Inspection Report

16 & 17 November 2022

Faith House

Type of Service: Nursing Home
Address: 25 Orpen Park, Belfast, BT10 0BN
Telephone Number: 028 9061 2318

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Board of Trustees – Faith House **Responsible Individual:** Mr Mervyn Wishart	**Registered Manager:** Mrs Jane Moore **Date registered:** 9 January 2015
Person in charge at the time of inspection: Mrs Jane Moore	**Number of registered places:** 35
Categories of care: Nursing Home (NH) I – Old age not falling within any other category PH – Physical disability other than sensory impairment TI – Terminally ill	**Number of patients accommodated in the nursing home on the day of this inspection:** 28
Brief description of the accommodation/how the service operates: This is a registered nursing home which provides nursing care for up to 35 patients. The home is situated over one floor and includes individual bedrooms, a communal dining room, communal bathrooms and two communal lounges. There is a mature garden and seating area for patients to use. There is a residential care home which occupies part of the ground floor and the registered manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 17 November 2022, from 9.30am to 5.30pm and on 16 November 2022 from 10.35am to 1.45pm by care and pharmacist inspectors.

The inspection focused on care delivery and medicines management to determine if the home was delivering safe, effective and compassionate care and if the service was well led. The inspection assessed progress with all areas of improvement identified in the home since the last care inspection.

The first day of the inspection focused on medicines management within the home and found that robust arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were well maintained. There were auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed. No areas for improvement were identified regarding the management of medicines.

Patients were positive when describing living in the home and the care provided by staff. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surrounding and in their interactions with staff.

Areas for improvement were identified during the care inspection and can be found in the Quality Improvement Plan (QIP) (Section 7.0).

The findings of the report were discussed with the manager following the inspection and will provide the manager with the necessary information to improve staff practice and the patients' experience.

RQIA would like to thank the patients and staff for their assistance throughout the inspection.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement, registration information, and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with Mrs Heather Weir, nursing sister, at the end of the first day of inspection and with Mrs Jane Moore, the manager, at the conclusion of the second day of the inspection.

4.0 What people told us about the service

We spoke with patients and staff individually and in small groups. A variety of opinions was provided from patients including "I am very well looked after…credit to the girls", "staff are run off their feet", "not enough patients meetings" and "I have nothing but good to say about the care". This feedback was discussed with the manager following the inspection for her review.

Staff told us that the manager was supportive and patients were well looked after. Comments included “Some issues with staffing shortages at times”, “mainly good team work” and “training is good”. This feedback was discussed with the manager following the inspection for her review.

No patient or relative questionnaires were received and there were no responses to the online survey.

A record of compliments received about the home was kept and shared with the staff team.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 28 October 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (4) (a) **Stated:** First time	The registered person shall ensure fluid thickening agents are stored securely.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 2 **Ref:** Regulation 30 **Stated:** First time	The registered person shall ensure all notifiable events are reported to RQIA in a timely manner. This is in relation to accidents and incidents.	**Carried forward to the next inspection**
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.	

Area for improvement 3 **Ref:** Regulation 29 **Stated:** First time	The registered person shall ensure the actions resulting from the monthly monitoring visits are followed up in a timely manner and this is documented in the reports of such visits.	**Partially met**
	Action taken as confirmed during the inspection: Review of a number of monthly monitoring visit reports identified that not all actions had been followed up and signed as completed in a timely manner. This area for improvement has been partially met and has been stated for a second time.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 35 **Stated:** Second time	The registered person shall ensure that quality improvement audits in relation to infection prevention and control are reviewed and updated regularly to provide assurance on the safe delivery of care within the home.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 2 **Ref:** Standard 41.7 **Stated:** First time	The registered person shall ensure the competency and capability assessment for the person in charge of the home in the absence of the manager is completed and up to date.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

