Unannounced Care Inspection Report
8 October 2018

Rose Court Nursing Home

Type of Service: Nursing Home (NH)
Address: 30 Westbourne Avenue, Ballymena, BT43 5LW
Tel No: 028 2564 8165
Inspector: Kieran McCormick

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 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 registered nursing home which is registered to provide nursing care for up to 18 persons.

3.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual(s):** Gavin O'Hare-Connolly	**Registered Manager:** Andrea Harkness - Acting
Person in charge at the time of inspection: Andrea Harkness – Manager	**Date manager registered:** Application received - registration pending
Categories of care: Nursing Home (NH) DE – Dementia	**Number of registered places:** 18

4.0 Inspection summary

An unannounced inspection took place on 8 October 2018 from 12.55 to 17.25 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 Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified during the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the holistic culture and ethos of care delivery; communication between staff and patients; staff awareness relating to adult safeguarding, the dining experience of patients and governance arrangements. Other notable areas of good practice were also found in relation to teamwork, understanding of roles and responsibilities and completion of Regulation 29 monitoring visits.

An area requiring improvement was restated regarding the assessment of individual patient fluid intake and a new area for improvement was identified regarding the contemporaneous completion of patient activity records.

Patients appeared relaxed and content in their environment displaying confidence in the ability and willingness of staff to meet their care needs. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings. There was evidence that the management team listened to and valued patients and their representatives.

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	0	*2

*The total number of areas for improvement includes one which has been stated for a second time which has been carried forward for review at the next care inspection.

Details of the Quality Improvement Plan (QIP) were discussed with Andrea Harkness, 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 dated 30 April 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 30 April 2018. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

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 which includes information in respect of serious adverse incidents (SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report
- pre-inspection audit

During the inspection the inspector met with three patients and eight staff. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. Ten patients' questionnaires and ten patients' relatives/representatives questionnaires were left for distribution. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. The inspector provided the manager with 'Have we missed you cards' which were then placed in a prominent position to allow patients and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision. A poster informing visitors to the home that an inspection was being conducted was displayed on the door entering the nursing home.

The following records were examined during the inspection:

- duty rota for all staff from 23 October to 6 September 2018
- incident and accident records
- three patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits
- complaints record
- compliments received
- RQIA registration certificate
- a sample of monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

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 30 April 2018

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

6.2 Review of areas for improvement from the last care inspection dated 30 April 2018

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 6 **Stated:** Second time	The registered person shall ensure that net pants, stockings, socks and tights are provided for each patient's individual use and not used communally.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and observation of the laundry area and linen stores provided assurances that the practice of communal use of the identified clothing items had ceased.	

Area for improvement 2 **Ref**: Standard 12 **Stated:** First time	The registered person shall review the existing fluid management and assessment arrangements in the home so to ensure that daily targets are reflective of individualised assessed need.	**Not met**
	Action taken as confirmed during the inspection: A review of fluid records evidenced that the current fluid assessment tool did not provide a realistic or person centred fluid target for each individual patient. In the case of 14 of the 16 patients in the home the target had been consistently not met as it did not appear to provide a realistic or achievable target for the patient. **This area for improvement has not been met and has been stated for a second time.**	
Area for improvement 3 **Ref**: Standard 12 **Stated:** First time	The registered person shall ensure that the practice of mixing together tea and biscuits for patient consumption is ceased. A selection of snack and drink options should be available at each tea/drink round to accommodate all patients individual dietary and dysphagia needs.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and observation of meal times and drinks rounds provided assurance that the practice mentioned above had ceased.	
Area for improvement 4 **Ref**: Standard 35 **Stated:** First time	The registered person shall ensure that where a shortfall/action has been identified, during the course of auditing, that a corresponding action plan is implemented and reviewed to address this.	**Met**
	Action taken as confirmed during the inspection: A sample of audits reviewed evidenced that a corresponding action plan had been implemented and completed where relevant.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The manager confirmed the planned daily staffing levels for the home. A review of the staffing rota from 23 October to 6 September 2018 evidenced that the planned staffing levels were adhered to. The manager advised that staffing for the home had recently been reviewed; the manager was advised to review staffing again, if required, when the home is at full occupancy. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner.

We discussed the provision of mandatory training with staff. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Observation of the delivery of care evidenced that training had been embedded into practice, for example, the moving and handling of patients.

Staff who met with the inspector were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices, for example bed rails, alarm mats. These assessments informed the care planning process. There was also evidence of consultation with relevant persons.

We reviewed accidents/incidents records from August 2018 in comparison with the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were maintained appropriately and notifications were submitted in accordance with regulation.

Discussion with the manager and review of records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. From a review of records, observation of practices and discussion with the manager and staff there was evidence of proactive management of falls.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounge/s, dining room/s and storage areas. The home was found to be warm, fresh smelling and clean throughout. Fire exits and corridors were observed to be clear of clutter and obstruction. Some environmental issues were identified during the inspection these were discussed with the manager and maintenance staff, all matters were addressed prior to the conclusion of the inspection.

