Weaver's House
RQIA ID: 11974
Moneymore Road
Cookstown
BT80 8EH

Inspector: Lyn Buckley
Inspection ID: IN022007

Tel: 02886 767684
Email: manager.weavers
@runwoodhomes.co.uk

Unannounced Care Inspection
of
Weaver's House

18 May 2015

1. Summary of Inspection

An unannounced care inspection took place on 18 May 2015 from 11:40 to 15:30. The focus of this inspection was continence management which was underpinned by selected criterion from DHSSPS Care Standards for Nursing Homes, April 2015:

Standard 4: Individualised Care and Support
Standard 6: Privacy, dignity and Personal Care
Standard 21: Health Care.
Standard 39: Staff training and development.

Overall 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, three 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.

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 29 July 2014.

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	3

The details of the QIP within this report were discussed with the registered manager, Brenda Rushe, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Runwood Homes Ltd Mr Nadarajah (Logan) Logeswaran	**Registered Manager:** Brenda Rushe
Person in Charge of the Home at the Time of Inspection: Lisa McDonald	**Date Manager Registered:** 16 January 2015
Categories of Care: NH- DE to a maximum of 30 patients RC – DE to a maximum of 24 residents RC I, PH and PH(E) to a maximum of 11 residents	**Number of Registered Places:** 65
Number of Patients/Residents Accommodated on Day of Inspection: Nursing 26 Residential 24	**Weekly Tariff at Time of Inspection:** Nursing £593 - £727 Residential £470 - £604

3. Inspection Focus

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

Standard 4: Individualised Care and Support, criterion 4 and 8
Standard 6: Privacy, dignity and Personal Care, criterion 1,3,4,8 and 15
Standard 21: Heath care, criterion 6, 7 and 11
Standard 39: Staff training and development, criterion 4

4. Methods/Process

Please note that patients and residents will be referred to as patients for the purpose of this report.

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

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

Prior to inspection the following records were analysed:

- inspection report and quality improvement plan from the previous care inspection on 29 June 2014.
- incident reports submitted, from 1January 2015 to date, in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.

During the inspection, the inspector met with the majority of patients either individually or in small groups; five nursing and care staff and two support staff.

The following records were examined during the inspection:

- complaints records
- safeguarding investigation reports
- four patient care records
- the report from the regulation 29 monitoring visit conducted on 1 April 2015
- a random selection of staff induction/competency and capability assessments
- policies and procedures relating to the inspection focus
- staff training records in relation to the inspection focus and the previous QIP.

5. The Inspection

5.1 Review of Requirements and Recommendations from Previous Inspection

The previous inspection of the home was an announced pre-registration inspection on 15 December 2014. There were no requirements or recommendations made. The last care inspection was an unannounced secondary care inspection on 29 July 2014.

5.2 Review of Requirements and Recommendations from the last care inspection

Previous Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 12 (1) **Stated:** First time	It is required that management review the patient/resident dining experience to ensure the issues identified by the inspector are addressed and that good practice is maintained.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and observation of the serving of the lunch time meal evidenced that this requirement had been met.	
Requirement 2 **Ref**: Regulation 14 (2) (c) **Stated:** First time	It is required that management reviews food hygiene arrangements throughout the home to ensure the areas identified by the inspector are addressed Food hygiene requirements must be adhered to by any staff handling food. Small kitchen areas must be effectively managed.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager, review of training records, observation of the serving of the lunchtime meal and the small kitchen areas adjacent to dining rooms evidenced that this requirement has been met.	

Previous Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 28.6 **Stated:** First time	It is recommended that training records are maintained in accordance with minimum standards and available in the home for inspection.	**Met**
	Action taken as confirmed during the inspection: Review of records evidenced that this recommendation had been met.	
Recommendation 2 **Ref**: Standard 27 **Stated:** Second time	It is recommended the (regulation 29). Report includes the times of the visit by the regional manager and that action plans devised following the visit are dated to ensure they are linked to the correct visit's report and tracked for compliance	**Met**
	Action taken as confirmed during the inspection: Review of records confirmed that this recommendation had been met.	
Recommendation 3 **Ref**: Standard 12.13 **Stated:** Second time	It is recommended that following completion of induction the registered manager/deputy manager records a statement of capability and competency following completion of staff inductions to finalise and confirm the person has been successful.	**Met**
	Action taken as confirmed during the inspection: Review of a selection of induction records evidenced that this recommendation had been met.	

