Unannounced Care Inspection Report
27 February 2017

Rush Hall

Type of Service: Nursing Home
Address: 51 Broighter Road, Limavady, BT49 9DY
Tel no: 02877769326
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Rush Hall took place on 27 February 2017 from 09.30 to 16.30 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led. Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. A review of records, discussion with the registered manager and staff and observations of care delivery evidenced that action had been taken to improve the effectiveness of the care. The majority of requirements and recommendations made as a result of the previous inspection had been complied with. One requirement and two recommendations were made as a result of this inspection.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	*5

The total number of recommendations above includes one recommendation that has been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Fiona Archer, registered 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced finance inspection undertaken on 15 November 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Claire Maureen Royston	**Registered manager:** Fiona Archer
Person in charge of the home at the time of inspection: Fiona Archer	**Date manager registered:** 15 April 2016
Categories of care: NH-DE, NH-I	**Number of registered places:** 66

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

- 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
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with nine patients, six care staff, two registered nurses and four patients' representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- accident and incident records
- audits in relation to wound care
- records relating to adult safeguarding
- one staff recruitment and selection record
- one agency staff induction record
- complaints received since the previous care inspection
- one competency and capability assessment for the registered nurse with responsibility of being in charge of the home
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 15 November 2016

The most recent inspection of the home was an unannounced finance inspection. The completed QIP was returned and approved by the finance inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next finance inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 14 October 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 30 (1) (c) **Stated:** First time	The registered persons must ensure that RQIA is notified of any serious injury to a patient in the home.	**Met**
	Action taken as confirmed during the inspection: A review of notifiable events submitted since the previous care inspection evidenced that any serious injury sustained in the home was notified appropriately.	
Requirement 2 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time	The registered person must ensure that patients' needs are assessed and that a treatment plan is developed, implemented accordingly and recorded to evidence all care provided, with particular reference to wound care. Consideration should also be given to the use of wound photography in keeping with best practice.	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced improvements in the overall management of wound care. Wound assessments and care plans were completed on a regular basis; and there was evidence that the wound dressings were being changed, in line with the patient's care plan. The requirement as stated has been met, however, deficits were identified in the quality of the repositioning records, specifically during the night and a new requirement has been made in this regard. Refer to section 4.3.2 for further detail.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 39.1 and 39.9 **Stated:** First time	The registered persons should ensure that agency staff inductions are completed and records retained in the home. Agency staff profiles, which evidence the training and competency level achieved, should also be retained.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of records evidenced that agency staff completed an induction to the home. Agency staff profiles were also maintained.	
Recommendation 2 **Ref**: Standard 39 **Stated:** First time	The registered persons should ensure that competency and capability assessments are completed on an annual basis, for registered nurses who have the responsibility of being in charge of the home, in the absence of the registered manager.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and a review of records confirmed that this recommendation had been met.	
Recommendation 3 **Ref**: Standard 38.3 **Stated:** First time	The registered persons should ensure that, before making an offer of employment, any gaps in an employment record are explored and explanations recorded.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of the recruitment records confirmed that the proforma for interviewing staff had been further developed to ensure that any gaps in employment were explored and recorded.	

Recommendation 4 **Ref**: Standard 48.1 **Stated:** First time	The registered persons should ensure that the current fire risk assessment and fire management plan is revised on a regular basis and action is taken when necessary or whenever the fire risk has changed. This relates specifically to patients who are newly admitted to the home and those that are no longer residing in the home.	**Met**
	Action taken as confirmed during the inspection: A review of the fire management plan confirmed that this was up to date and included all patients who were accommodated in the home.	
Recommendation 5 **Ref**: Standard 32.1 **Stated:** First time	The registered persons should ensure that care plans are developed, as appropriate, to address patients' palliative and end of life care needs.	**Met**
	Action taken as confirmed during the inspection: A review of care records confirmed that patients' end of life care needs were included in the care plans.	
Recommendation 6 **Ref**: Standard 35.4 **Stated:** First time	The registered persons should ensure that the wound analysis audit tool is further developed to ensure that shortfalls identified during this inspection are identified and follow up action taken to address any identified deficits.	**Partially Met**
	Action taken as confirmed during the inspection: Although there was evidence that a wound audit tool had been developed; and an action plan generated in relation to any shortfalls identified, the audit was not sufficiently robust, in that it did not identify the deficits in the repositioning records, identified during this inspection. This recommendation was not fully met and has been stated for the second time.	