Area for improvement 3 **Ref:** Standard 40 **Stated:** First time	The registered person shall ensure staffs' performance is appraised and supervision is provided to promote the delivery of quality care and services.	**Partially met**
	Action taken as confirmed during the inspection: Review of the supervision and appraisal matrix evidenced that while a number of supervisions and appraisals had been completed overall there were low numbers of compliance with appraisals completed. This area for improvement has been partially met and has been stated for a second time.	
Area for improvement 4 **Ref:** Standard 23 **Stated:** First time	The registered person shall ensure that processes and records for the prevention of pressure damage are in place, maintained and accurately recorded. This is in relation to the use of pressure relieving mattresses.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 5 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure care records are reviewed and kept up to date with the patients' accurate information and current care requirements. This is in relation to preferred name, dietary supplements and dependency level.	**Partially met**
	Action taken as confirmed during the inspection: Review of a sample of care records showed that while the patients preferred name was recorded, not all records for dietary supplements and patient dependency levels were in place for those who required this. This area for improvement has been partially met and has been stated for a second time.	

Area for improvement 6 **Ref:** Standard 4.5 **Stated:** First time	The registered person shall ensure care plans have recorded evidence of involvement of the patient and their relatives in the development and review of all care plans.	**Not met**
	Action taken as confirmed during the inspection: Review of a sample of care plans identified that there had been no recorded involvement of the patient and their relatives in their development and review. This area for improvement has not been met and has been stated for a second time.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

There were systems in place to ensure staff were trained and supported to do their job. Review of the staff training matrix showed that staff were progressing well with mandatory training and additional training was provided in dementia awareness and allergy awareness.

Staff confirmed they had received an induction to prepare them to care for patients. Records identified that staff were registered with their professional bodies including the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC).

Staff had received supervision of their practice throughout the year, however, the annual appraisal process showed poor compliance overall. This area for improvement has been stated for a second time.

Staff said there was good team work and that they felt well supported in their role, however they felt that at times staffing levels were not adequate for patient care needs, and also said that the patients were well looked after. This was also noted on discussion with patients who said that staff were busy and they have to wait longer when they call for assistance. This was discussed with the manager for her to address and an area for improvement was identified.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the manager was not on duty.

It was noted that there was enough staff in the home to respond to the needs of the patients in a timely way; and to provide patients with a choice on how they wished to spend their day. For example, patient buzzers were answered in a timely manner.

Staff told us that the patients' needs and wishes were very important to them. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

5.2.2 Care Delivery and Record Keeping

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, bed rails, alarm mats. It was established that safe systems were in place to manage this aspect of care.

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. In addition, patient care records were maintained which accurately reflected the needs of the patients. Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly.

Patients who are less able to mobilise require special attention to their skin care.
These patients were assisted by staff to change their position, however, care records did not accurately reflect that the care records for position changes were up to date. An area for improvement was identified.

Where a patient was at risk of falling, measures to reduce this risk were put in place. For example, patients were provided with buzzer mats or bed rails where this was assessed as appropriate.

Examination of records and discussion with staff confirmed that the risk of falling and falls were well managed. There was evidence of appropriate onward referral as a result of the post falls review.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this may include simple encouragement through to full assistance from staff.

The dining experience was an opportunity of patients to socialise, music was playing, and the atmosphere was calm and unhurried. It was observed that patients were relaxed during their dining experience. Staff had made an effort to ensure patients were comfortable.

There was choice of meals offered, the food was attractively presented and smelled appetising. There was a variety of drinks available. The portion size for the majority of the meals was notably small and on review of the care records there was no evidence of this being the preferred choice for patients. Patients also identified that snack portions were very small. An area for improvement was identified.

A range of snacks and drinks were available for patients throughout the day, however, on discussion with staff and a patient it was noted that there was very limited choice in snacks for patients who required their food to be modified. This was brought to the attention of the manager for her to address and will be reviewed at the next inspection.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain. If required, records were kept of what patients had to eat and drink daily. Review of records identified that not all significant weight loss was recorded as having been reported to the medical practitioner. An area for improvement was identified.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans should be developed to direct staff on how to meet patients' needs; and include any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially. Daily records were kept of how each patient spent their day and the care and support received.

