reflective of current needs. The named nurse / carer discusses the care plan with the Resident or their representative and obtains consent for proposed	Moving towards complian

interventions. If the resident has been part of a multi disciplinary review or any recommendations made at the annual care review these will be reflected in the care plan. Advice given by other health care professional is also taken into account. For advice regarding tissue viability a referral can be made via Call Management to the Clinincal Nurse Facilitator team for the BHSCT or to the district nursing team for residential residents. Wound documentation is being developed to meet the criterion set down. Should the Home require equipment, outside of the Regional Contract requirements then this should be obtained from the funding HSCT. Advice can be sought from Care Managers, the Clinincal Nurse Facilitators or District Nursing Team. If a resident suffers from lower limb or foot ulceration, a referral is made to the BHSCT podiatrist for treatment. The podiatrist assesses the wound and advises staff about the treatment plan. This often occurs in conjunction with Tissue Viability.	

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**
Care plans and risk assessments are reviewed as necessary and at least monthly. Daily records are kept for all residents / patients.	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 has strong ethos of encouraging learning. All staff are encouraged and supported to keep their skills and knowledge up to date, in order to provide safe and effective care. The Home has a training room with access to internet and a library of resources. The home currently has nurses who have completed courses in palliative care, wound care, infection control and dementia care. Staff are also encouraged and supported to complete their QCF training. Several staff have obtained their levels 2 and 3. Nursing interventions in regards to wound care are based on CREST (Clinical Resource Efficiency Team) guidelines 1998 for general wound care; National Institute for Clinical Excellence (2005) 'The management of pressure ulcers in primary and secondary care: a clinical practice guideline' for pressure ulcer care. For the management of leg ulcers, RCN (2006) Clinical Practice Guidelines for the nursing management of patients with venous leg ulcers; CREST (1998) Guidelines for the assessment and management of leg ulceration and SIGN (1998) The care of patients with chronic leg ulcer. These documents are available online and in house for consultation purposes. The Home uses the European Pressure Ulcer Advisory Panel (EPUAP) grading tool for pressure ulcers.	Moving towards complian

The Home has copies of the new 2014 guidelines from the Health Promotion Agency on nutrition. Practices within the Home are informed by these guidelines. There is also up to date information on the MUST guidelines available for consultation. The Home has recently held training on MUST for nursing staff and nutritional needs and thickening agents for all care staff.	

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**
Patient / resident records are kept in line with regulations and professional requirements. Menu records are kept and also a record kept of the variations provided in relation to special diets. Those patients / residents who are deemed at risk in relation to their nutritional status are monitored closely. A nutritional intake chart is recorded daily. A record is kept in the patient's / resident's documentation when a meal is refused. The action taken when such occurs is also recorded. If this becomes a regular occurrence the advice of the GP / Community Dietician is sought. Where appropriate the situation is discussed with the patient. This enables staff to find out if there is an underlying reason for same, and if any intervention could resolve the situation. If cognitive impairment is present, staff may wish to discuss the situation with the family and fully inform them of the intended action to be taken.	Moving towards complian

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**
Each resident is assessed on an ongoing basis. Their daily evaluation documentation is updated by a member of staff on each shift. Any changes in condition are noted and appropriate alterations to care plans made at this time. The input of other health professionals is also recorded.	Substantially compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care planning is person centered and every affort is made to include the patient / resident where possible. If the patient / resident is unable to participate in care planning, reviews or other multi disciplinary meetings their representatives is encouraged to attend on their behalf. Information received or made during these reviews will be recorded and included in future care planning records. New documentation is being drawn up to further facilitate this process. All care plans are signed by the patient / resident or their represenative.	Moving towards compliance

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**
Patients / residents are offered a full and varied menu that takes into account their likes / dislikes and nutritional needs. The menu offers choice and is set in 3 week cycles. They are reviewed seasonally i.e. 4 times a year. Nutritional records are kept according to assessed needs and reviewed on a regular basis. The Home is reviewing the dining experience in the Nursing Wing and is considering introducing protected meal times.	Moving towards compliance

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**
We are ensuring all staff who assist residents with their nutritional requirements have had up to date training incorporating recommendations made by SALT / dieticians. We will be ensuring all staff have access to and can fully understand the information and recommendations contained in care plans and nutritional risk assessments. We ensure all related risks are known and managed effectively. Meals are provided according to regulations and current guidelines. Meal times are traditional but the wishes of the	Moving towards compliance

resident are taken into consideration also and can be flexible where necessary. Wound care training is available to all nurses and we are encouraging dissemaination of good practice within the staff group.	

