Faith House
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25 Orpen Park
Belfast
BT10 0BN

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Unannounced Care Inspection
of
Faith House

27 April 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced care inspection took place on 27 April 2015 from 10.30 to 16.30. Overall on the day of the inspection the home was found to be delivering safe, effective and compassionate care. Areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) appended to this report.

The focus of this inspection was continence management which was underpinned by selected criterion from:

Standard 4: Individualised Care and Support; Standard 6: Privacy, Dignity and Personal Care; Standard 21: Heath Care and Standard 39: Staff Training and Development.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 standards until compliance is achieved. Please also refer to section 6.2 of this report.

For the purposes of this report the term 'patients' will be used to described those living in Faith House which provides both nursing and residential care.

1.1 Actions/Enforcement Taken Following the Last Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 02 October 2014.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	3

The details of the QIP within this report were discussed with the Jane Moore as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Board of Trustees - Faith House Mr Mervyn Wishart	**Registered Manager:** Mrs Jane Moore
Person in Charge of the Home at the Time of Inspection: Mrs Jane Moore	**Date Manager Registered:** 12/01/2015
Categories of Care: RC-I, NH-I, NH-PH, NH-TI	**Number of Registered Places:** 65
Number of Patients Accommodated on Day of Inspection: **Total 59** 33 Nursing 26 Residential	**Weekly Tariff at Time of Inspection:** Nursing £637 Residential £514

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the selected criteria from the following standards have been met:

Standard 4: Individualised Care and Support, criteria 4 and 8
Standard 6: Privacy, Dignity and Personal Care, criteria 1, 3, 4, 8 and 15
Standard 21: Heath Care, criteria 6, 7 and 11
Standard 39: Staff Training and Development, criterion 4

4. Methods/Process

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

- discussion with the registered manager;
- discussion with patients;
- discussion with staff;
- discussion with relatives/representatives;
- review of care records;
- observation during a tour of the premises; and
- evaluation and feedback.

The inspector met with twenty five patients individually and with others in groups, ten members of staff and three patients' relatives/visitor/representatives.

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection;
- the registration status of the home;
- written and verbal communication received since the previous care inspection;
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year; and
- the previous care inspection report.

The following records were examined during the inspection:

- staff duty rotas;
- staff training records;
- five care records;
- a selection of policies and procedures; and
- guidance for staff in relation to continence care.

5. The Inspection

5.1 Review of Requirements and Recommendations from Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 02 October 2014. The completed QIP was returned and approved by the inspector. The findings of this inspection are outlined in section 5.2.

5.2 Review of Requirements and Recommendations from the last care inspection

Previous Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref: Regulation 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.	**Met**
	Action taken as confirmed during the inspection: A review of five patient care records evidenced advice provided by relevant allied professionals was incorporated into the respective patients' care	

	records. The policy on wound care management has been reviewed to ensure that staff adhere to specialist advice.	
Requirement 2 **Ref: Regulation 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 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.	**Met**
	Action taken as confirmed during the inspection: A review of the environment evidenced that the identified carpet area had been cleaned and a schedule is in place to ensure it is regularly cleaned. All patient chairs were observed to be clean. The identified carpet had been replaced. The areas underneath the identified bath hoist and raised toilet seat had been cleaned and were being cleaned daily. This was evident in the cleaning schedules. The identified cupboard door had been repaired.	

Previous Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref: Standard 1.2**	Ensure a residents/relatives meeting is held as soon as possible.	**Met**
	Action taken as confirmed during the inspection: A review of the minutes of residents/relatives meetings evidenced that there was a meeting held 18 December 2014. Meetings are scheduled for the coming year.	
Recommendation 2 **Ref: Standard 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.	**Met**
	Action taken as confirmed during the inspection: A review of five care records evidenced that relatives and their representatives have been involved in discussions and agreeing and planning care.	
Recommendation 3 **Ref: Standard 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.	**Met**
	Action taken as confirmed during the inspection: The policy on assessment, care planning and evaluation has been reviewed to include the necessity to ensure relatives/representatives are involved in discussions regarding patients' care.	
Recommendation 3 **Ref: Standard 26.2**	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	**Met**

	intake against the patient's fluid target is established; • action to be taken if targets were not being achieved; and • a record of reconciliation of fluid intake in the daily progress notes.	
	Action taken as confirmed during the inspection: A review of five patients' care records evidenced that nursing staff verify patients' total fluid intake, where necessary. An effective reconciliation of the total fluid intake against fluid targets was evident in the care records. There was evidence of the action taken if patients did not meet fluid targets set. There was evidence in the daily progress notes that fluid intake was reconciled at the end of 24 hours.	

Continence Care and Management

Is Care Safe? (Quality of Life)

There were up to date policies in place for continence care and management and care of urinary catheters. The following recommended guidelines were in place and available for staff:

- RCN continence care guidelines.
- British Geriatrics Society Continence Care in Residential and Nursing Homes.
- NICE guidelines on the management of urinary incontinence.
- NICE guidelines on the management of faecal incontinence.

Discussion with the registered manager and review of induction records confirmed that a number of staff had received continence training on induction. The registered manager also confirmed that five registered nursing staff were trained and competent in male and female catheterisation. Discussion with care staff confirmed that they had received training in continence care. All staff were knowledgeable about the important aspects of continence care including the importance of dignity, privacy and respect as well as skincare, hydration and reporting of any concerns.

Is Care Effective? (Quality of Management)

Review of five patients' care records evidenced that there were no completed bladder or bowel continence assessments in the five patients care records reviewed.

There was evidence in five patients' care records that bladder and bowel continence care plans were developed, reviewed and updated on a monthly basis or more often as deemed appropriate. The care plans reviewed addressed the patients' needs in regard to continence management.

