Colinvale Court
RQIA ID: 1074
Glen Road
Belfast
BT11 8BU

Inspectors: Elaine Connolly and Heather Sleator
Inspection ID: 022531

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Unannounced Care Inspection of Colinvale Court

16 April 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 16 April 2015 from 10:00 to 15:30. Overall on the day of the inspection the home was found to be delivering safe, effective and compassionate care.

Areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) appended to this report.

This inspection was underpinned by The Nursing Homes regulations (Northern Ireland) 2005 and The Department of Health, Social Services and Public Safety's (DHSSPS) Care Standards for Nursing Homes (2015).

1.1 Actions/Enforcement Taken Following the Last Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection of 29 January 2015. However, conditions had previously been imposed on the registration of the home on 23 September 2014 as part of RQIA's enforcement procedures. The conditions in place were:

1. The registered person must ensure that a nurse manager, with sole responsibility for Colinvale Court, is working in the home. The nurse manager will take control of the day to day management and control of Colinvale Court
2. Admissions to Colinvale Court will cease until such times as compliance with the specific actions stated in the failure to comply notices has been attained
3. The registered provider must ensure that regulation 29 monthly reports and copies of any other monitoring reports are provided to RQIA within three working days of the visits/reports having been completed. This condition will continue until such time that RQIA is satisfied that the home is operating in sustained compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Nursing Homes Minimum Standards 2008.

1.2 Actions/Enforcement Resulting from this Inspection

As a result of this inspection and the sustained improvement in the areas inspected the conditions imposed on the registration of the home on 23 September 2014 were removed. A new certificate of registration to reflect this has been issued to the registered persons.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	3

The details of the QIP within this report were discussed with Stephanie Shannon, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Person: Mr Raymond Murphy	**Registered Manager:** Ms Stephanie Shannon
Person in Charge of the Home at the Time of Inspection: Ms Stephanie Shannon	**Date Registered:** 1 April 2005
Categories of Care: NH - DE	**Number of Registered Places:** 50
Number of Patients Accommodated on Day of Inspection: 30	**Weekly Tariff at Time of Inspection:** £581.00 per week

3. Inspection Focus

The focus of this inspection was to review the level of compliance attained regarding the requirements and recommendations made as a result of the previous inspection of 29 January 2015.

4. Methods/Process

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

Prior to inspection the following records were examined:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection including relevant monthly Regulation 29 reports
- the returned quality improvement plans (QIP) 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 15 patients, three care staff, three nursing staff, two housekeeping staff and the activities coordinator.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- the staff duty rota
- three patient care records
- review of quality of services provided as detailed in the completed audits of care records, cleanliness of the home and infection control measures
- policy on continence care.

5. The Inspection

5.1 Review of Requirements and Recommendations from Previous Inspection

The previous inspection of the home was an unannounced pharmacy inspection dated 2 March 2015. The completed QIP was returned and approved by the pharmacy inspector.

Further validation of compliance will be followed up by the pharmacy inspector.

5.2 Review of Requirements and Recommendations from the last Care Inspection of 29 January 2015.

Previous Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 15 (2) (a) and (b)	The registered persons must ensure the assessment of need and risk assessments for any patient are fully completed. Evidence must also be present in care records of the regular evaluation of needs assessments.	**Met**
	Action taken as confirmed during the inspection: The review of three patients' care records evidenced the assessment of need and risk assessments had been fully completed. Evidence was present of the regular evaluation of assessed need.	
Previous Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref:** Standard 25.2	The care record audit process should ensure that: • care records for each patient reflect their dementia needs and the impact on daily life.	**Met**
	Action taken as confirmed during the inspection: A system of audit of patients care records had been implemented. The completed audits identified all aspects of care, including the cognitive/dementia needs of the patient which had been completed and the information was present within patients care records.	

