Rosemount Care Centre
RQIA ID: 11088
2 Moy Road
Portadown
BT62 1QL

Inspector: Sharon McKnight
Laura O'Hanlon
Inspection ID: IN022239

Tel: 028 3833 1311
Email:rosemountmanager@zestcarehomes.co.uk

Unannounced Care Inspection
of
Rosemount Care Centre

3 March 2016

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 3 March 2016 from 10 10 hours to 15 45 hours.

The focus of this inspection was to determine what progress had been made in addressing the requirements and recommendations made during the previous care inspection on 16 July 2015.

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, one area for improvement was identified and is set out in the Quality Improvement Plan (QIP) within this report.

For the purposes of this report, the term 'patients' will be used to described those living in Rosemount Care Home which provides both nursing and residential care.

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 July 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	**0**	**1**

The details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager, Ms Claire McKenna, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Zest Care Homes Ltd	**Registered Manager:** Claire McKenna
Person in Charge of the Home at the Time of Inspection: Claire McKenna	**Date Manager Registered:** 1 November 2011
Categories of Care: NH-I, NH-DE, RC-DE Maximum of 19 places in NH-I, 20 places in NH-DE and 32 places in RC-DE.	**Number of Registered Places:** 71
Number of Patients Accommodated on Day of Inspection: 37 nursing 32 residential	**Weekly Tariff at Time of Inspection:** Nursing £628.00 Residential £495.00

3. Inspection Focus

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

4. Methods/Process

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

- discussion with the registered manager
- discussion with staff
- discussion with patients
- discussion with two relatives
- review of records
- observation during a tour of the premises
- evaluation and feedback

Prior to inspection the following records were analysed:

- notifiable events submitted to RQIA since 16 July 2015
- the registration status of the home
- verbal and written communication received by RQIA
- the returned quality improvement plan from the care inspection conducted on 16 July 2015
- the last care inspection report
- the inspector's pre inspection assessment

During the inspection, the inspectors met with 28 patients individually and with the majority in small groups, 2 nursing sisters, one registered nurse, eight care staff, the activity co-ordinator, two domestic assistants and two patient's relatives.

The following records were examined during the inspection:

- seven patient care records
- staff training records
- staff duty rosters
- fire risk assessment
- records of fire safety checks
- a selection of polices
- incident and accident records

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the Rosemount Care Centre was an unannounced care inspection dated 16 July 2015. The completed QIP was returned and was approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection dated 16 July 2015

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 27(4)(b) **Stated:** First time	The registered person must ensure that adequate precautions are taken against the risk of fire. It is required that: • The fire risk assessment is updated to ensure that it is current • the clothing stored under the stairs is removed • the weekly fire safety checks are recommenced and arrangements put in place to ensure that they are completed when identified staff are on annual leave.	**Met**
	Action taken as confirmed during the inspection: A copy of the fire risk assessment, dated 22 July 2015, was available in the home. The areas under the stairs were clear. Records were maintained of weekly fire checks. A review of the records evidenced that here were no checks recorded for the period 26 November 2015 to 7 January 2016. The registered manager explained that the home had an infectious outbreak during this period and travel by staff between units was not permitted. Following discussion with the registered manager it was agreed that she would contact public health for advice on how best to manage fire safety checks during an outbreak situation. This requirement is assessed as met.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 36, criterion 2. **Stated:** First time	It is recommended that the policies regarding end of life care should be reviewed and updated to ensure that are reflective of best practice guidance. To ensure that staff knowledge and care delivery is reflective of best practice in palliative and end of life care it is recommended that when the policy is updated staff should receive an induction/training on the content. This recommendation is assessed as met.	**Met**
	Action taken as confirmed during the inspection: A review of the policies related to palliative and end of life care evidenced that they had been reviewed in November 2015. Policies made reference to best practice guidance, for example GAIN Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, December 2013	
Recommendation 2 **Ref**: Standard 20 criterion 2. **Stated:** First time	It is recommended that further opportunities, to discuss end of life care, are created by the registered nurses. Any expressed wishes of patients and/or their representatives should be formulated into a care plan for end of life care. This should include any wishes with regard to the religious, spiritual or cultural need of patients'.	**Met**
	Action taken as confirmed during the inspection: Six care plans reviewed contained evidence that discussion had taken place regarding end of life. These discussions included religious, spiritual or cultural needs. This recommendation is assessed as met.	

