Unannounced Post-Registration Care Inspection Report
11 March 2019

Rathview Home Treatment House

Type of Service: Nursing Home (NH)
Address: 12a Drumnakilly Road, Omagh, BT79 0JN
Tel No: 028 8283 3247
Inspector: Kieran McCormick

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care up to 6 persons.

3.0 Service details

Organisation/Registered Provider: Western HSC Trust **Responsible Individual:** Anne Kilgallen	**Registered Manager:** Emma Keyes
Person in charge at the time of inspection: Eugene Gillease – acting manager	**Date manager registered:** 21 December 2018
Categories of care: Nursing Home (NH) MP – Mental disorder excluding learning disability or dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years.	**Number of registered places:** 6

4.0 Inspection summary

An unannounced inspection took place on 11 March 2019 from 12.30 hours to 15.30 hours.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified during the pre-registration care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to infection prevention and control and the home's environment. There were examples of good practice found with care records, governance arrangements, communication with wider members of the multi-disciplinary team and the maintaining of good working relationships.

Two areas requiring improvement were identified regarding the completion of notifiable events to RQIA and clinical observations for patients who have sustained a head injury.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	2	0

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Eugene Gillease, manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the pre-registration inspection dated 22 January 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 22 January 2019. Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 22 January 2019.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report
- pre-inspection audit

During the inspection the inspector met with four staff, there were no patients accommodated in the home at the time of the inspection. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. We provided the manager with 'Have we missed you cards' which were then placed in a prominent position to allow patients and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision. A poster informing visitors to the home that an inspection was being conducted was displayed on the front door of the nursing home.

The following records were examined during the inspection:

- duty rota for all staff for weeks beginning the 4 March 2019 and 11 March 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC)
- incident and accident records
- one patients care record
- a selection of governance audits
- patient register
- RQIA registration certificate
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 22 January 2019

The most recent inspection of the home was an unannounced care inspection.

The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 22 January 2019

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 44 **Stated:** First time **To be completed by:** 1 March 2019	The registered person shall ensure that the environmental issues identified during this inspection are addressed. **Action taken as confirmed during the inspection**: Observations of the environment confirmed that additional PPE stations had been fitted along with additional alcohol dispensers, paper towel dispensers were fitted in ensuite bathrooms. Thumb locks had been fitted for patients to be able to control the locking of their bedroom door, work outstanding to the observation panels on patient bedroom doors is due completion on the 19 March 2019.	**Met**
Area for improvement 2 **Ref**: Standard 35 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that an appropriate tool is implemented for the auditing of accidents and incidents that occur in the home. In addition all completed audits should be signed, dated and have a supporting action plan, where relevant, with detail of the person responsible for completing any identified actions within a specific timescale.	**Met**

	Action taken as confirmed during the inspection: We reviewed an audit tool devised for the auditing of accidents and incidents, the above suggestions had been included and further suggestions were provided to enhance the effectiveness of the audit tool.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The manager confirmed the planned staffing levels for the home and stated that these were subject to review to ensure the assessed needs of the patients were met. A review of the duty roster for weeks beginning the 4 March 2019 and 11 March 2019 evidenced that that the planned staffing levels were adhered to. Discussion staff evidenced that there were no concerns regarding staffing levels.

Discussion with the manager and a review of records confirmed that the manager was knowledgeable regarding their role and responsibilities in relation to adult safeguarding and their duty to report concerns. Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

A review of electronic systems confirmed that a process was in place to monitor the registration status of registered nurses with the NMC.

We reviewed a sample of accidents/incidents records. Records were maintained appropriately however a recent incident which resulted in a patient sustaining a head injury had not been notified to RQIA under Regulation 30. We were further concerned to note that central nervous system (CNS) observations had not been completed on the patient. These concerns were discussed with the manager and two areas for improvement under the regulations were made.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, the lounge and dining room. No concerns or issues were raised with regard to the environment. The home was found to be warm, fresh smelling and clean throughout. Environmental issues identified at the last inspection were noted to have been appropriately actioned.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing arrangements, infection prevention and control and the home's environment.

Areas for improvement

An area for improvement was identified in relation to the completion of notifiable events to RQIA and CNS observations for patients who have sustained a head injury.

	Regulations	Standards
Total number of areas for improvement	2	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of one patients care record evidenced that the personal well-being recovery care plan was in place to direct the care required. Care records reflected the assessed needs of the patient. There was evidence that the care planning process included input from the patient and their representatives. Additional information to inform the care needs of the patient was available from the Trust electronic care record system. There was evidence of regular communication with representatives within the care records. Validated risk assessments were completed as part of the admission process and reviewed as required, although it was noted that the Malnutrition Universal Screening Tool (MUST) assessment had not been completed. This was discussed with the manager and members of nursing staff who were reminded to ensure that this assessment was completed for each patient at the time of admission.

Care records reflected that, where appropriate, referrals were made to other relevant healthcare professionals. Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities.

All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

There was information available to patients and representatives in relation to advocacy services.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, teamwork and communication between patients, staff and other key stakeholders.

Areas for improvement

No areas for improvement were identified within this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We arrived in the home at 12.30 hours and were greeted by staff who were helpful and facilitated the inspection process. There were no patients accommodated in the home during the course of the inspection.

Staff were aware of the requirements regarding patient information, confidentiality and issues relating to consent.

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were modern and clean with individual ensuite facilities.

There were systems in place to obtain the views of patients and their representatives on the running of the home. There had been no complaints or concerns raised by patients or their representatives since the home opened.

Relative and patient questionnaires were provided; none were returned within the timescale.

Staff were asked to complete an on line survey, we had no responses received before the issue of this report.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date will be shared with the manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home and the environment.

Areas for improvement

No areas for improvement were identified within this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was displayed in the front corridor area of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the manager's hours were recorded. Staff were able to identify from the duty rota the person in charge of the home in the absence of the manager.

Whilst no complaints had been received, there were systems in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Discussion with the manager and review of records evidenced that a number of audits were completed to assure the quality of care and services.

Discussion with the manager and review of records did not provide assurances that systems were in place to ensure that notifiable events were investigated and reported to RQIA, an area for improvement regarding this has been made in section 6.4.

Discussion with the manager and review of records post inspection evidenced that quality monitoring visits were completed on a monthly basis on behalf of the responsible individual in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. We advised the manager to ensure that quality monitoring visits were promptly completed and returned for their review and availability within the home.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, staffing and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified within this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Eugene Gillease, manager as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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 the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that notifiable events reportable to RQIA are submitted. Ref: Section 6.4
	Response by registered person detailing the actions taken: Incident reported to staff and details of incident documentated and reported to line manager. Advice sought from medical profession for medical follow up and treatment of head injury for patient. CNS observations completed for 24 hour period and recorded in observation chart record to be kept in patients notes. Patients next of kin informed regarding incident and treatment following head injury. Future team meetings in Rathview discussions regarding head injury incidents all staff aware of recommendations following head injury incidents and documented in the minutes of the meetings.
Area for improvement 2 **Ref:** Regulation 13 1 (a) (b) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that CNS observations are commenced on any patient with a head injury. Ref: Section 6.4
	Response by registered person detailing the actions taken: Following all incidents of head injury in Rathview house staff will complete 24 hours of CNS observations recorded in observation chart and placed in patients notes.

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

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