5.3 Continence management

Is Care Safe? (Quality of Life)

Policies and procedures were in place to guide staff regarding the management of continence.

Regional and national guidelines for the management of urinary catheters, constipation (RCN and NICE) and improving continence care (RCN) were available in the home

Discussion with staff and the registered manager confirmed that staff had received training in 2014 relating to the management of the urinary and bowel incontinence.

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.

Discussion with staff confirmed that there was a number of registered nurses staff trained and assessed as competent in urinary catheterisation. The registered manager informed the inspector that there was support, and training opportunities from within the local health and social care trust, if staff required an update in their training of catheterisation.

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

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 individual continence needs. A care plan was in place to direct the care to adequately meet the needs of the patients. The specific type of continence pads the patient required was recorded.

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, fluid requirements and patients' dignity were addressed in the care plans inspected. Records relating to the management of bowels were reviewed which evidenced that staff made reference to the Bristol Stool. However, a recommendation is made that these charts are recorded accurately and consistently across the home and that senior staff evidence any action taken to address concerns regarding the bowel pattern and particularly for those patients requiring laxative therapy.

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

A recommendation is also made to ensure that staff date and sign any record they create in accordance with best practice and professional guidance.

Is Care Compassionate? (Quality of Care)

Discussion with the registered manager confirmed where patients, or their families, have a personal preference for the gender of the staff providing intimate care their wishes would be respected. However, this was not incorporated into care plans; a recommendation is made.

Staff were observed to attend to patient's continence needs in a dignified and personal manner.

Patients spoken with confirmed that they were treated with dignity and respect, that staff were polite and respectful and that their needs were met in a timely manner. Good relationships were evident between patients and staff.

Areas for Improvement

Three recommendations are made in relation the recording of bowel management; care planning in relation to patient preferences and the dating and signing of records.

Number of Requirements	**0**	**Number Recommendations**:	**3**

6 Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager, Brenda Rushe, 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 the 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 will be completed by the 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 by the registered manager. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 4.9 **Stated:** First time **To be Completed by:** 30 June 2015	The registered person should ensure that charts relating to the management of bowels are recorded accurately ad consistently throughout the home and that senior staff evidence any action taken to address concerns regarding the bowel pattern and particularly for those patients requiring laxative therapy. **Response by Registered Manager Detailing the Actions Taken:** From the inspection there has been a laxative audit commenced on each floor. Nurses and CTM's are now recording as part of their daily evaluation when residents bowels move and are ensuring that this tallys up with the care assistants bowel records. Nurses and CTM's are also checking daily when residents bowels have last went and if no movement in 3 days laxative given or if already on laxitive then it is requested from the GP that it can be increased due to no movements.
Recommendation 2 **Ref**: Standard 37 **Stated:** First time **To be Completed by:** 30 June 2015	The registered person should ensure that staff date and sign any record they create in accordance with best practice and professional guidance. **Response by Registered Manager Detailing the Actions Taken:** A supervision has been done with all staff to ensure they date and sign everything the record and the importance of this. Random spot checks are currently being carried out by senior staff to ensure that staff are adhering to this.
Recommendation 3 **Ref**: Standard 4.5 **Stated:** First time **To be Completed by:** 30 June 2015	The registered person should ensure that where patients, or their families, have a personal preference for the gender of the staff providing intimate care their wishes would be recorded in the patient's care plan **Response by Registered Manager Detailing the Actions Taken:** If a resident has a preference a care plan is in place to reflect this. Staff curently devising care plans for residents who have no preference but as evidence that they have been asked and should this change the care plan can be ammended.

Registered Manager Completing QIP	Brenda Rushe	**Date Completed**	26/06/15
Registered Person Approving QIP	Logan N Logeswaran	**Date Approved**	26/06/15

RQIA Inspector Assessing Response	Lyn Buckley	Date Approved	30/06/15

Please ensure the QIP is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address