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Unannounced Care Inspection
of
Bethany Care Home

19 February 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 19 February 2016 from 11:00 to 15:45 hours.

This inspection sought to assess compliance with **Standard 23 – Prevention of Pressure Damage** and to assess progress with the issues raised during and since the previous inspection**.**

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 2015.

1.2 Actions/Enforcement Resulting from this Inspection

During the inspection a disclosure was made to the inspector in relation to a potential safeguarding matter. The information was communicated to the Belfast Health and Social Care Trust's (BHSCT) adult safeguarding team in accordance with the regional safeguarding protocol.

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	2

The details of the Quality Improvement Plan (QIP) within this report were discussed with the Justin Bradley, support manager, at the conclusion of the inspection as part of the inspection process.

Details of the inspection findings, including the potential safeguarding concerns disclosed during the inspection, were discussed with the acting manager, Maura McIntyre, by telephone on 22 February 2016. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four Seasons Health Care Dr Maureen Claire Royston – Responsible Person	**Registered Manager:** See box below
Person in Charge of the Home at the Time of Inspection: Mr Justin Bradley – Support Manager	**Date Manager Registered:** Miss Maura McIntyre - Acting Manager
Categories of Care: NH – I, PH, PH (E) and TI	**Number of Registered Places:** 40
Number of Patients Accommodated on Day of Inspection: 31	**Weekly Tariff at Time of Inspection:** £593 - £667

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standard has been met:

Standard 23 – Prevention of Pressure Damage

4. Methods/Process

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

- discussion with Mr Justin Bradley and brief discussion with a regional manager prior to the inspection conclusion
- discussion with Ms Maura McIntyre, acting manager, by telephone on 22 February 2016
- discussion with patients and relatives
- discussion with staff on duty
- review of a selection of records
- observation during a tour of the premises
- evaluation and feedback.

Prior to inspection the following records were analysed:

- notifiable events submitted since the last care inspection on 6 July 2015
- the registration status of the home
- any communication/information received by RQIA regarding the home since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report
- the inspector's pre inspection assessment.

During the inspection the delivery of care and care practices were observed. A random sample of patient bedrooms, bathrooms, sluice and storage rooms, the lounge areas and the dining room was undertaken.

The inspector spoke with five patients, four care staff, two registered nurses (RNs) two support staff and two patient's visitors/representatives.

The following records were examined during the inspection:

- three patient care records including care charts
- one patient's care charts pertaining to repositioning
- a sample of staff duty rotas from 4 January to 21 February 2016.

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

5.2 Review of Requirements and Recommendations from the Last Care (Same specialism) Inspection

Last Care Inspection Statutory Requirements		**Validation of Compliance**
There were no requirements made.		
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 39 **Stated:** First time	The registered person should ensure that staff are made aware of regional guidance and standards that underpin the delivery of care in relation to communicating effectively; death and dying and palliative/end of life care.	**Met**
	Action taken as confirmed during the inspection: Mr Bradley confirmed from the training records that staff had completed training in relation to communicating effectively and palliative/end of life care.	

Recommendation 2 **Ref**: Standard 44.1 **Stated:** First time	The registered person should ensure that the replacement/repair of wash hand basin surrounds is agreed within a reasonable timeframe to ensure adherence to infection control measures	**Met**
	Action taken as confirmed during the inspection: Observations confirmed that this recommendation had been met.	
Recommendation 3 **Ref**: Standard 6.1 **Stated:** First time	The registered person should consider how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times.	**Met**
	Action taken as confirmed during the inspection: Observation and discussion with Mr Bradley confirmed that this recommendation had been met.	

5.3 Standard 23 – Prevention of Pressure Damage

Is Care Safe? (Quality of Life)

A sampling of training records and discussion with nursing and care staff evidenced that staff had completed training in relation to the prevention of pressure damage.

Review of care records evidenced that an assessment of a patient's skin was undertaken at the pre admission assessment and again on the day of admission. This included the appropriate completion of body maps to indicate areas of concern

Staff spoken with confirmed that when a patient was being transferred to hospital a skin assessment and body map was undertaken and included in the transfer information. Similarly a skin assessment and body map was completed on the patient's return to the home. Any concerns were reported to the patient's care manager/the Belfast Health and Social Care Trust (BHSCT).

The Braden pressure risk assessment tool was in place and completed on admission and thereafter reviewed on, at least, a monthly basis.

Is Care Effective? (Quality of Management)

Review of patient records and discussion with staff confirmed that any patient identified as being at risk of developing a pressure ulcer had a care plan in place detailing the specific actions/treatments and care required.

The care plans reviewed included reference to the patient's specific pressure relieving needs. For example, the frequency of repositioning and the use of equipment such as pressure

relieving mattresses/cushions and slide sheets to aid in the reduction of friction when moving a patient.

However, a review of repositioning charts evidenced that the delivery of care did not always happen within the prescribed timeframe. For example, in all of the records reviewed 'gaps' between entries of up to five or six and a half hours were evidenced. Details were discussed during feedback. A recommendation has been made.

In addition, observation and discussion with care staff, evidenced that it was custom and practice to complete care charts for the morning shift after lunch was finished and patients were 'settled' back to their rooms or lounge. It was evident that recording of care charts such as repositioning and food/fluid intake was not contemporaneous and care staff confirmed that entries were not made at the time at which care was actually delivered. Staff were attempting to recall details up to six hours after care delivery. This was concerning and was discussed with Mr Bradley during feedback and with Ms McIntyre, the manager, on 22 February 2016 by telephone. A recommendation has been made.

