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Unannounced Care Inspection
of
Bangor – Stewart Suite

31 March 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 31 March 2016 from 10.00 to 16.00.

The focus of this inspection was continence management which was underpinned by selected criteria from:
Standard 4: Individualised Care and Support
Standard 6: Privacy, Dignity and Personal Care
Standard 21: Heath Care
Standard 39: Staff Training and Development.

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

1.1 Actions/Enforcement Taken Following the Last Care 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 6 July 2016.

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	0	3

The details of the Quality Improvement Plan (QIP) within this report were discussed with Tiago Moreira, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four Seasons Dr Maureen Claire Royston	**Manager:** Tiago Moreira
Person in Charge of the Home at the Time of Inspection: Tiago Moreira	**Date Manager Registered:** Registration pending
Categories of Care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 30
Number of Patients Accommodated on Day of Inspection: 27	**Weekly Tariff at Time of Inspection:** £593 per week

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, criterion 8**
Standard 6: **Privacy, Dignity and Personal Care, criteria 1, 3, 4, 8and 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 manager
- discussion with patients
- discussion with staff on duty during the inspection
- review of care records
- observation during a tour of the premises
- evaluation and feedback

Prior to inspection the following records were analysed:

- inspection report and quality improvement plan (QIP) from the previous care inspection on 6 July 2015
- incident reports submitted in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005

During the inspection, the inspector met with approximately 15 patients, two care staff, ancillary staff and two registered nurses.

The following records were examined during the inspection:

- policies and procedures pertaining to the inspection focus
- staffing arrangements
- three patient care records
- staff training records
- accident recording
- complaints record

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 6 July 2015. There were no requirements or recommendations made at this inspection. The report, signed by the registered persons was returned and approved by the specialist inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection dated 6 July 2016.

No Requirements or recommendations were made as a result of the last inspection**.**

5.3 Continence Management

Is Care Safe? (Quality of Life)

Policies and procedures were in place to guide staff regarding the management of continence.

A resource file on the management of continence/incontinence had been developed and was available for staff. The file included regional and national guidelines for the management of urinary catheters), constipation (RCN and NICE) and improving continence care (RCN)

In discussion the manager was unable to confirm that training relating to the management of the urinary and bowel incontinence had been completed by staff in 2015 and 2016. Training records evidenced staff had completed training in respect of continence management in April 2014. The manager was unable to locate any more recent information. A recommendation has been made that staff complete refresher training in respect of continence management. The review of the staff induction training programme evidenced that continence care/management is included at the time of induction. The manager informed the inspector that there was support, and training opportunities from the local health and social care trust, if staff required an update in their training of catheterisation and/or the management of stomas.

In discussion 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. However, staff were observed carrying bedlinen, in their hands, after assisting a patient with personal care. Staff should always have the appropriate equipment available and ready in accordance with infection prevention and control procedures. A recommendation has been made that staff are updated regarding the correct procedures in respect of infection prevention and control.

Observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.

Is Care Effective? (Quality of Management)

Review of three patients' care records did not evidence a consistent approach to the completion of the continence assessment. The continence assessment in one care record stated the patient was fully continent. However, a continence product assessment had been completed and the patient was stated as using a specific continence product. The second continence assessment reviewed stated the patient was continent. The review of recording in the patient's care records evidenced that the patient was incontinent. The care plan had not been updated to reflect the patient's changing need. These findings were discussed with the manager who agreed to ensure nursing staff implemented a consistent approach in respect of continence management and care records accurately reflected patient assessed need. A recommendation has been made. Care plans reviewed identified the specific type of continence aid required by patients.

There was evidence in the patients' care records that the assessment and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. However, as discussed in the previous paragraph, the information was not always accurate.

The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Care plans referred to patients normal bowel patterns and care staff maintained a record using the Bristol Stool chart of bowel movements. There was evidence in patients' progress records that nursing staff were monitoring and evaluating patients' bowel function.

Urinalysis was undertaken as required and patients were referred to their GPs appropriately.

The management of urinary catheters was reviewed. Registered nurses (RNs) spoken with were knowledgeable regarding the management of urinary catheters and the rationale for the use of urinary catheters. Urinary catheters were only inserted on the instructions of the patient's GP or consultant. Registered nurses are currently updating their competency based skills in relation to catheter care.

