Unannounced Follow Up Care Inspection Report
7 August 2017

Colinvale Court

Type of Service: Nursing Home (NH)
Address: Glen Road, Belfast, BT11 8BU
Tel No: 028 9060 4314
Inspector: Heather Sleator

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 nursing home registered to provide nursing care for up to 50 persons.

3.0 Service details

Organisation/Registered Provider: Mr Raymond Liam Murphy	**Registered Manager:** Vincy Vincent
Person in charge at the time of inspection: Norma Gilgunn – Deputy Manager	**Date manager registered:** 13 June 2016
Categories of care: Nursing Home (NH) DE – Dementia.	**Number of registered places:** 50

4.0 Inspection summary

An unannounced inspection took place on 7 August 2017 from 09.50 to 16.45 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 DHSSPS Care Standards for Nursing Homes 2015.

The inspection was carried out following information received from an anonymous caller to RQIA. The information was discussed with the adult safeguarding team from Belfast Health and Social Care Trust and it was agreed that RQIA would undertake an inspection in the first instance. The purpose of the inspection was to identify possible breaches in the Nursing Homes Regulations (Northern Ireland) 2005.

Concerns were raised in relation to the following areas:

- staffing arrangements
- cleanliness and hygiene standards in the home
- continence management
- the arrangements for the administration of medications

It is not the remit of RQIA to investigate complaints or whistleblowing concerns made by or on behalf of individuals, as this is the responsibility of the registered providers and the commissioners of care. However, if RQIA is notified of a potential breach of regulations or minimum standards, it will review the matter and take appropriate action as required; this may include an inspection of the home.

The following records were examined during the inspection:

- staffing arrangements
- the environment
- care practice including meals and mealtimes
- patients' care records
- continence management and clinical waste disposal arrangements

The specific concerns raised by the anonymous caller were not substantiated during the inspection and it was evident that patients' needs were being met in a safe and compassionate manner.

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	2*

*The total number of areas for improvement includes one standard which has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Norma Gilgunn, Deputy 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 most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 10 May 2017. Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 10 May 2017.

5.0 How we inspect

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

- notifiable events since the previous care inspection
- 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

During the inspection the inspector met with six patients individually and the others in small groups and eight staff. There were no patients' visitors/representatives available at the time of the inspection.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- staff duty rota from 31 July to 13 August 2017
- quality assurance audits of care records, infection prevention and control and the environment
- three patient care records
- supplementary care records
- cleaning schedules
- regulation 29 monthly quality auditing reports

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as 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 10 May 2017

The most recent inspection of the home was an unannounced medicines management inspection.

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

This QIP will be validated by the pharmacist inspector at the next medicines management inspection.

6.2 Review of areas for improvement from the last care inspection dated 16 February 2017

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 4.8 **Stated:** First time	The registered provider should ensure care plans evidence the desired daily fluid intake for individual patients and the action to be taken, and at what stage, should the desired target not be met.	**Not met**
	Action taken as confirmed during the inspection: The review of three patient care records did not evidence that an assessment had been undertaken by registered nurses regarding the risk of dehydration for patients nor was a corresponding care plan present regarding the fluid intake of patients. Refer to section 6.3.3	
Area for improvement 2 **Ref:** Standard 35.6 **Stated:** First time	The registered provider should establish a system to ensure any shortfall identified through audit, is actioned in a timely manner.	**Met**
	Action taken as confirmed during the inspection: The review of quality assurance audits in respect of care records, infection prevention and control and the environment evidenced that where a shortfall had been identified through audit remedial action had been taken.	

Area for improvement 3 **Ref:** Standard 35.7 **Stated:** First time	The registered provider should ensure an action is generated at the conclusion of each monthly quality monitoring visit, where applicable. The subsequent monthly quality monitoring visit should commence with an evaluation of the previous action plan in respect of compliance	**Met**
	Action taken as confirmed during the inspection: The review of the quality monitoring report completed by the responsible person evidenced that each report commenced with an evaluation of the previous action plan in respect of compliance	

6.3 Inspection findings

6.3.1 Staffing arrangements

The registered manager of the home, Vincy Vincent was on leave at the time of the inspection. We were facilitated throughout the inspection by Norma Gilgunn, Deputy Manager, and Raymond Murphy, Responsible Person.

