Longfield Care Home
RQIA ID: 1184
2 Longfield Road
Eglinton
BT47 3PY

Inspector: Bridget Dougan
Inspection ID: IN023556

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Unannounced Care Inspection
of
Longfield Care Home

21 March 2016

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced care inspection took place on 21 March 2016 from 12.30 to 17.30.

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.

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 20 October 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	2	4*

*the total number includes both new and restated recommendations.

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

2. Service Details

Registered Organisation/Registered Person: Maureen Claire Royston	**Registered Manager:** Caroline Thorn
Person in Charge of the Home at the Time of Inspection: Caroline Thorn	**Date Manager Registered:** Acting
Categories of Care: NH-PH, NH-PH(E), NH-I	**Number of Registered Places:** 46
Number of Patients Accommodated on Day of Inspection: 45	**Weekly Tariff at Time of Inspection:** £613 - £657

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous care 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 acting manager
- discussion with registered nurses and care staff
- discussion with patients
- a general tour of the home and a review of a random sample of patients' bedrooms, bathrooms and communal areas
- examination of a selection of patient care records
- observation of care delivery
- evaluation and feedback

During the inspection, 20 patients were spoken with individually and the majority of others in small groups. Four care staff and three registered nurses were also consulted.

Prior to inspection the following records were analysed:

- notifiable events submitted since the last care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report and returned Quality Improvement Plan (QIP)

The following records were examined during the inspection:

- validation of evidence linked to the previous QIP
- four patient care records
- staff training records
- staff induction records
- policies and guidance documents pertaining to the standards examined

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 20 October 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection 20 October 2015.

Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 32 **Stated:** First time **To be Completed by:** 31 October 2015	The registered manager should review the arrangements to support staff following the death of a patient.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed the arrangements in the returned Quality Improvement Plan following the previous inspection on 20/10/15. Staff have the opportunity to discuss their feelings following a resident's death with the registered manager. Support services are also available for staff through Macmillan and Foyle Hospice. Discussion with staff confirmed their satisfaction with these arrangements.	

Recommendation 2 **Ref**: Standard 23.2 **Stated:** First time **To be Completed by:** 21 October 2015	Where a patient is assessed as at risk of pressure damage, the condition of the patients skin should be documented each time the patient is repositioned	**Partially Met**
	Action taken as confirmed during the inspection: An electronic care records system was in place. Registered nurses and care staff confirmed there was no facility on the system for care staff to record the condition of patient's skin following repositioning. The acting manager confirmed that discussions had taken place with Epicare and the system would be updated to include skin integrity.	

5.3 Continence Management

Is Care Safe? (Quality of Life)

Policies and procedures regarding continence management, catheter care and stoma care were available to guide staff.

Best practice guidance on continence care was available in the home for staff to consult. These included:

- The management of urinary incontinence (NICE)
- The management of faecal Incontinence (NICE)
- Continence care in Care Homes (RCN)
- Four Seasons Healthcare continence care guidelines.

Discussion with the acting manager and a review of the training records confirmed that ten registered nurses received training and were assessed as competent on 25/03/15 in male and suprapubic catheterisation. Registered nurses and care staff had received additional training in 2015 relating to the management of urinary and bowel incontinence. Staff had completed training on the use and application of incontinence aids. A review of the induction template for care staff evidenced that the management of toileting needs was included in the induction process. Four registered nurses attended training in October 2014 in the management of stoma care and this was disseminated to care staff during supervision. Registered nurses informed the inspector that update training in the management of stomas would be beneficial. A recommendation was made.

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.

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 not been identified for the home. A recommendation has been made.

Is Care Effective? (Quality of Management)

Review of four patients' care records evidenced that a continence assessment was in place for each patient. This assessment clearly identified the patient's continence needs. The specific type of continence product assessed to meet the needs of the patient was recorded as part of the continence assessment and in two of the care plans reviewed. A recommendation was made.

Braden pressure ulcer assessments and Malnutrition Universal Screening Tool (MUST) risk assessments had been completed, however they had not been consistently reviewed on a monthly basis within all four patients care records.

While continence care plans were in place, they had not been reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, and dignity were addressed in the care plans inspected. However fluid requirements had not been well documented. Target fluid intake had not been recorded in care plans and there was no evidence that nurses had recorded patients' actual fluid intake in daily progress notes. Registered nurses advised that fluid intake was recorded by care staff on the "touch screen" of the electronic records and totalled by night staff. While a verbal handover was provided by night staff, there was no evidence that fluid intake had been recorded in nursing care records. Electronic touch screen records did not provide a history of fluid intake over the previous days. A requirement has been made in this regard.

There was evidence within the care records of patient and/or representative involvement in the development of the care plans.

