Colinvale Court
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BT11 8BU

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Unannounced Care Inspection
of
Colinvale Court

12 August 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 12 August 2015 from 10:30 to 17:30.

Overall on the day of the inspection, concerns and areas of improvement were identified and are required to be addressed to ensure that care in the home is safe, effective and compassionate. These areas are set out in the Quality Improvement Plan (QIP) within this report. Refer also to Section 1.2 below.

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 Sections 5.2 and 6.2 of 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 16 April 2015.

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	8

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

2. Service Details

Registered Organisation/Registered Person: Raymond Murphy	**Registered Manager:** Stephanie Shannon
Person in Charge of the Home at the Time of Inspection: Ibin Paul, Deputy Manager	**Date Manager Registered:** 1 April 2005
Categories of Care: NH-DE	**Number of Registered Places:** 50
Number of Patients Accommodated on Day of Inspection: 35	**Weekly Tariff at Time of Inspection:** £593 per week

3. Inspection Focus

The focus of this inspection was to review the level of compliance attained regarding the recommendations made as a result of the previous inspection of 16 April 2015.

The inspection also sought to assess progress with the issues raised during and since the previous inspection.

RQIA had recently received information expressing concerns in relation to the following areas:

- safeguarding issues
- management and staffing issues
- care practices, such as deficits in personal care delivery

The information in relation to these issues is being investigated by the Adult Safeguarding Team, Belfast Health and Social Care Trust in accordance with Regional Safeguarding Procedures. The investigation had commenced and was ongoing at the time of inspection. RQIA are not involved in the investigation process but will be kept informed of the investigation outcome.

RQIA undertook this inspection to review the care being provided to patients.

4. Methods/Process

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

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
- the previous care inspection report

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with 12 patients, three care staff, two registered nurses and housekeeping staff.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- personal care recording charts
- audits of the environment, cleanliness and hygiene
- nursing care records

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 16 April 2015. The completed QIP was returned and approved by the nursing inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref:** Standard 36 **Stated:** First time	The policy documentation in relation to continence care should be revised. Policy documentation should reflect best practice guidance and be signed and dated by the registered manager.	**Met**
	Action taken as confirmed during the inspection: A review of the policy on continence care evidenced the policy had been revised and reflected best practice guidance. The policy had been signed and dated by the registered manager.	
Recommendation 2 **Ref:** Standard 36 **Stated:** First time	Policy documentation should be consolidated to ensure a user friendly and easily accessible reference library of information is available in the home. Policy documentation should be in accordance with Appendix 2: Policies and Procedures of the Care Standards for Nursing Homes 2015.	**Met**
	Action taken as confirmed during the inspection: At the previous inspection, there were three policy files and computerised documentation. Policy documentation had been consolidated into one accessible reference folder for staff.	

Recommendation 3 **Ref:** Standard 14 **Stated:** First time	The registered manager should write to Trust representatives should there be difficulty in getting personal toiletries and clothing for any patient who does not have access to their personal allowance as agreed.	**Met**
	Action taken as confirmed during the inspection: The deputy manager stated there was no longer an issue regarding obtaining personal toiletries and clothing for patients who do not have access to their personal allowance. Discussion takes place at the care review with Trust representatives and patients and/or their representatives.	

5.3 Additional Areas Examined

5.3.1. Nursing care records

Following the observation of care practice during the inspection, three patients' care records were selected for review. The review of the care records focused on the management of behaviours that challenge, restrictive practice and the adherence to the nursing process following the admission of a patient.

Restrictive practice

Evidence was not present that staff had adhered to best practice guidance regarding the use of a restrictive practice. A care plan for the use of a sensor mat had not been written. Discussion with the patient's representative and a member of the multidisciplinary team in November 2014, confirmed the use of a sensor mat as the patient had an increased risk of falling. Reference was subsequently made in nursing care records in December 2014; however, a care plan had not been written.

The use of any restrictive practice must be in accordance with best practice guidance which nursing staff are required to adhere to. A recommendation has been made.

A recommendation had also been made at the care review of November 2014 that life story information in respect of the patient should be in place. There was no evidence in the nursing records or the patient's bedroom that lifestory work had been completed. Lifestory information is an important aspect of dementia care as it enables staff to communicate with patients on a more personal and meaningful manner. Lifestory information should be present for all patients, as far as possible. A recommendation has been made.