5.3 Is Care Safe? (Quality of Life)

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. There were no concerns raised regarding staffing levels during discussion with patients, relatives and staff.

Training opportunities were available via an e learning system, internal face to face training arranged by the registered manager and training provided by the local health and social care trust. A review of staff training records evidenced staff completion of mandatory training; for example 90% of staff had completed training in moving and handling, 88% in safeguarding vulnerable adults and 80% in food hygiene. The registered manager had systems in place to monitor staff attendance and compliance with training.

A review of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents were appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Reports included a written statement from any staff who witnessed the accident or incident; this is good practice.

Records evidenced that an analysis of accidents was being undertaken monthly to identify trends. However, the analysis considered the occurrence of accidents in the entire home and did not examine the accidents on a unit by unit basis. It was recommended that a monthly analysis of falls is completed for each unit within the home to identify specific trends and issues within each care setting.

A general inspection of the home was undertaken to examine a number of patients' bedrooms, lounges, bathrooms and toilets at random. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was generally fresh smelling, clean and appropriately heated. Discussion with a domestic assistant confirmed that daily work schedules were in place.

Is Care Effective? (Quality of Management)

Discussion took place with 28 patients individually and with the majority of others in smaller groups. Comments from patients regarding the quality of care, staff response to nurse call bells, meals and life in the home were positive. Patients did not raise any issues or concerns about care delivery in the home.

Two patients' relatives spoken with confirmed that they were happy with the standard of care and communication with staff in the home. The relative was unsure of aspects of care as they had been absent from the home for a period. This was shared with the nursing sister who readily agreed to meet with the relative to update them.

Staff commented positively with regard to the delivery of care. Staff were observed to be responding promptly to the needs of patients. The relationships between staff and patients were friendly and relaxed. Staff spoken with confirmed that they were supported appropriately and worked well as a team.

A review of four patients care records evidenced that assessments and initial plans of care were in place within 24 hours of patients being admitted to the home; care plans and assessments were subject to regular review. A review of one patient's care records evidenced that weight loss was managed appropriately. Staff spoken with were knowledgeable regarding individual patient need.

The home employed three activity co-ordinators, one full time and two on a part time basis. We discussed at length the range of activities provided with the full time activity co-ordinator. Activities were planned on a weekly basis and were delivered in small group settings or on a one to one basis dependent on patient need. A calendar of seasonal activities was displayed in the activity room and included dates for St Patrick's day celebrations, a spring fair in May and a vintage afternoon tea party in July.

Patients in the dementia unit were involved in planting summer flowers on the morning of the inspection. The activity co-ordinator explained that patient participation varied from those who could take an active role in activities to those engaged in talking about the activity to patients, who due to their degree of dementia were observers.

Patients in the frail elderly unit spoke positively regarding the range of activities provided. Records were maintained of the activities provided, which patients attended and comments regarding participation. The activity co-ordinator was knowledgeable regarding patients' previous interests and the particular activities that individual patients enjoyed. Patients and staff spoken with valued the role of the activity co-ordinators within the home.

Is Care Compassionate? (Quality of Care)

A tour of the home was undertaken mid-morning and early afternoon. There was a calm atmosphere in the home and staff were quietly attending to the patients' needs. Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference.

Patients spoken with commented positively in regard to the care they received. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable in their surroundings. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner.

Areas for Improvement

A monthly analysis of falls should be completed for each unit within the home to identify specific trends and issues within each care setting.

Number of Requirements:	**0**	**Number of Recommendations**:	**1**

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Claire McKenna, 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 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 in this report do not absolve the registered provider/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan			
Recommendations			
Recommendation 1 **Ref:** Standard 22.10 **Stated:** First time **To be Completed by:** 31 March 2016	It is recommended that a monthly analysis of falls is completed for each unit within the home to identify specific trends and issues within each care setting.		
	Response by Registered Person(s) Detailing the Actions Taken: A monthly falls analysis is now undertaken for each of the 4 units rather than for the entire home to identify. This was implemented the day after the inspection 4/3/16 and has been backdated to January 2016 in order to assess trends throughout the full year.		
Registered Manager Completing QIP	CLAIRE McKENNA CM McKenna.	**Date Completed**	31/03/16
Registered Person Approving QIP	PHILIP SCOTT Phil Scott	**Date Approved**	31/03/16
RQIA Inspector Assessing Response	Sharon McKnight	**Date Approved**	6-05-16

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