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 and the rationale for use of urinary catheters. Urinary catheters were only inserted on the instructions of the patient's GP or consultant. There was evidence in the records reviewed that staff had consulted the relevant practitioner when issues pertaining to the management of the urinary catheter had arisen. However, fluid balance had not been well documented. There was no evidence that the amount of urinary output had been recorded in the care records inspected. Statements such as "catheter draining well" had been recorded in daily progress notes. A requirement has been made with regard to the management of fluid balance.

The management of care records was discussed with the acting manager. The inspector was informed that a comprehensive audit of care records was being undertaken and a number of care plans were being re-written. A requirement has been made with regard to the management of care records.

Is Care Compassionate? (Quality of Care)

Staff were observed to treat patients with dignity and respect and to respond to patients' requests promptly. Good relationships were evident between patients and staff. Patients confirmed that they were happy in the home and that staff were kind and attentive.

Areas for Improvement

It is recommended that update training in stoma care be provided for all relevant staff.

A continence link nurse should be identified for the home.

A requirement has been made to ensure that patient' assessments and care plans have been reviewed and updated on a monthly basis or more often as deemed appropriate.

The specific type of continence product assessed to meet the needs of the patient should be included in the continence care plan.

The registered manager should review the management of fluids. Care records should clearly identify fluid intake targets, whether these have been met and the actions taken to address any deficits. For patients with urinary catheters, the amount of urinary output should be recorded on a daily basis.

Number of Requirements:	**2**	**Number of Recommendations**:	**3**

5.4 Additional Areas Examined

5.4.1 Consultation with Patients, Patient Representatives and Staff

Twenty patients, four care staff and three registered nurses were consulted as part of the inspection process. The feedback received indicated that safe, effective and compassionate care was being delivered. One patient raised an issue with regard to the assessment of appropriate seating. This was discussed with the acting manager and assurances were provided following the inspection that this had been followed up and that relevant seating would be provided in a timely manner.

A number of patients were unable to express their views verbally. All patients appeared well presented and comfortable in their surroundings.

Some patients' comments received are detailed below:

- "I am happy here, I have no complaints"
- "the staff are all very good to me"
- "I would like to get up out of bed"

The view from staff during conversations was that they took pride in delivering safe, effective and compassionate care to patients.

Areas for Improvement

No areas for improvement were identified.

Number of Requirements:	0	Number of Recommendations:	0

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Caroline Thorn, acting 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	
Statutory Requirements	
Requirement 1 **Ref:** Regulation 16 (2) (b) **Stated:** First time **To be Completed by:** 31 March 2016	The registered manager should ensure that patient' assessments and care plans have been reviewed and updated on a monthly basis or more often as deemed appropriate. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: All resident care plans audited monthly on each unit. Resident Traca completed weekly and identified areas actioned and recorded.
Requirement 2 **Ref:** Regulation 13 (1) (a) **Stated:** First time **To be Completed by:** 31 March 2016	The registered manager should review the management of fluids. Care records should clearly identify fluid intake targets, whether these have been met and the actions taken to address any deficits. For patients with urinary catheters, the amount of urinary output should be recorded in care records on a daily basis. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: All residents reassessed requiring fluid management. Targets recorded on epicare and fluid intake recorded over 24hour period. Supervision carried out with nurses to ensure fluid intake /output recorded in daily records. Home manager to monitor records weekly to identify compliance
Recommendations	
Recommendation 1 **Ref**: Standard 23.2 **Stated:** Second time **To be Completed by:** 31 March 2015	Where a patient is assessed as at risk of pressure damage, the condition of the patients skin should be documented each time the patient is repositioned **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: supervisions have been conducted in relation to the compliance with this .The manager will audit this weekly to review compliance as part of the resident care TRACA
Recommendation 2 **Ref**: Standard 39.9 **Stated:** First time **To be Completed by:**	The registered manager should ensure that update training in stoma care be provided for all relevant staff. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Stoma nursing coming to review resident on 13th May and to organise

30 June 2016	date for training.

Recommendation 3 **Ref**: Standard 39.7 **Stated:** First time **To be Completed by:** 30 April 2016	It is recommended that a continence link nurse is identified for the home. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Continence link nurse identified for home
Recommendation 4 **Ref**: Standard 21.11 **Stated:** First time **To be Completed by:** 30 April 2016	It is recommended that the specific type of continence product assessed to meet the needs of the patient should be included in the continence care plan. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: All residents prescribed a continence product have had their care plans reviewed and product included. This care plan is then reviewed monthly.

Registered Manager Completing QIP	L McCloskey	**Date Completed**	13.05.16
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	13.05.16
RQIA Inspector Assessing Response	Bridget Dougan	**Date Approved**	16/05/16

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