The Regulation and Quality Improvement Authority

Madelayne Court
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Portstewart
BT55 7LG

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# Unannounced Care Inspection of Madelayne Court

## 18 November 2015



The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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## 1. Summary of Inspection

An unannounced care inspection took place on 18 November 2015 from 09.45 to 16.45.

The focus of this inspection was continence management which was underpinned by selected criteria from:

**Standard 4: Individualised Care and Support; Standard 6: Privacy, Dignity and Personal Care; Standard 21: Heath care and Standard 39: Staff Training and Development.**

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, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

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.

For the purposes of this report, the term 'patients' will be used to described those living in Madelayne Court 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 15 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 |
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| **Total number of requirements and recommendations made at this inspection** | 0 | 9 |

The total number of recommendations made at this inspection includes two recommendations which were made at the inspection carried out on 15 April 2015. These recommendations were not met and have been stated for the second time.

The details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Mabel Cole, Registered Manager and Ms Gemma Boyd, Deputy Manager as part of the inspection process. Inspection outcomes were also discussed with Mr John Rafferty, NI Operational Director by telephone post inspection. The timescales for completion commence from the date of inspection.

## 2. Service Details

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| **Registered Organisation/Registered Person:**<br>Runwood Homes LTD<br>Mr Nadarajah (Logan) Logeswaran | **Registered Manager:**<br>Mrs Mabel Cole |
| **Person in Charge of the Home at the Time of Inspection:**<br>Mrs Mabel Cole | **Date Manager Registered:**<br>14 September 2015 |
| **Categories of Care:**<br>RC-I, NH-PH(E), NH-MP(E), NH-I, NH-TI, NH-DE | **Number of Registered Places:**<br>66 |
| **Number of Patients Accommodated on Day of Inspection:**<br>64 | **Weekly Tariff at Time of Inspection:**<br>£470.00 - £724.00 |

## 3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the selected criteria from the following standards have been met:

**Standard 4: Individualised Care and Support, criteria 8**
**Standard 6: Privacy, Dignity and Personal Care, criteria 1, 3, 4, 8 and 15**
**Standard 21: Heath Care, criteria 6, 7 and 11**
**Standard 39: Staff Training and Development, criteria 4**

## 4. Methods/Process

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

- discussion with the registered manager
- discussion with patients
- discussion with staff
- discussion with patient representatives
- review of a selection of records
- observation during a tour of the premises
- evaluation and feedback.

The inspector met with six patients individually and with the majority of others in groups, two patient representatives, four care staff, one ancillary staff member, the activities co-ordinator and two registered nursing staff.

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.

The following records were examined during the inspection:

- a sample of staff duty rotas
- staff training records
- staff induction templates for registered nurses and care assistants
- competency and capability assessment template for nurse in charge
- eight care records and a selection of supplementary assessments and charts
- a selection of policies and procedures
- incident and accident records
- care record audits
- regulation 29 reports
- guidance for staff in relation to continence care
- records of complaints.

## 5. The Inspection

### 5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of Madelayne Court was an announced estates inspection dated 13 October 2015. The completed QIP was returned and approved by the estates inspector.

**Review of Requirements and Recommendations from the Last Care Inspection 15 April 2015**

| Last Care Inspection Recommendations | | Validation of Compliance |
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| **Recommendation 1**<br><br>**Ref**: Standard 13.1<br><br>**Stated:** Second time | The registered manager must ensure that the programme of activities and events provides positive outcomes for patients/residents and is based on the identified needs and interests of patients/residents including their spiritual needs. | **Partially Met** |
| | **Action taken as confirmed during the inspection**:<br>An activities co-ordinator was appointed in September 2015. Discussion with the staff member advised that the programme of activities is still under review and development to ensure that it meets the identified needs and interests of patients living in the home. A range of activities that had been provided and are scheduled was discussed. A random sample of an activity schedule was reviewed. A written record of outcomes from the activities delivered is still in work in progress however, verbal feedback from patients was positive in regards to the variety of activities available and the enjoyment gained from same. The activities co-ordinator and the registered manager confirmed that a representative from Runwood Homes Ltd is working collaboratively with Madelayne Court to enhance this area of practice.<br><br>This recommendation has been partially met. Findings from the inspection were discussed with senior management at RQIA post inspection and it was agreed that given the appointment has only been made recently and the assurances given by the registered manager a decision was made that this recommendation would not be stated again. | |