4.3 Inspection findings

4.3.1 Staffing arrangements

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the week commencing 20 February 2017 evidenced that the planned staffing levels were adhered to. Discussion with patients, staff and relatives evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty.

The registered manager explained there were currently three registered nurse vacancies. These vacancies were being filled by permanent staff working additional hours or agency staff. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.3.2 Care practices and care records

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with nine patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Personal care records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of food and fluid intake charts confirmed that patients' fluid intake had been monitored and records in relation to patients' bowel movements evidenced that they had been closely monitored.

A review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments generally informed the care planning process and both were reviewed as required. For example, where a patient had a wound, there was evidence of regular wound assessments and review of the care plan regarding the progress of the wound. A review of the daily progress notes evidenced that the dressing had been changed according to the care plan. Where applicable, specialist healthcare professionals were involved in prescribing care in relation to the management of wounds. Wound care records were also supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines. However, a review of repositioning records evidenced that one identified patients had not been repositioned in line with the care plan. This was discussed with the registered manager. A requirement has been made in this regard.

Patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans. Moving and handling risk assessments were also reviewed on a regular basis and were reflected in the care plans; however, one identified patient required particular rehabilitative care and although there was evidence that this was being managed appropriately, this particular aspect of the patient's care was not included in their care plan. A recommendation has been made in this regard.

Staff demonstrated an awareness of the importance of contemporaneous record keeping; however, patient charts regarding personal hygiene, repositioning, and food and fluid intake were observed in a folder in a lounge on the ground floor. This meant that any one entering this room could have access to the content of these charts and that the staff were not maintaining confidentiality with regards to the patients' personal care records. This was discussed with the registered manager during feedback. A recommendation has been made in this regard.

Areas for improvement

A requirement has been made that where nursing needs are identified care must be delivered to ensure individual patient needs are met. This refers specifically to the repositioning records of patients who are at risk of developing pressure sores and require regular repositioning, in keeping with their care plan.

A recommendation has been made that where patients require specialist equipment to be used, this is provided and the specific instructions for its use are included in the care plan. Records in relation to skin integrity checks should be maintained accordingly.

A recommendation has been made that consideration is given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times.

Number of requirements	1	**Number of recommendations**	2

4.3.3 Consultation

During the inspection, we met with nine patients, six care staff, two registered nurses and four patients' representatives. Some comments received are detailed below:

Staff

"The care is excellent, we have a lot of long serving staff here".
"I think it is excellent here, we don't rush things".
"The care is good".
"The care is adequate, I couldn't identify any areas for improvement".
"We provide good care, the staff genuinely care and take the patients into their hearts".
"The patients are well looked after".

One staff member commented in relation to the night time routine on the second floor, stating that the patients' preferences for going to bed early were not always respected. However, all patients and relatives consulted with stated that the patients could chose when to go to bed and what time they rose in the morning. The review of the care records evidenced that where patients requested or required to go to bed early, this information was included in their care plans.

The registered manager also provided assurances that they would reiterate to all staff that comments on the care provided can be made through the Quality of Life (QOL) electronic system.

Patients

"Everything is fine".
"I have no complaints, I get everything I need".
"I am treated very well, the girls are very good".
"They are very good to me, I definitely have no complaints".
"I couldn't say a word, they are very good".
"They are a good crowd here".

Patients' representatives

"The people here are all very nice, very good and helpful".
"I might book myself in here, it is all very good".
"The care is great".