Management confirmed that issues in relation to the recording of care charts and, in particular, repositioning charts were 'ongoing' and addressed with staff through the home's audit processes. However, there was no evidence available at the time of the inspection to support this as the manager was on leave. The manager confirmed, by email on 24 February 2016, the action taken by the management team to address identified deficits in recording of patient care charts. Details were also provided regarding additional support to be implemented following the inspection.

Staff spoken with demonstrated their knowledge and understanding of how to prevent pressure damage and how to recognise and report if damage occurred using the European, National and Regional grading system for pressure ulcers.

Staff confirmed that when a wound was not responding to treatment a referral would be made to the Trust's Tissue Viability Specialist Nurse (TVN) or podiatry services as appropriate.

Is Care Compassionate? (Quality of Care)

Discussion with patients and their relative/representatives confirmed that patients' needs were met in a timely and respectful manner. Patients and relatives stated that staff were kind and attentive and that they felt safe, well cared for and comfortable in the home. Patients and relatives confirmed that they knew who to go to if they had a concern and they said they were confident that the manager would address any concerns.

Staff were observed to be responding to patients in a dignified manner. Fresh drinking water and nurse call bells were within reach.

Patients were observed to be well groomed, relaxed and comfortable in their surroundings and with staff

Observation of moving and handling techniques evidenced that staff promoted the dignity of the patients.

Areas for Improvement

It was recommended that any patient identified as 'at risk' of pressure damage, using a validated tool, is repositioned in accordance with their care plan and that care charts accurately reflect this.

It was recommended that patient records are recorded contemporaneously to ensure they are accurate and reflective of the care delivered.

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

5.4 Additional Areas Examined

5.4.1 Staffing

In addition to the comments made by patients, staff and relatives within section 5.3 of this report; concerns regarding the staffing levels within the home were raised by staff with the inspector in relation to 'short notice sick leave' not being 'covered' and new staff not receiving supernumerary shifts as part of their induction.

RQIA were unable to substantiate the concerns raised by staff in relation to short notice sick leave and induction supernumerary shifts.

Observations of the care delivery evidenced that patents needs were being met in a timely manner. For example, staff were observed to be responding promptly to nurse call bells and requests for assistance.

Patients and relatives confirmed that they did not have to wait long for assistance when requested. However, they did comment that staff were "sometimes rushed off their feet".

Discussion with the management team in relation to planned staffing levels and a review of duty rotas from 1 January to 21 February 2016 evidenced that staffing levels were kept under review to ensure they met the assessed needs of the patients accommodated. It was also confirmed that sick leave was being managed in accordance with the home's policy on attendance.

Review of nursing and care staff duty rotas evidenced that sick leave was in the main 'covered' by staff working extra shifts of by agency staff.

In relation to staff induction, it was confirmed, through discussion with the manager, that new staff were provided with supernumerary shifts as part of their induction programme and that the period of supernumerary practice was based on the needs and experience of the new staff member. Duty rotas confirmed that induction shifts were identified as 'supernumerary' on the rota.

The support manager confirmed, during feedback, that a system of management and senior manager cover was in place for 'out of hours' and at weekends. Assurances were provided that the staffing levels for the remainder of the day, of the inspection, and over the weekend would be 'as planned'.

5.4.2 Environment

A review of the home's environment was undertaken which included observation of a random sample of bedrooms, bathrooms, lounges and dining room and stores/sluices on each floor.

The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients were observed relaxing in their bedroom or in one of the lounges. Patients and relatives spoken with were complimentary regarding the home's environment. Housekeeping and maintenance staff are to be commended for their efforts.

Areas for Improvement
There were no areas for improvement identified.

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

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mr Bradley, support manager and Mrs Maura McIntyre, manager, by telephone on 22 February 2016, 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.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 23.3 **Stated:** First time **To be Completed by:** 31 March 2016	Any patient identified as 'at risk' of pressure damage, using a validated tool, should be repositioned in accordance with their care plan and care charts should accurately reflect this. Ref: Section 5.3
	Response by Registered Person(s) Detailing the Actions Taken: Outcome of inspection was discussed with staff during staff meeting and the importance of ensuring repositioning charts are accurately completed. The completion of charts is monitoed daily as part of QoL system and will continue to be monitored as part of the monthly visit on behalf of the registered provider. Support visits from the resident experience team will continue to reinforce accurate recording of care charts is completed.
Recommendation 2 **Ref**: Standard 4.9 **Stated:** First time **To be Completed by:** 31 March 2016	Patient records should be recorded contemporaneously to ensure they are accurate and reflective of the care delivered. Ref: Section 5.3
	Response by Registered Person(s) Detailing the Actions Taken: An alternative area to keep charts has been allocated to allow staff easy access to charts and encourage contemporaneous completion. A random selection of charts is checked on daily basis as part of the Quality of life system and monitoring of records will continue as part of the auditing system by Home Management and Senior Management.

Registered Manager Completing QIP	Maura McIntyre	**Date Completed**	30/03/16
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	31.03.16
RQIA Inspector Assessing Response	Lyn Buckley	**Date Approved**	04/04/2016

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

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.