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| **Recommendation 2**<br><br>**Ref**: Standard 8.1<br><br>**Stated:** Second time | It is recommended that the MUST screening tool is used to identify patients/residents who are at risk of malnutrition. | **Partially Met** |
| | **Action taken as confirmed during the inspection:**<br>A sample of MUST assessments for both the Dunserverick and Dunluce Units were examined. The majority of these were reviewed at monthly intervals however some gaps were evidenced in the records for the Dunserverick unit. A review of weight monitoring for patients evidenced that these had been completed and actions had been taken as and when required. The registered manager provided evidence of audits completed in regards to nutrition and /malnutrition, however the audit tool did not include an analysis in regards to MUST assessments and outcomes. This was discussed with the registered manager who agreed to review the auditing process to include a review of the supplementary assessments and charts pertaining to this area of practice. These findings were discussed with senior management post inspection.<br>Given the evidence and observations made and as no concerns were identified regarding patients' weights and nutritional status this recommendation has not been stated again. Assurances were provided by management that a robust system would be implemented to enhance practice in this regard. | |
| **Recommendation 3**<br><br>**Ref**: Standard 25.13<br><br>**Stated:** Second time | It is recommended that the Annual Quality Report is made available for patients/residents and relatives to view if they wish. | **Partially met** |
| | **Action taken as confirmed during the inspection:**<br>The Annual Quality Report was available at the inspection in April 2014 when this recommendation was initially made. However at this inspection the Annual Quality Report was not available. Since the previous care inspection there has been a change of registered manager and operational director. An assurance was given by the NI Operational Director that this would be addressed therefore this recommendation has not been stated again. | |

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| **Recommendation 4**<br><br>**Ref**: Standard 36.2<br><br>**Stated:** First time | All policies and procedures should be reviewed to ensure that they are subject to a three yearly review:<br><br>• A policy on communicating effectively should be developed in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News*<br>• A policy on palliative and end of life care should be developed in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines (2013)*<br>• A policy on death and dying should be developed in line with current best practice, such as DHSSPSNI (2010) *Living Matters: Dying Matters* and should include the procedure for dealing with patients' belongings after a death<br>• The policy on pain management should be further developed to include procedural guidance on the use of the McKinley syringe driver.<br><br>The policies and guidance documents listed above, should be made readily available to staff. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>These policies have been reviewed and are available for staff. | |
| **Recommendation 5**<br><br>**Ref**: Standard 4.1<br><br>**Stated:** First time | It is recommended that registered nurses develop care plans, as relevant, on patients requiring end of life care.<br><br>Care plans should include patients' and or their representatives':<br><br>• Communication needs and wishes<br>• Cultural, spiritual and religious preferences<br>• Environmental considerations. | **Not Met** |
| | **Action taken as confirmed during the inspection**:<br>A review of patient care records evidence that care plans regarding end of life care had not been developed to the standard expected. This | |

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| | recommendation has been stated for a second time. | |