The staff duty rosters from 31 July to 13 August 2017 were reviewed. Staffing arrangements were reflective of the duty roster and planned staffing levels were adhered to, as far as possible. Agency staff were on duty at the time of the inspection. In discussion with the registered nurses it was confirmed that the use of agency staff was required due to a number of staff vacancies. In discussion with an agency staff member it was confirmed that agency staff receive induction training when commencing in the home. The staff member stated, "It's a very good home," management were supportive and approachable and that she had been brought in for a period of induction before she commenced working in the home. The staff member stated that this was a 'surprise' as this had not occurred in other homes that she had been sent to work in. Evidence was available in the registered manager's office of the completed induction training records of agency staff. Staff stated that they would speak to the manager of the home if they had any issue and were confident they would be listened to.

Comments from staff included:

"It's great here, I really love it, you bond with the patients."
"Management are very good, they listen to you."
"I go to the deputy manager, she's very good."

Observation of the delivery of care and discussion with staff evidenced that patients' needs were met by the levels and skill mix of staff on duty. Staff stated that they felt that the staffing arrangements in the home were good except when there was short notice/casual sickness. On these occasions it could be problematic to get additional staff to cover. Staff interactions with patients were observed to be compassionate, caring and timely.

Consultation with 6 patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Patients confirmed that they were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Areas of good practice

Staffing arrangements were reflective of the duty roster and planned staffing levels were adhered to, as far as possible. Agency staff confirmed that they received induction when commencing work in the home

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.3.2 Care practice

Staff spoken with stated that they felt care delivery was of a good standard and that they felt, as previously discussed, that the staffing arrangements in the home were appropriate to meet the needs of the patients. Patients were observed to be appropriately dressed and observation of care delivery evidenced that patient's hygiene and continence needs were being addressed in accordance to patients' requests or their needs. There were daily personal care records maintained by staff to confirm when patients' personal care needs had been addressed. There was evidence of adequate stocks of continence products which were stored appropriately. There was no evidence that staff were not adhering to the appropriate disposal of clinical waste procedures. In discussion with the deputy manager it was stated that a patient, will on occasion, remove their continence product and dispose of it as and where they remove it. Staff are aware of this and they try to ensure that any used continence product is disposed of appropriately.

The serving of the midday meal was observed. Tables were attractively set with cutlery, condiments and napkins. In discussion with staff it was stated that they were trying to make the dining experience as 'nice as possible' for patients and had coordinated the dining tables with the décor in the lounge. Those patients who had their lunch in the lounge or their own bedroom were served their meal on a tray which was set with cutlery and condiments and the food was covered prior to leaving the dining room. The meals were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch. Registered nurses were observed supervising and assisting patients with their meals and monitoring patients' nutritional intake.

Areas of good practice

The approach to meals and mealtimes evidenced improvement, there was a calm atmosphere in the home patients appeared content.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.3.3 Care records.

Review of three patient care records did not evidence that a range of validated risk assessments were completed as part of the admission process and reviewed as required. The review of the care records evidenced that there was a lack of consistency regarding the risk assessments in use and that the risk assessments and care plans for two patients had not been reviewed on a regular basis. Evidence was not present that registered nurses regularly reviewed and updated patient care records on a monthly basis. Weaknesses were identified in relation to the process as the review of care records did not evidence that patients care plans had been reviewed and revised, where applicable, to reflect current need. The review of one care record did not reflect a revised care plan for distressed reactions and a second care record reviewed did not evidence that registered nurses were reporting and evaluating on a patients weight loss despite a care plan being in place regarding this area of care.

The review of the care plans within the care records evidenced that with the exception of one care record, they had not been reviewed on a regular basis by the registered nurses. The review of the care records also evidenced that registered nurses were recording patients' daily fluid intake. There was no evidence that a risk assessment regarding the management of hydration/risk of dehydration had been completed, a care plan written and the action to be taken should the desired daily fluid intake not be achieved. This had been a recommendation of the previous inspection report of 16 February 2017 and has been stated for a second time in this report. The review of patient care records also evidence that care planning and support in respect of behaviours that challenge and smoking were poor and/or not being adhered to by staff. The care planning process has been identified as an area for improvement under regulation.

The following weaknesses were identified:

- lack of consistency and evidence of review of risk assessments
- lack of consistency and evidence of review and evaluation of care plans
- poor care planning regarding the management of behaviours that challenge
- lack of adherence to the interventions with care plans, for example; smoking
- management of hydration/risk of dehydration
- management of weight loss

The auditing of patient care records was reviewed. The audits evidenced that 10 care records had been reviewed and remedial action to be taken identified. None of the care records reviewed at the time of inspection had been included in the completed audits. A more robust and consistent approach to auditing of care records should be established. This was identified as an area for improvement under the standards.

Personal or supplementary care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans, the frequency of repositioning was recorded on the repositioning record and staff were reporting on the condition of the patient's skin. Nutritional intake, including fluid intake were being maintained by care staff.