Observation of practices, care delivery, discussion with staff and review of records evidenced that infection prevention and control best practice guidance was adhered to.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff management, staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, governance and risk management.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of three patients' care records evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patients. Care records contained details of specific care requirements and a daily record was maintained to evidence the delivery of care. Care records were consistently reviewed/evaluated by registered nursing staff.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as Trust care managers, General Practitioners (GPs), speech and language therapists (SALT) and dieticians. Supplementary care charts such as patient repositioning, food and fluid intake records evidenced that contemporaneous records were maintained. However fluid records evidenced that the current fluid assessment tool did not provide a realistic or person centred fluid target for each individual patient. As a result a previous area for improvement has been stated for a second time.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the manager or the nurse in charge.

All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff were able to describe the arrangements for staff/team meetings provided in the home.

There was evidence of regular communication with representatives within the care records. The manager advised that the last relatives' meeting was held on the 4 October 2018.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the completion and review/evaluation of patients care records, liaising with other members of the multi-professional team, teamwork and communication between patients and staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We arrived in the home at 12.55 and were greeted by staff who were helpful and attentive. Patients were observed seated in the lounge areas or were in the comfort of their own bedroom area. Patients had access to fresh fruit, snacks, water and/or juice.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff were also aware of the requirements regarding patient information and patient confidentiality. Discussion with the manager and staff confirmed that communication with patients often required a highly knowledgeable and focused approach due to patients' varying care needs. Observation of staff interaction with patients evidenced the provision of such care and this is commended.

Observations, discussion with staff and review of the activity programme displayed evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. However a review of the records did not provide assurances that activities provided were being contemporaneously documented, as a result an area for improvement under the standards was made.

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences.

We observed the serving of the lunchtime meal. Patients were assisted to the dining area or had trays delivered to them as required. Staff were observed assisting patients with their meal appropriately and a registered nurse was overseeing the mealtime. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes. Staff were observed to be promptly and attentively attending to patient's needs. Staff were calm in their approach and provided reassurance to patients who appeared distressed. Patients able to communicate indicated that they enjoyed their meal and the standard of food on offer.

There were systems in place to obtain the views of patients and their representatives on the running of the home, a suggestions box was available. Cards and letters of compliment and thanks were available in the home. Comments on a recently received thank you card included:

"….on behalf of my late sister I would like to thank you all for the tender loving care my sister received in your nursing home, it was greatly appreciated by me and the wider family circle".

Consultation with three patients individually, confirmed that they were happy and content living in Rose Court. 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.

There were no responses received from relatives or patient representative questionnaires.

Staff were asked to complete an online survey; we had no completed responses within the timescale specified.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, the meal time experience, dignity and privacy, staff knowledge of patients' wishes, preferences and assessed needs.

Areas for improvement

The following area was identified for improvement in relation to the contemporaneous completion of records relating to the delivery of activities.

	Regulations	Standards
Total number of areas for improvement	0	1

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. All staff spoken with were able to describe their roles and responsibilities and confirmed that there were good working relationships within the home. Staff also stated that management was responsive to any suggestions or concerns raised.

The certificate of registration issued by RQIA was appropriately displayed in the home. The manager was knowledgeable in regards to the registered categories of care for the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been a change of management arrangements for the home. RQIA were notified appropriately and an application for registration with RQIA has been received. Discussion with staff evidenced that the manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the manager.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes 2015. The inspector was able to evidence actions taken in relation to complaints received.

Discussion with the manager and a review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, IPC practices and care records. In addition, robust measures were also in place to provide the manager with an overview of the management of accidents/incidents, IPC practices and restraint.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed on a monthly basis on behalf of the responsible individual in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents and maintaining good working relationships.

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 Andrea Harkness, 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 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 via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 12 **Stated**: Second time **To be completed by:** Immediate action required	The registered person shall review the existing fluid management and assessment arrangements in the home so to ensure that daily targets are reflective of individualised assessed need. **Ref: 6.2 & 6.5** **Response by registered person detailing the actions taken:** Rather than using the 30mls per kg tool every resident has been reassessed and all fluid targets have been reviewed. Targets are now person centred and realistic for each individual resident in the home. An average intake over 1 week obtained and a target intake set. This is reviewed regularly.
Area for improvement 2 **Ref**: Standard 11 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that activities records are contemporaneously completed and maintained to evidence the delivery of activities to individual patients. **Ref: 6.6** **Response by registered person detailing the actions taken:** Every resident has been assessed to determine individual likes and dislikes. Files have been devised and are placed in the unit for staff to refer to and document daily activities. A tracker has been commenced to monitor documentation, which is reviewed weekly. As well as the activity co ordinators completing daily activites, the staff member supervising the lounge also completes moment to moment occupation and activity therapy throughout the day.

Please ensure this document is completed in full and returned via Web Portal

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