A sample of care records were reviewed and showed that not all assessed needs had a care plan in place and care plans were not regularly reviewed and updated. There was no evidence of patient involvement in planning their own care and the details of care plans had not been shared with patients' relatives, if this was appropriate. This area for improvement has been stated for a second time.

5.2.3 Management of the Environment and Infection Prevention and Control

Observation of the home's environment evidenced that the home was generally warm, well decorated and tidy.

Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were suitably furnished and comfortable. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Staff were aware of their training in these areas and how to respond to any concerns or risks.

There was evidence that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example any outbreak of infection was reported to the Public Health Authority (PHA).

Observation of the environment and staff practice identified a number of Infection Prevention and Control (IPC) issues. This included inappropriate storage of equipment, covers on switches to allow appropriate cleaning and a number of taps which were not suitable for appropriate hand washing. An area for improvement was identified.

Staff were observed to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

Visiting arrangements were managed in line with Department of Health (DoH) and IPC guidance.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV. They could have family/friends in their room of one of the lounges to visit and could go out with family if desired.

Patients also told us that patient meetings were not held regularly to provide an opportunity for patients to comment on aspects of the running of the home. This was discussed with the manager who agreed to ensure meetings were held on a regular basis and documented. This will be followed up at the next inspection.

It was observed that staff offered choices to patients throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

There was a range of activities provided for patients by staff. The range of activities included prayer meetings, Christmas card making, knitting, word games, chair exercises, crafts and bible reading. On review of care records one to one activity sessions were not provided on a regular basis. This was discussed with the manager who agreed to review this provision. This will be reviewed at the next inspection.

Staff recognised the importance of maintaining good communication with families. Staff assisted patients to make phone calls. Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs Jane Moore has been the manager in this home since 9 January 2015.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to patients. There was evidence of auditing across various aspects of care and services provided by the home. The audits for hand hygiene were mixed in with the audits for the residential care home. This was discussed with the manager who agreed to separate the records.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

There was a system in place to manage complaints. Following discussion with patients it was identified that not all complaints were documented and followed up appropriately. An area for improvement was identified.

Staff commented positively about the senior staff and described them as supportive, approachable and always available for guidance.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; however, where action plans for improvement were put in place, these were not always followed up in a timely way to ensure that the actions were correctly addressed. This area for improvement has been stated for a second time.

5.2.6 Medicines Management

Personal medication records and care plans

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by the GP, the pharmacist or during a hospital admission.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered.
It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to state that they were accurate.

Copies of patients' prescriptions/hospital discharge letters were retained in the home so that any entry on the personal medication record could be checked against the prescription.

All patients should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets etc.

Care plans were in place for pain, distressed reactions and modified diets. Other appropriate care plans were in place, for example, the management of medicines for Parkinson's. Advice was provided on ensuring that patient specific detail is included as necessary. Where specialist medication is obtained from a separate supplier, it was agreed that this would be added to the patients' care plan.

Medicine supply and storage

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that each patient's medicines are available for administration as prescribed.

It is important that medicines are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

The records inspected showed that medicines were available for administration when patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Satisfactory arrangements were in place for the disposal of medicines.

Medicine administration

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

Within the home, a record of the administration of medicines was completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. The records had mostly been completed in a satisfactory manner. Staff were reminded that two members of staff should check and sign handwritten additions to verify their accuracy. The nursing Sister agreed to remind staff of this expected practice.

Controlled drugs

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs should be recorded in a controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

Governance and audit

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The audits completed at the inspection indicated that medicines were administered as prescribed. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. A robust audit system will help staff to identify medicine related incidents.