Areas of good practice

Supplementary care records had been diligently recorded by care staff.

Areas for improvement

Areas identified for improvement under the regulations was in relation to the assessment and care planning process.

Two areas were identified for improvement under the care standards. The management of hydration/risk of dehydration has been stated for a second time and a more robust and consistent approach to the auditing of care records should be established.

	Regulations	Standards
Total number of areas for improvement	2	1

6.3.4 Environment

A review of the home's environment was undertaken which included a number of bedrooms, bathrooms, shower and toilet facilities, sluice room, storage rooms and communal areas. The areas reviewed were found to be clean and warm and a homely atmosphere was evident throughout. Housekeeping staff were on duty and confirmed that they had adequate stock of cleaning products and equipment.

We observed that the bins outside of the home were overstocked with clinical waste bags, some of which were on the ground as there was no room in the bins. This was discussed with the responsible person who stated that they had recently changed to a different removal contractor. The contractor would not remove clinical waste as the disposal bags of the previous contractor were still being used by staff. The responsible individual had discussed this with staff and the excess waste disposal bags of the previous contractor had been removed. The responsible individual contacted the waste disposal company and by the end of the inspection the bins containing clinical waste had been emptied by the contractor.

Pest control had completed an inspection of the premises on the day of the inspection.

Areas of good practice

The home was clean, warm and a homely atmosphere was evident. Housekeeping staff stated they had sufficient stock of cleaning products.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.3.5 Administration of medication

A concern had been reported that a patient had been administered a medication from another patients stock. This was discussed with the deputy manager who confirmed that on one occasion this had in fact occurred. The deputy manager stated that the incident occurred on a public holiday and the dispensing chemist for the home was not working on that day. The deputy manager stated that it was in the patient's best interest to have the medication and she therefore made the decision to 'borrow' the same tablet from another patient's stock and administer it to the patient. The deputy manager stated this was not a usual occurrence and contact with the dispensing chemist had been made the following day. The deputy manager reviewed the stock of all patients' medication following this to ensure a similar situation did not occur. This was discussed with the pharmacy inspector who stated this was not a practice that was advocated however the necessary follow up action had been taken by management.

Areas of good practice

With the exception of one occasion generally the administration and storage of medicines was in accordance with regulations and standards.

Areas for improvement

No areas for improvement were identified 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 QIP. Details of the QIP were discussed with Norma Gilgunn, Deputy 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 DHSSPS 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 to Nursing.Team@rqia.org.uk for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 15 (2) (a) and (b) **Stated:** First time **To be completed by:** 2 October 2017	The registered person shall ensure that the assessment of patient need, included risk assessment is completed in a consistent manner and evidence is present of regular review. **Ref: Section 6.3.3**
	Response by registered person detailing the actions taken: An action plan been devised and group individual discussion has been taken place with all nursing staff . The assessment of patient needs are now documented and ongoing and going forward will be completed in a consistant manner .This will be fully documented and available for review at all the times.
Area for improvement 2 **Ref:** Regulation 16 (1) and (2) **Stated:** First time **To be completed by:** 2 October 2017	The registered person shall ensure that care plans are written in response to the assessed needs of patients and are regular reviewed so as to reflect current need. Prescribed care interventions should be adhered to by all staff. **Ref: Section 6.3.3**
	Response by registered person detailing the actions taken: Care plans are currently being updated and all nursing staff have been given additional time to ensure that care records are updated and monitored as necessary .
Action required to ensure compliance with The Care Standards for Nursing Homes 2015	
Area for improvement 1 **Ref:** Standard 4.8 **Stated:** Second time **To be completed by:** 2 October 2017	The registered person shall ensure care plans evidence the desired daily fluid intake for individual patients and the action to be taken, and at what stage, should the desired target not be met. **Ref: Section 6.3 and 6.3.3**
	Response by registered person detailing the actions taken: Daily fluid intake chart are fully updated and are reviwed regularly .If the chart shows any shortfalls ,the GP will be consulted immediately . The care plan now has a separate facility to detail the fluid intake of all residents

Area for improvement 2 **Ref:** Standard 35.6 **Stated:** First time **To be completed by:** 2 October 2017	The registered person shall ensure that a robust and consistent approach to the auditing of patient care records is established. Evidence should be present that where a shortfall had been identified during audit the appropriate remedial action had been taken and the outcome validated by the registered manager. **Ref: Section 6.3.3**
	Response by registered person detailing the actions taken: The nurse Manager will provide a robust system evidencing the auditing of patient care records .It is intended that this system will safe guard against any short falls and that appropriate remedial action is taken without delay as and when required .The out come will be validated by the Nurse Manager .

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

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