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| **Recommendation 6**<br><br>**Ref**: Standard 39.4<br><br>**Stated:** First time | Training should be provided to staff, relevant to their roles in:<br><br>• Communicating effectively<br>• Death, dying and bereavement<br>• Palliative and end of life care. | **Partially Met** |
| | **Action taken as confirmed during the inspection**:<br>Training records evidenced that four staff members had completed training in the areas identified. The registered manager advised that training was scheduled across Runwood Homes Ltd which staff would be able to access. This recommendation has been partially met and given the percentage of staff that still has to complete training; the recommendation has been stated for a second time. | |
| **Recommendation 7**<br><br>**Ref**: Standard 32<br><br>**Stated:** First time | Relevant information on support services should be further developed, to ensure that patients and their relatives have access to support services that are based in Northern Ireland.<br><br>A palliative care link nurse should be appointed, to ensure that there is a nominated person in the home with up to date knowledge and skills in providing symptom control and comfort. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Information for bereavement services was available and accessible for patients and /or their representatives.<br><br>The home has appointed two palliative care link nurses. One of the link nurses was on duty at time of inspection and discussed their role and how they are proposing to develop and enhance systems and processes to further enhance this area of practice. | |

## 5.3 Standards 4, 6, 21 and 39

### Is Care Safe? (Quality of Life)

Policies and procedures were in place to guide staff regarding the management of continence however; these policies had not been reviewed since 2011. This was discussed at feedback and a recommendation has been made that all policies pertaining to the management of continence should be reviewed and reflect current best practice.

A resource file on the management of continence/incontinence had been developed and was available for staff. The file included regional and national guidelines for the management of urinary incontinence, no other guidelines were available. Additional resources and best practice guidelines should be sourced and made available for staff reference. The registered manager gave assurances that this would be addressed.

Discussion with staff and the registered manager confirmed that six staff had received training in relation to the use and application of continence products in February 2015. Staff were knowledgeable about the important aspects of continence care including the importance of dignity, privacy and respect as well as skincare, hydration and reporting of any concerns.

Five registered nurses and eight care staff had completed training in Stoma Care in February 2015 and five staff had completed training in relation to a Stoma Cardinal pump in November 2015. Registered nurses had also completed male catheterisation training in January 2015. Discussion with registered nurses advised that they could benefit from training in supra pubic catheterisation which is currently being managed by the district nursing team. A recommendation has been made in this regard.

Observation during the inspection and discussion with staff evidenced that there were adequate stocks of continence products available in the nursing home.

A continence link nurse has been identified for the home.

### Is Care Effective? (Quality of Management)

Review of three patients' care records evidenced that a continence assessment was recorded and reviewed on a monthly basis for each patient. However, the continence assessment did not make provision to include information on bowel pattern and type, stoma and catheter needs. There was evidence in the patients' care records that assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate.

The promotion of continence, skin care, and patient's dignity were addressed in the care plans reviewed. Care plans did not refer to patient's bowel patterns and type however staff were referencing the Bristol stool chart for the recording of bowel movements. Details in relation to fluid requirements identified some inconsistences for example in one care record no fluid target had been identified and in a second care record fluid input was not being recorded. A

recommendation has been made that the care plans include details on patient's normal bowel pattern and type and fluid targets should be recorded. Fluid intake and /or output should be recorded as deemed appropriate.

Records reviewed evidenced that urinalysis was undertaken as required and patients were referred to their GPs appropriately.

The management of urinary catheters was reviewed. Registered nurses spoken with were knowledgeable regarding the management of urinary catheters. Two care plans relating to the management of urinary catheters were reviewed. Some inconsistencies were identified in that one care plan did not include the frequency of changing the catheter and evaluations did not provide evidence of when the catheter had been changed. The care plan did include catheter care however there was no evidence of this being delivered. A recommendation has been made.

Continence assessments were completed by the district nursing team for patients living in the residential unit. Care plans were reflective of outcomes of assessments undertaken.

**Is Care Compassionate? (Quality of Care)**

During the inspection staff were noted to treat patients with dignity and respect. Good relationships were very evident between patients and staff. Staff were observed to respond to patients' requests promptly. Patients spoken with confirmed that they were treated with dignity and respect and that there needs were met in a timely manner.

**Areas for Improvement**

Policies and procedures pertaining to continence management should be reviewed to ensure that they are current and reflective of best practice guidelines.

It is recommended that training is provided for the management of supra pubic catheterisation for staff in accordance with their roles and responsibilities.