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. Three staff, four patients and four relatives had returned their questionnaires, within the timeframe for inclusion in this report. All respondents indicated that they were either 'satisfied' or 'very satisfied' that the care was safe, effective and compassionate; and that the home was well-led. No written comments were provided.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.3.4 Management and governance arrangements

All those consulted with knew who the registered manager was and stated that they were available at any time if the need arose. There was a clear organisational structure within the home and there was a system in place to identify the person in charge of the home, in the absence of the registered manager.

Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

It was evident that action had been taken to improve the effectiveness of the care following the last inspection; however, one recommendation was only partially met and has been stated for the second time. This related to the robustness of the wound audits, which did not identify that patients were not being repositioned in line with their care plans. As discussed in section 4.2, the recommendation made in this regard has been stated for the second time.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.3.5 Environment

A review of the home's environment was undertaken which included bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. RQIA acknowledges that the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout; however, a review of the equipment cleaning records completed by the care staff, evidenced gaps in completion of up to one week. This was discussed with the registered manager. A recommendation has been made in this regard.

The access arrangements to and egress from the home were discussed with the registered manager. The keypad locking systems on the doors in the dementia unit were appropriately secured. However, to exit the first floor, using the elevator, patients would require a member of staff to enable them to do so. This meant that the patients were potentially restricted in their ability to freely move throughout the home. A recommendation has been made in this regard.

Areas for improvement

A recommendation has been made that records of equipment cleaning are maintained in line with best practice.

A recommendation has been made that the use of the elevator door keypad on the first floor, is reviewed in conjunction with guidance from the Department of Health on human rights and the deprivation of liberty (DoLs); and the home's registration categories.

Number of requirements	0	**Number of recommendations**	2

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Fiona Archer, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 13 (1) (a) **Stated:** First time **To be completed by:** 27 April 2017	The registered persons must ensure that where nursing needs are identified care must be delivered to ensure individual patient needs are met. This refers specifically to the repositioning records of patients who are at risk of developing pressure sores and require regular repositioning, in keeping with their care plan. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: Re positioning records will be reviewed by the manager when completing the wound care audit to ensure this is in line with the residents care plan . The records will be spot checked and signed by the nursing staff on a daily basis .
Recommendations	
Recommendation 1 **Ref**: Standard 35.4 **Stated:** Second time **To be completed by:** 27 April 2017	The registered persons should ensure that the wound analysis audit tool is further developed to ensure that shortfalls identified during this inspection are identified and follow up action taken to address any identified deficits. **Ref: Section 4.2 and 4.3.4**
	Response by registered provider detailing the actions taken: The wound audit has been developed to include the checking of repostioning records to identify deficits in this area and prompt remedial action
Recommendation 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 27 April 2017	The registered persons should ensure that where patients require specialist equipment to be used, this is provided and the specific instructions for its use are included in the care plan. Records in relation to skin integrity checks should be maintained accordingly. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: The equipment required for the identified resident has been included in the care plan and records are maintained on skin integrity .
Recommendation 3 **Ref**: Standard 37.1 **Stated:** First time **To be completed by:** 27 April 2017	The registered persons should ensure that consideration is given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: Records are now manitained in a secure cupboard to maintain confidentiality. This will be monitored by the manager on daily walkarounds .

Recommendation 4 **Ref**: Standard 46.2 **Stated:** First time **To be completed by:** 27 April 2017	The registered persons should ensure that records of equipment cleaning are maintained in line with best practice. **Ref: Section 4.3.5**
	Response by registered provider detailing the actions taken: cleaning records are maintained and spot checked by the manager on a regular basis.
Recommendation 5 **Ref**: Standard 5 **Stated:** First time **To be completed by:** 27 April 2017	The registered persons should ensure that the use of the elevator door exit keypad on the first floor is reviewed in conjunction with guidance from the Department of Health on human rights and the deprivation of liberty (DoLs); and the home's registration categories. **Ref: Section 4.3.5**
	Response by registered provider detailing the actions taken: This is currenty being reviewed to confirm best practise and agree a company wide approach .

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