Behaviours that challenge

Care plans were present to assist staff with the management of behaviours/distressed reactions of a patient. The care plans had prescribed interventions to support the patient. However, the review of the patient's progress records did not evidence that staff were adhering to the prescribed interventions and were not explicit in their recording. Progress records made reference to the patient's 'bad form' but did not state how the patient presented, how staff supported the patient at these times or the patient's response to any support given.

This is poor recording and does not evidence a consistent and therapeutic approach to supporting the patient at times when distressed reactions are displayed. A recommendation has been made.

Nursing process

Nursing staffs' understanding and adherence to the nursing process was assessed during the review of the nursing care records of a patient who had been recently admitted to the home. It was concerning that the patient's assessment of need, risk assessments and care plans were not written within the recommended time period of five days, as stated in the DHSSPS Care Standards for Nursing Homes, 2015. Care plans were written 12 days post admission and the majority of risk assessments were completed 17 days following admission. It was also concerning that care plans had been written before risk assessments had been completed. A recommendation has been made.

Nursing staff had not updated the patient's care plans following an admission to hospital. Instructions on the discharge letter had not been transferred to the relevant care plan. There was no evidence in the nurses' handover report book which is in use in this home, of the specific instructions as per the discharge letter from hospital. This is poor practice. Nursing care plans must be updated to reflect the needs of a patient at any given time and take into account the recommendations from relevant health and social care professionals. A requirement has been made.

A requirement and recommendations have been made to ensure that the care and treatment provided to patients adheres to the patients' prescribed care plans and meets their individual needs.

5.3.2. Care practice

Meals and mealtimes

Colinvale Court is designed and provides five separate living areas for patients. These are called Beech, Cherry, Oak, Elm and Glen. The areas, with the exception of Glen, provide a lounge and dining room and the patients who use a specific named area ideally have their bedroom close to the lounge/ dining room of the unit. However, recently three of the units had been closed as there were a number of vacancies in the home and a management decision was taken to close three of the units. The number of patients accommodated in the home has increased from this decision was taken; and this was evident during the observation of the serving of the midday meal. There was one dining table per unit with each table seating six patients. One lounge/dining room was accommodating 17 patients. This resulted in a large number of patients having their meal in the lounge area or their bedroom. Evidence should be present that the dining arrangements are agreeable to patients and are not as a result of a management strategy in the home. A recommendation has been made.

Personal care

The personal care afforded to patients was observed with areas for improvement identified. A number of patients were observed to have long and unclean fingernails. The personal care recording charts were reviewed and evidenced that up until the time of the inspection, the care of patients' nails had been recorded with a 'tick'. This system did not confirm whether the patient's nails were clean or had been cut. This was discussed with staff who stated they were aware that the identified patients needed nail care and that those patients had not cooperated with staff to attend to this need when being assisted to get dressed that morning.

Nail care was reviewed again in the afternoon and the identified patients had received attention and personal care recording stated their nails had been cut. A recommendation has been made that staff confirm the care intervention they afford to patients when completing records, for example; nails were cut, glasses cleaned and hair combed.

5.3.3. Governance and management arrangements.

A system to monitor the quality of services provided by the home was in operation. The system incorporated the completion of quality audits, either by the registered manager or a nominated member of staff, on a regular basis. On this occasion, the audits reviewed included nursing care records, infection control and the cleanliness and hygiene of the home.

Audits of the care records reviewed during the inspection did not identify the issues discussed in section 5.3.1. Audits should have identified that risk assessments and care plans had not been completed within the timescales as stated in the care standards. Audits of care records did not consistently evidence that where a shortfall had been identified remedial action had taken place within a specified timescale. A recommendation has been made.

Dining chairs had been observed as requiring a thorough cleaning due to a build-up of food debris. Management had delegated the responsibility of cleaning the dining chairs to night staff. A review of the work schedule for night staff evidenced staff had signed to say that dining chairs had been cleaned. Audits of the cleanliness of the home did not evidence that the cleanliness of the dining chairs to be an issue. A more robust approach to the auditing of work allocated to staff should be implemented. A recommendation has been made.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ibin Paul, deputy 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 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 16 (1) and 16 (2) (b) **Stated:** First time **To be Completed by:** 11 September 2015	The registered person must ensure that nursing care records are revised as and when patients' needs change. **Ref: Section 5.2.1**
	Response by Registered Person(s) Detailing the Actions Taken: All Care Plans are currently being reviewed and rewritten. This process should be completed by Friday 9/10/2015.
Recommendations	
Recommendation 1 **Ref:** Standard 18.6 **Stated:** First time **To be Completed by:** 30 September 2015	Evidence should be present in nursing care records that the use of a restrictive practice is in accordance with best practice guidelines. Nursing care records should evidence the reason for the restrictive practice, monitoring and the regular evaluation. **Ref: Section 5.2.1**
	Response by Registered Person(s) Detailing the Actions Taken: This issue has been fully addressed and censor mats are being used as appropriate. Care Plans have been updated accordingly.
Recommendation 2 **Ref:** Standard 4.3 **Stated:** First time **To be Completed by:** 30 September 2015	Patients' life story information should be developed and readily available to enable staff to engage with patients' in a meaningful way. Staff should action the decisions made with families and health care professionals to develop life story books. **Ref: Section 5.2.1**
	Response by Registered Person(s) Detailing the Actions Taken: Life story information is curently in place and is being updated with families and the activities co-ordinator as applicable. Medical Care Plans have been requested from GP's where relevant.
Recommendation 3 **Ref:** Standard 26.5 & 25.6 **Stated:** First time **To be Completed by:** 30 September 2015	Staff should follow agreed strategies to support patients who display distressed reactions. When recording in respect of distressed reactions, staff should accurately describe the behaviour, staff interventions, if any, and the patient's response to care interventions. Staff should not generalise displayed behaviours when recording, for example, stating 'in bad form.' **Ref: Section 5.2.1**
	Response by Registered Person(s) Detailing the Actions Taken: Staff have been instructed in this regard and all such issues are now being recorded appropriately in the behavioual chart and Care Plans.

Recommendation 4 **Ref:** Standard 4.1 **Stated:** First time **To be Completed by:** 4 September 2015	A detailed plan of care should be generated from a comprehensive, holistic assessment from the time of admission and completed within five days of admission to the home. **Ref: Section 5.2.1**
	Response by Registered Person(s) Detailing the Actions Taken: The manager has ensured that the relevant Care Plan is in place within the appropriate time scale.
Recommendation 5 **Ref:** Standard 12.20 **Stated:** First time **To be Completed by:** 4 September 2015	Dining arrangements in the two units currently in use, Beech and Oak, should be reviewed to ensure patients have the opportunity to sit at the dining table, if they wish to. The number of patients per lounge/dining room should be reviewed to ensure the area has the capacity to accommodate 15 plus patients. **Ref: Section 5.2.2**
	Response by Registered Person(s) Detailing the Actions Taken: This recommendaation is now being fully implemented.
Recommendation 6 **Ref:** Standard 4.9 **Stated:** First time **To be Completed by:** 4 September 2015	Staff should be explicit when recording the personal care afforded to patients, at any given time. Care records, including personal care charts, should evidence the actual care given. **Ref: Section 5.2.2**
	Response by Registered Person(s) Detailing the Actions Taken: Personal care records have been introduced and regular audits are resigned to Nursing staff for completion and signature.
Recommendation7 **Ref:** Standard 35.6 **Stated:** First time **To be Completed by:** 4 September 2015	Quality audits, for example, an audit of nursing care records, should evidence the remedial action taken when a shortfall has been identified. Evidence should also be present to confirm management have verified that the remedial action had been completed. **Ref: Section 5.2.3**
	Response by Registered Person(s) Detailing the Actions Taken: The rewriting of Care Plans is ongoing after review. The audit process is in place and as a number of shortfalls have been identified a full review/ revision of care plans is currently in progress.

Recommendation 8 **Ref:** Standard 35.6 **Stated:** First time **To be Completed by:** 4 September 2015	Management should ensure that a robust system for monitoring the tasks/work allocated to staff has been completed to a satisfactory standard, should be in evidence. **Ref: Section 5.2.3** **Response by Registered Person(s) Detailing the Actions Taken:** Individual staff have been insstructed in relation to tasks/ work allocation and this will be monitored on a ongoing basis going forward.

Registered Manager Completing QIP	Geetha Rajappan, Acting Interim Manager	**Date Completed**	29/09/2015
Registered Person Approving QIP	Raymond L Murphy	**Date Approved**	29/09/2015
RQIA Inspector Assessing Response	Heather Sleator	**Date Approved**	29/09/15

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