Management and staff were familiar with the type of incidents that should be reported. The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

The management of medicines on admission and medication changes

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

A review of records indicated that satisfactory arrangements were in place to manage medicines for patients new to the home or returning from hospital. Written confirmation of the medicine regimes was obtained at or prior to admission and details shared with the GP/community pharmacy as necessary. The medicine records had been accurately completed. There was evidence that nurses had followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration.

Staff training and competency assessment

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that they staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

There were records in place to show that nurses responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal. Medicines management policies and procedures were in place.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and/or the Care Standards for Nursing Homes (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	3*	8*

* the total number of areas for improvement includes four that have been stated for a second time and one which has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Jane Moore, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 29 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure the actions resulting from the monthly monitoring visits are followed up in a timely manner and this is documented in the reports of such visits. Ref: 5.1 and 5.2.5
	Response by registered person detailing the actions taken: actions following from reg 29 monthly monitoring visit will be recorded and signed as actioned each month
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the infection prevention and control (IPC) issues identified in the report are addressed. Ref: 5.2.3
	Response by registered person detailing the actions taken: following discussion with relevant parties:- maintenance, infection control link for the home and manager issues are being addressed.
Area for improvement 3 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure all notifiable events are reported to RQIA in a timely manner. This is in relation to accidents and incidents.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1 and 5.2.5

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 40 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure staffs' performance is appraised and supervision is provided to promote the delivery of quality care and services. Ref: 5.1 and 5.2.1 **Response by registered person detailing the actions taken:** responsible staff ensuring that appraisals and supervisions are completed
Area for improvement 2 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure care records are reviewed and kept up to date with the patients' accurate information and current care requirements. This is in relation to preferred name, dietary supplements and dependency level. Ref: 5.1 and 5.2.2 **Response by registered person detailing the actions taken:** Registered provider along with senior staff are ensuring that dependency tool is within each carefile and updated monthly
Area for improvement 3 **Ref:** Standard 4.5 **Stated:** Second time **To be completed by:** 30 December 2021	The registered person shall ensure care plans have recorded evidence of involvement of the patient and their relatives in the development and review of all care plans. Ref: 5.1 and 5.2.2 **Response by registered person detailing the actions taken:** signatory form for completion at admission and 3 monthly review in place for evidence of involvement of patient and NOK
Area for improvement 4 **Ref:** Standard 41 **Stated:** First time	The registered person shall ensure the number and ratio of staff on duty at all times meet the care needs of patients. Ref: 5.2.1

To be completed by: With immediate effect	**Response by registered person detailing the actions taken:** a registered nurse is responsible for completion of offduty and registered person will review to ensure staffing in line with dependency of patients
Area for improvement 5 **Ref:** Standard 23 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure there are clear documented processes for the prevention of pressure damage and this is followed for all patients who required this. Ref: 5.2.2
	Response by registered person detailing the actions taken: Staff complete BRADEN risk assessments at admission and monthly or when changes in general health, where risk is identified processes are put in place such as regular repositioning, use of pressure relieving equipment, need for nutritional input, discussion with GP. Care plans are put in place and all staff made aware of plan of care.
Area for improvement 6 **Ref:** Standard 12.15 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all meals are served in suitable portion sizes which meet the needs of each patient. Ref: 5.2.2
	Response by registered person detailing the actions taken: ,care plans will reflect the preferences of patients re their meal sizes.
Area for improvement 7 **Ref:** Standard 12.12 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure significant changes in patient's weight are notified to a medical professional for advice. Ref: 5.2.2
	Response by registered person detailing the actions taken: Staff continue to monitor weight and complete the MUST Tool and where appropriate refer to the dietician and GP

Area for improvement 8 **Ref:** Standard 16 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure all complaints are taken seriously and dealt with promptly and effectively. Ref: 5.2.5
	Response by registered person detailing the actions taken: all complaints raised by patient/NOK/other party are documented within complaints folder and actions shared with the person raising it. Once a satisfactory outcome achieved complaint is closed.

Please ensure this document is completed in full and returned via the Web Portal

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