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	COMPLIANCE LEVEL
	Provider to complete

Appendix 2

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

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

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

References

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

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Primary Unannounced Care Inspection

Faith House Private Nursing Home

2 October 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 Mrs Jane Moore, 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.	14 (1) (b)	The registered person shall make arrangements for patients to receive, where necessary, treatment, advice and other services from any other healthcare professional. Recommendations made by the Tissue Viability Nurse (TVN) must be incorporated into the respective patient's care plan and followed until instructed otherwise. Any nursing treatment that deviates from the TVN's recommendations must show a decision making process by the registered nurse who will assume accountability for their decision. **Ref; Section B**	One	All nursing staff aware of the importance of ensuring recommendations made by TVN are implemented. These recommendations should be reflected within care plan and dressing file. Where staff feel recommendations need to be reviewed they will liase with TVN and not make changes unless instructed to do so. Policy re wound management has been updated to reflect this	From the date of the inspection
2.	13 (7)	In the interest of infection prevention and control, the following issues are required to be addressed; • the carpet on the ground floor corridor running up the ramp area leading to the upper bedrooms was observed to be stained in several places. This carpet should be deep cleaned to remove the stains or replaced.	One	• carpet on ground floor corridor has been shampooed and a cleaning schedule for area has been implemented. Consideration is being given to replacement of same.	30 November 2014

		• one patient's bedroom armchair had food and drink spillages and needs cleaned. • one patient's bedroom carpet was notably stained around the vicinity of the patient's armchair, this carpet should ne deep cleaned to remove the stains or replaced. • the underneath of a bath hoist seat and a raised toilet seat in an identified bathroom, need to be cleaned. These items should be included in the cleaning schedule, and • the hole in a cupboard door in one identified patient's bedroom should be repaired, in order to facilitate a surface that can be effectively cleaned. **Ref; Section 11.8**		• bedroom chairs are being checked regularly by all staff and domestic team being advised when cleaning required. • patients carpet has been replaced. bedroom was also repainted. • Domestic staff are responsible for ensuring bathrooms are cleaned daily. New documentation sheets being implemented to ensure where appropriate hoist chairs and raised toilet seats are cleared. • maintenance have addressed and repaired cupboard door.	

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.	1.2	Ensure a residents/relatives meeting is held as soon as possible. **Ref; Section 9 Follow up on issues for the previous inspection**	One	Residents meeting being held on 18th December 2014 at 14.30pm. Relatives meeting being held at 18.30pm on same day. New 3 monthly plan in place for 2015.	31 December 2014
2.	5.3	Nursing care plans should evidence that patients or their representatives have been involved in discussions regarding the agreeing and planning of nursing interventions and/or following subsequent changes to the plans of care. **Ref; Section B**	One	Staff aware of the need to ensure patient and or NOK are involved in care planning at admission and on any occassion of change in care.	From the date of the inspection
3.	26.2	The Policy on Assessment, Care Planning and Evaluation should be further developed to state the registered nurse's responsibility to evidence that patients or their representatives have been involved in discussions regarding the agreeing and planning of nursing interventions and/or following subsequent changes to the plans of care. **Ref; Section B**	One	Policy has been updated to reflect need of ongoing updating to NOK re patients Care. Implementation of 3 monthly review with patient and or NOK from Jan 2015.	31 December 2014

4.	5.3	Where a patient is assessed as at risk of dehydration the patient's records should evidence that; (a) a registered nurse verifies the patient's total fluid intake over the 24 hour period. (b) an effective reconciliation of the total fluid intake against the patient's fluid target is established. (c) action to be taken if targets were not being achieved. (d) a record of reconciliation of fluid intake in the daily progress notes. **Ref; Section B and E**	One	Patient fluid target has been agreed at 1200mls (nutritional guidelines and menu checklist 2014). Target intake to be recorded on fluid chart. Charts to be totaled over 24hr period and recorded in daily progress notes. Where evidence of not meeting target, patient to be placed on hourly fluids and observed over 3days. If no improvement GP to be contacted.	From the date of the inspection

The registered provider / manager is required to detail the action taken, or to be taken, in response to the issue(s) raised in the Quality Improvement Plan. The Quality Improvement Plan is then to be signed below by the registered provider and registered manager and returned to:

The Regulation and Quality Improvement Authority
9th floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

SIGNED: [signature] **SIGNED:** [signature]

NAME: MERVYN WISHART **NAME:** JANE MOORE

Registered Provider **Registered Manager**

DATE 8/12/2014 **DATE** 8/12/2014.

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	yes	Donna Roger	12/12/14
Further information requested from provider			