Care plans relating to the management of urinary catheters did contain information regarding the frequency of changing the catheter in accordance with the type and evidenced based practice and that 'catheter care' was to be provided.

Review of patient's care records evidenced that patients and/or their representatives were consulted/informed of regarding care.

Is Care Compassionate? (Quality of Care)

Discussion with the manager confirmed where patients, or their families, have a personal preference for the gender of the staff providing intimate care their wishes would be respected, as far as possible. Arrangements were in place for the deployment of staff, if required, to ensure that patients' wishes were adhered to.

Staff were observed to attend to patient's continence needs in a dignified and personal manner.

Patients spoken with confirmed that they were treated with dignity and respect, that staff were polite and respectful and that their needs were met in a timely manner. Good relationships were evident between patients and staff.

Areas for Improvement

It is recommended that staff undertake refresher training in respect of continence management.

It is recommended that staff are updated regarding the correct procedures in respect of infection prevention and control.

It is recommended that nursing staff implemented a consistent approach in respect of continence management and care records accurately reflected the assessed needs of patients.

Number of Requirements:	**0**	**Number of Recommendations:**	**3**

5.4 Additional Areas Examined

5.4.1. The Environment

An observational tour of the home confirmed a high standard of cleanliness and hygiene was evident. All areas of the home were viewed and discussions were held with housekeeping staff. Staff were very clear as to their role and had an organised approach to their duties. The home employs a hospitality manager who has the responsibility of ensuring all areas of the home maintain a good standard of cleanliness and hygiene.

5.4.2. Consultation with Patients, Representatives and Staff

Part of the methodology in collecting data for the inspection process included speaking with staff, patients and patient's relatives asking them to give their own personal views on their impression of Stewart Suite.

Overall feedback from the staff, patients and representatives involved confirmed that safe, effective and compassionate care was being delivered in the home.

A few patient comments are detailed below:
'It's very good here.'
'Staff couldn't be better.'
'I think this is a marvellous place.'
'I like the company of others and staff are very good.'

Two patient representatives provided the following comments:
'Staff are very helpful.'
'The food is very good; my (relatives) eats it all.'
'Everywhere is very clean.'
'Staff keep me informed of my (relative) health and if there's a change.'

The general feeling from the staff during conversations indicated that they took pride in delivering safe, effective and compassionate care.

A few staff comments are detailed below:
'Patients are well looked after.'
'Everyone works together, it's a good home.'
'I like it here.'

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Tiago Moreira, 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 Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 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 must be completed by the registered person/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. 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 in this report do not absolve the registered provider/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 provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref:** Standard 39.4 **Stated:** First time **To be Completed by:** 31 July 2016	It is recommended that staff undertake refresher training in respect of continence management. . Management should ensure effective systems are in place to monitor that staff's knowledge and skills gained through training are embedded into practice. **Ref: section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Training has been arranged for all staff to attend in relation to continence management. Staff knowledge and understanding will be monitored through discussion and supervision.
Recommendation 2 **Ref:** Standard 47.3 **Stated:** First time **To be Completed by:** 31 July 2016	It is recommended that staff are updated regarding the correct procedures in respect of infection prevention and control. Management should ensure effective systems are in place to monitor that staff's knowledge and skills gained through training are embedded into practice. **Ref: section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Infection control training is being updated for all staff to ensure they are familiar with the correct procedures. Group supervisions will be carried out with staff to re-enforce the training and discuss best practices. Infection Control audits will be completed and any actions recorded in an action plan which will be shared with all staff.
Recommendation 3 **Ref:** Standard 21.11 **Stated:** First time **To be Completed by:** 31 May 2016	It is recommended that nursing staff implemented a consistent approach in respect of continence management and care records accurately reflected the assessed needs of patients. **Ref: section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Care records have been reviewed and updated and reflect the current assessed needs of all residents. These records will be updated when there is any change to these assessed needs. Monitoring of records will be completed through the audit process..

Registered Manager Completing QIP	Tiago Moreira	**Date Completed**	23/05/2016
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	23.05.16
RQIA Inspector Assessing Response	Heather Sleator	**Date Approved**	25/05/2016

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