Care plans should include information on patient's bowel patterns and bowel types. Information regarding fluid requirements should be recorded and both fluid intake and outputs should be recorded in daily progress records unless otherwise indicated.

It is recommended that care plans pertaining to the management of urinary catheters are detailed to include all information and care required to provide safe and effective care of the urinary catheter. Daily and monthly evaluations recorded should be meaningful and informative in relation to the care plan interventions recorded.

| Number of Requirements: | 0 | Number of Recommendations: | 4 |
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**5.4 Additional Areas Examined**

**4.1. Records and record keeping**

A review of patient care records evidenced in some cases that registered nurses were not care planning using a specific, measurable and person centred approach. For example, care plans stated, "ensure the bag is changed" and "ensure adequate fluid intake". Other examples were

provided during feedback and the registered manager and registered nurse agreed that these statements were not appropriate. A recommendation has been made.

On review of care records (MUST tool) and discussion with a registered nurse, there was an indication that some entries made were not contemporaneous however; there was limited evidence to fully validate this information. All other records reviewed were found to be dated in full, timed and signed in accordance with professional and best practice guidance. This was discussed during feedback with the registered manager and with the operational director post inspection. The Operational Director advised that this matter was being investigated by Runwood Homes Ltd and that actions had already been taken as soon as it had been raised during inspection. These findings were also discussed with senior management at RQIA. Given the matter raised, a recommendation has been made that training should be provided for all registered nurses in relation to the minimum standards, professional guidance and legislative requirements in regards to record keeping.

**4.2. Environment and infection control**

A tour of the premises was undertaken and the majority of the patients' bedrooms, sitting areas, dining rooms, and bath/shower and toilet facilities were viewed. The home was found to be warm, clean, and comfortable in most areas, however a number of wall surfaces and skirting boards were unclean and damaged in the Dunserverick unit. Talcum powder was observed on the floor of an en suite and on a shower chair for the duration of the inspection despite cleaning procedures being undertaken. Vanity units were unclean and damaged with items left open for example toothpaste and tooth brushes lying amongst other toiletry items. This was discussed at feedback and a recommendation has been made that systems should be implemented to ensure practices and the environment are in accordance with infection prevention and control guidance.

It was evidenced that toiletries were held in unlocked cupboards/ areas in patients' bedrooms/en-suites in the Dunserverick unit. Taking into account the category of care of patients in this unit, this matter was discussed with the registered manager who agreed to risk assess this practice and action accordingly.

In two identified bathrooms/shower rooms items of equipment were being stored inappropriately. The registered manager advised that this was due to redecoration and refurbishment work that was being undertaken. An assurance was provided by the registered manager that these items would be removed and stored appropriately.

**6. Quality Improvement Plan**

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Mabel Cole, Registered Manager and Gemma Boyd, 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 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 | |
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| **Statutory Requirements: Nil Requirements** | |
| **Recommendations** | |
| **Recommendation 1**<br><br>**Ref**: Standard 4.1<br><br>**Stated:** Second time<br><br>**To be Completed by:**<br>**11 January 2016** | It is recommended that registered nurses develop care plans, as relevant, on patients requiring end of life care.<br><br>Care plans should include patients' and or their representatives':<br><br>• Communication needs and wishes<br>• Cultural, spiritual and religious preferences<br>• Environmental considerations.<br><br>**Ref section: 5.1** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>A new personalised Care plan has been developed for end of life to ensure that Patients and their representatives needs and wishes are addressed taking into account their cultural,religious and environmental preferences. |
| **Recommendation 2**<br><br>**Ref**: Standard 39.4<br><br>**Stated:** Second time<br><br>**To be Completed by:**<br>**11 January 2016** | Training should be provided to staff, relevant to their roles in:<br><br>• Communicating effectively<br>• Death, dying and bereavement<br>• Palliative and end of life care.<br><br>**Ref section: 5.1** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Training is planned for 28/1/16 by Ross Mawhineey and this training is available in other venues for staff.New policies and procedures will be cascated at staff meetings. |
| **Recommendation 3**<br><br>**Ref**: Standard 39<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>**18 February 2016** | It is recommended that training in regards to supra pubic catheterisation is provided for staff in relation to their roles and responsibilities. Additional training should be provided for registered nurses and care staff whom have not completed continence management and product application training.<br><br>**Ref Section: 5.1** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Supra Pubic catheterisation Training is planned for february 2016. Continence Management & product application Training took place 24/11/15 and is planned again in January 2016. |