Recommendation 2 **Ref**: Standard 19.1	Care records should evidence: • bowel function and pattern, referencing the Bristol Stool Chart, should be recorded in patients' progress notes and monthly evaluation of care • patients' care plans should state the type of continence product in use and the level of assistance and support required. **Action taken as confirmed during the inspection:** The review of three patient care records evidenced that nursing staff were monitoring patients' bowel pattern and were referencing the Bristol Stool chart in the patient's progress record and the monthly evaluations of care. Care plans evidenced the type of continence product to be used and the level of support and assistance required by the patient.	**Met**
Recommendation 3 **Ref**: Standard 19.1	The registered manager should ensure that continence products are stored in an organised manner and that there is sufficient stock of continence products and any other equipment/aids needed by staff regarding continence management. **Action taken as confirmed during the inspection:** The stock control and storage of continence products was managed in an organised manner. Products were stored in the bathrooms of each designated unit. Sufficient stock was in evidence.	**Met**

Recommendation 4 **Ref**: Standard 19.2	The registered manager should ensure policy documentation in relation to urinary and faecal continence is updated and reflect best practice guidelines. The following guidelines to be readily available to staff and used on a daily basis: • British Geriatrics Society Continence Care in Residential and Nursing Homes • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence. **Action taken as confirmed during the inspection:** The recommended guidelines were available for staff reference. However, it was recommended all policy documentation in relation to continence management should be condensed and consolidated for ease of access by staff. The information should be preceded by the home's policy on continence management which references the best practice guidelines. A further recommendation was also made that the three policy folders are condensed and consolidated to be more user friendly.	**Partially Met**
Recommendation 5 **Ref**: Standard 19.4	Consideration should be given to identifying a link nurse for continence management. The nurse should be given additional training in respect of continence management, as and when required. **Action taken as confirmed during the inspection:** A link nurse for the management of continence had been identified and training, provided by Belfast Health and Social Care Trust, had been arranged for the identified nurse.	**Met**

Recommendation 6 **Ref**: Standard 19.4	Regular audits of the management of incontinence should be undertaken and the findings acted upon to enhance good standards of care. **Action taken as confirmed during the inspection:** Regular audits of the management of incontinence were completed by nursing staff on a monthly basis. The monthly review of patients' assessed need and care plans included continence care.	**Met**
Recommendation 7 **Ref**: Standard 15.1	The registered persons should liaise with Trust representative and/or patients' representatives regarding patients finance so as to ensure patients have sufficient personal toiletries and clothing. **Action taken as confirmed during the inspection:** The registered manager had spoken with a number of Trust representatives regarding patients' personal allowances. However, it was recommended that if difficulty remained in this area Trust representatives should be informed, in writing, of the issue.	**Partially Met**
Recommendation 8 **Ref**: Standard 34.2	The registered person should ensure staff are aware that all equipment used in the home evidences a high standard of cleanliness; this includes the trolley used to transport patients' mid-morning tea. **Action taken as confirmed during the inspection:** The equipment used by staff was observed during the inspection. Equipment was clean and fit for purpose. The review of the audits regarding cleanliness, evidenced the cleanliness of the equipment in the home was assessed by management.	**Met**

Recommendation 9 **Ref**: Standard 30.1	The registered persons should review staffing arrangements in terms of the deployment of staff in the home throughout the day and take into account the needs and dependency of patients. **Action taken as confirmed during the inspection:** Staffing arrangements were reviewed and were satisfactory. Management have reviewed how staff are deployed to ensure the effective use of staff to meet patient need. Staff also confirmed that staffing arrangements were satisfactory.	**Met**

5.3 Inspection Findings

Is Care Safe? (Quality of Life)

A policy on continence care was available. Recommended best practice guidelines were also available for staff. In discussion with the manager and following a review of policy documentation it was recommended that the information is consolidated into one policy document. There were three policy folders for staff to reference. It was advised that policy documents are reviewed and condensed/consolidated as far as possible. This would then be easier for staff to access up to date policy and best practice documents. Discussion with three staff confirmed that they were knowledgeable regarding the level of support patients needed in relation to their continence needs.

The previous review of staff training records in relation to continence management evidenced training is completed at the time of induction and refresher training had been undertaken by staff between September and November 2014. The registered manager confirmed that a link nurse for continence care had been identified and the nurse is scheduled to undertake further training provided by Belfast Health and Social Care Trust in the near future.

Is Care Effective? (Quality of Management)

The registered manager now has sole responsibility for Colinvale Court and continues to be supported and mentored by an external management consultant. The management consultant undertakes the monthly monitoring visit, in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 and provides a report of the visit. The reports of the monthly visits are available in the home for patients or their representatives to read.