The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken as required and patients were referred to their GPs as appropriate. Arrangements were in place to obtain advice and support from external health professionals and services.

Review of five patients' care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions.

Monthly quality monitoring also takes place within the home including an audit of care records which incorporates continence care.

Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.

Is Care Compassionate? (Quality of Care)

During the inspection staff were observed to treat the patients with dignity and respect. Good relationships were evident between patients and staff. Staff were observed to respond to patients' requests promptly. Patients confirmed that they were content and happy in the home. Patients stated that staff were kind and attentive and their needs were responded to in a timely way.

Areas for Improvement

There were no requirements and two recommendations made regarding continence care and management.

Number of Requirements	**0**	**Number Recommendations**:	**2**

5.3 Additional Areas Examined

5.4.1 Environment

An inspection of the premises identified that improvements in this area have continued and there is a refurbishment/redecoration programme in place. The registered manager informed the inspector that there are plans to include a visitors' room in the home and an area has been identified. An application for a minor variation is currently being processed with RQIA. There are also plans to improve the treatment/clinical room facilities in the home. A minor variation application has also been received by RQIA and the application has been approved. The registered manager informed the inspector that the work is due to commence shortly as a matter of priority.

The home was observed to be clean and tidy and with the exception of one identified bedroom there were no malodours detected. The registered manager has agreed to ensure this issue is addressed immediately. A domestic manager has recently been employed and plans are in place to review the cleaning schedules in the home to ensure the cleanliness of the home is maintained to a high standard.

5.4.2 Care records

Five care records were reviewed. Improvements were observed regarding the overall management of care records. The registered manager audits care records on a monthly basis and has identified areas for improvement. These issues are currently being addressed as part of formal supervision. It is recommended that the following issues are addressed;

- ensure when care plans are no longer recommended that they are clearly discontinued.
- overwriting was observed in care records. When care to be delivered changes, the care plan should be rewritten to avoid confusion.

5.4.3 Meal times

The inspector observed a number of patients being nursed in bed. The individual needs of patients, during the lunchtime meal were observed to have increased. A number of patients in bed were observed to require assistance with their food. However staff were not available to assist as lunch was being served in both dining areas. The registered manager agreed to review the serving of the lunch time meal to ensure all patients are assisted in a timely manner and in accordance to their needs.

5.4.4 Discussion with staff

The inspector spoke with approximately 10 members of staff during the inspection. All were positive in their responses regarding care in the home. All stated they attended regular staff meetings and felt they could approach the registered manager if needed. The following comments were made to the inspector.

- "morale has improved, we are working more as a team."
- "care is excellent and we are well supported."
- "the care is completed to the best of our ability, I think the care is great."
- "I like working here, I have completed all my training."

5.4.5 Discussion with patients

The inspector had discussion with approximately 25 patients, both individually and in groups. Patients with whom the inspector was able to have discussion with were very positive about their daily life in the home. Comments included:

- "staff are so kind."
- "we are all very happy here."
- "I enjoy the food, we always get a choice."
- "I can approach staff, they always have time for me."

5.4.6 Discussion with patients' representatives

RQIA spoke with three visiting relatives who commented that the food provided for patients was good, staff were friendly and the care afforded was very good. There were no concerns raised with the inspector during the inspector.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Jane Moore, registered manager as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained within the QIP 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.

6.1 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 and Residential Homes Regulations (2005).

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes (2015). They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref: Regulation 12 (4)**	Review the serving of the lunch time meal to ensure all patients receive their meals in a timely way and assisted as necessary in keeping with their needs.
Stated: First time **To be Completed by: 25 May 2015**	**Response by Registered Manager Detailing the Actions Taken:** staff completed audit of lunch time meals over a period of days to review dependency of patients noted and being addressed. Nutritional assistant in place from 8am-2pm. Allocation charts being implemented to ensure all areas of nursing wing are being monitored by staff over meal times such as bedrooms and dining rooms. Continual monitoring by management.
Recommendations	
Recommendation 1	Ensure bladder and bowel continence assessments are completed for all patients.
Ref: Standard 21 Criteria 11 **Stated: First time** **To be Completed by: 25 May 2015**	**Response by Registered Manager Detailing the Actions Taken:** new bladder and bowel assessments in place for all patients. Staff reviewing on monthly basis.
Recommendation 2	The identified care record of a patient with a catheter should have the care plan reviewed to include the type and size of catheter used.
Ref: Standard 21 Criteria 9 **Stated: First time** **To be Completed by: 25 May 2015**	**Response by Registered Manager Detailing the Actions Taken:** staff spoken to re importance of ensuring all details relating to catheter are included in care plan and reviewed monthly or as needed. Auditing of car plans to ensure in place.
Recommendation 3 **Ref: Standard 4 Criteria 8**	The registered manager shall ensure when care plans are no longer recommended that they are clearly discontinued. The registered manager shall ensure when care to be delivered changes that the care plan is rewritten to avoid confusion.
Stated: First time **To be Completed by: 25 May 2015**	**Response by Registered Manager Detailing the Actions Taken:** All staff responsible for documenting care plans advised of importance of reviewing care plans at end of a specific treatment and when any changes in care needs are seen. Complete new care plan documentation is been implemented into the home. Manager supporting staff during this change. Audits of care plans to ensure care plans updated and reviewed.

Registered Manager Completing QIP	Dave Toole	**Date Completed**	11/6/15
Registered Person Approving QIP	[signature]	**Date Approved**	11/6/15
RQIA Inspector Assessing Response		**Date Approved**	

Please ensure the QIP is completed in full and returned to** Nursing.Team@rqia.org.uk **from the authorised email address

The Regulation and Quality Improvement Authority

RQIA Inspector Assessing Response	**Donna Rogan**	**Date Approved**	2 July 2015