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| **Recommendation 4**<br><br>**Ref**: Standard 36 Criteria 4<br><br>**Stated:** First time<br><br>**To be Completed by: 18 February 2016** | It is recommended that all policies and procedures are reviewed and reflective of current best practice guidelines in relation to;<br><br>• the management of continence/incontinence<br>• catheterisation<br>• stoma care.<br><br>**Ref section: 5.1** |
| | **Response by Registered Person(s) Detailing the Actions Taken:** Assurance has already been given to RQIA that all policies and procedures will be reviewed by end of March 2016. In addition to this plan new policies and procedures are being developed by John Rafferty N I Operations Director and have already been issued. |
| **Recommendation 5**<br><br>**Ref**: Standard 4 Criteria (1)(7)<br><br>**Stated:** First time<br><br>**To be Completed by: 18 December 2015** | It is recommended that continence assessments and care plans are fully completed and include the patient's normal bowel pattern and bowel type. The care plan should also indicate the patients fluid target and input /output should be recorded were deemed as appropriate.<br><br>**Ref Section: 5.3** |
| | **Response by Registered Person(s) Detailing the Actions Taken:** Continence Assessments and care plans have been reviewed and completed indicating the patients normal bowel pattern and type. Patients fluid target is recorded in care plan and input/output for 24hr period is recorded.in daily notes |
| **Recommendation 6**<br><br>**Ref**: Standard 4<br><br>**Stated:** First time<br><br>**To be Completed by: 18 December 2015** | It is recommended that care plans pertaining to urinary catheters contain specific detailed information to ensure the safe management of catheterisation.<br><br>**Ref Section:5.3** |
| | **Response by Registered Person(s) Detailing the Actions Taken:** Care plans for residents with catheters now have specific information to ensure safe management and best practice.. |
| **Recommendation 7**<br><br>**Ref**: Standard 4<br><br>**Stated:** First time<br><br>**To be Completed by: 18 January 2016** | The registered person shall ensure that registered nurses develop care plans that are patient centred and that the care plan interventions are measurable, specific and relate to the assessed needs of the patient.<br><br>**Ref Section: 5.4.1** |
| | **Response by Registered Person(s) Detailing the Actions Taken:** Care plans are being developed to ensure that they are patient centred and specific to each individuals needs.All care plans are being reviewed against expected best practice. |

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| **Recommendation 8**<br><br>**Ref**: Standard 39<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>**31 January 2016** | It is recommended that record keeping training is provided for all registered nurses in accordance with minimum standards, professional guidance and legislative requirements.<br><br>**Ref Section: 5.4.1** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Training on Record keeping is organised for all registered Nurses on 19/1/16 |
| **Recommendation 9**<br><br>**Ref**: Standard 46 Criteria (1)(2)<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>**31 December 2015** | It is recommended that management systems pertaining to infection prevention and control are developed to ensure compliance with best practice.<br><br>Particular attention should focus on the areas identified on inspection.<br><br>**Ref Section: 5.4.2** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Infection control audit completed on 23/11/15 and will be reviewed three monthly. there are two infection control link nurses. |

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| **Registered Manager Completing QIP** | Mabel Cole | **Date Completed** | 18/12/15 |
| **Registered Person Approving QIP** | Logan.N. Logeswaran | **Date Approved** | 18/12/15 |
| **RQIA Inspector Assessing Response** | Sharon Lee | **Date Approved** | 4/1/2016. |

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