The review of three care records reflected patients' individual needs and wishes regarding continence care. Recording within patients' progress notes included reference to the management of urinary and faecal continence needs. Patients' bowel patterns are monitored by staff using the Bristol Stool chart. Care records also evidenced that the assessment of need and risk assessments were completed and evaluated on a regular basis.

A named nurse and key worker system was in operation. Information was present in the patients' bedrooms of the individual's named nurse. Life story information was also present in the patient's bedrooms.

There was evidence within the three care records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

Is Care Compassionate? (Quality of Care)

Discussion with the registered manager confirmed that staffing arrangements in the home were stable. There had been a reduction of the use of agency staff, except on night duty, and a review of how staff were allocated to work in the home had taken place. Discussion with six staff confirmed that the changes to staff deployment had meant that staff felt they had more time to give to patients, for example at mealtimes. Staff stated there were always other staff available in the designated units, to assist in providing care for the more dependent patients including personal care and assistance with eating and drinking.

Several periods of observation of staff interaction with patients confirmed that staff treated patients in a dignified manner. Staff were observed sitting beside patients talking and having time to spend with individuals. We joined in conversation with staff and patients, one patient, who had previously been quiet and withdrawn, became animated when discussing their previous employment as a shop owner. All grades of staff demonstrated their knowledge of individual patients. A member of the housekeeping team told of a patient's previous occupation and of how housekeeping staff engaged the patient by asking for the patient's assistance in everyday activities. This confirmed that staff were aware that dementia practice includes meaningful activity. During the inspection the activities coordinator was setting up a candy/flower trolley. The activities coordinator asked patients to help with painting the trolley and a number of patients joined in for short periods of time.

The environment of the home evidenced a more homely and domesticated appearance. Soft furnishings had been purchased, bedroom furniture upgraded and there was evidence of the activities patients were involved in. There had been an increase in the number of external activities for patients, for example, trips to the Titanic Centre and a local museum. Photographs were displayed on the notice boards in the home following these outings. Photographs were also displayed of the recent visit to the home of a 'petting farm' and all patients were able to benefit from the visit.

Patients appeared neatly dressed and a good standard of personal care was evident. Discussion with the registered manager regarding patients' personal allowance confirmed that the registered manager had spoken to care managers if there was difficulty in getting personal toiletries and clothing for some patients. The registered manager was advised to put the issue in writing to the care managers if the situation persists.

Areas for Improvement

Policy documentation should be reviewed to ensure the information is current and in accordance with legislation and best practice guidance. The review should include the condensing and consolidating of policy information to ensure a user friendly reference library of information is available for staff.

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

5.4 Additional Areas Examined – no additional areas were examined on this occasion.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Stephanie Shannon, registered 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 The 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 will be completed by the 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 by the registered manager. 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	
Recommendations	
Recommendation 1 **Ref**: Standard 36 **Stated:** First time **To be Completed by:** **16 June 2015**	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.
	Response by Registered Manager Detailing the Actions Taken: The continence policy has been updated to include relevant guidelines and has been insitu from 07/05/15.
Recommendation 2 **Ref:** Standard 36 **Stated:** First time **To be Completed by:** **16 July 2015**	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 Home standards for nursing Homes 2015.
	Response by Registered Manager Detailing the Actions Taken: The policy manual has been consolidated and is in the process of being revised to meet the current Nursing Homes Standards.
Recommendation 3 **Ref:** Standard 14 **Stated:** First time **To be Completed by:** **16 July 2015**	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.
	Response by Registered Manager Detailing the Actions Taken: A discussion has taken place with individual care managers, at present there are no issues. Care managers are working along side the Home Manager to ensure patients are receiving toiletries and clothing. Staff are recording when they request items from family members and when they are in receipt of such.

Registered Manager Completing QIP	Miss Stephanie J Shannon	**Date Completed**	20/05/15
Registered Person Approving QIP	Mr Raymond L Murphy	**Date Approved**	20/05/15
RQIA Inspector Assessing Response	**Heather Sleator**	**Date Approved**	**22/05/15**

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

Please provide any additional comments or observations you may wish to make below: