Bell Gray House
RQIA ID: 1205
48 Dublin Street
Newtownstewart
BT78 4AG

Inspector: Sharon Loane
Inspection ID: IN021872

Tel: 028 8166 2075
Email: Eileen.stanford@apexhousing.org

Unannounced Care Inspection
of
Bell Gray House

25 February 2016

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 25 February 2016 from 11.40 to 15.00.

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: Health care and Standard 39: Staff Training and Development.

On the day of the inspection, concerns and areas of improvement were identified and are required to be addressed to ensure that care in the home is safe, effective and compassionate. These areas are set out in the Quality Improvement Plan (QIP) within this report. Refer also to section 1.2 below.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015.

For the purposes of this report, the term 'patients' will be used to described those living in Bell Gray House 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 07 July 2015.

1.2 Actions/Enforcement Resulting from this Inspection

An urgent actions record regarding wound/pressure care management was issued to Eileen Stanford, Registered Manager at the end of the inspection. These actions are required to be addressed without delay to ensure the safety and wellbeing of patients in the home.

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	1	*3

*The total number of recommendations includes one recommendation stated for the second time.

The details of the Quality Improvement Plan (QIP) within this report were discussed with Eileen Stanford, Registered Manager as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Apex Housing Association Mr Gerald Kelly	**Registered Manager:** Mrs Eileen Stanford
Person in Charge of the Home at the Time of Inspection: Mrs Eileen Stanford	**Date Manager Registered:** 26 January 2016
Categories of Care: NH-LD, RC-I, NH-I,NH-PH	**Number of Registered Places:** 35
Number of Patients Accommodated on Day of Inspection: Nursing: 23 Residential: 5	**Weekly Tariff at Time of Inspection:** £493 - £613

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: **Health 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 on duty during the inspection
- review of care 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 (QIP) from the previous care inspection on 07 July 2015
- incident reports submitted in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland)
- written and verbal communication received since the previous care inspection

During the inspection, the inspector met with five patients, three care staff and two registered nurses.

The following records were examined during the inspection:

- policies and procedures pertaining to the inspection focus and the previous QIP
- complaints record
- safeguarding investigation reports
- three patient care records
- staff training records

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The last inspection of the home was an unannounced care inspection dated 07 July 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection 07 July 2015

Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 36 **Stated:** First time	It is recommended that a policy and procedure should be developed on communicating effectively. This should include reference to the regional guidance for breaking bad news.	**Met**
	Action taken as confirmed during the inspection: A review of the policy and procedure identified evidenced that these had been reviewed and updated August 2015 in accordance with the recommendation made.	
Recommendation 2 **Ref**: Standard 39 **Stated:** First time	It is recommended that the registered person ensures that all grades of staff receive training on the following; 1. Communication skills including the breaking of bad news 2. Palliative and end of life care, death and dying	**Met**
	Action taken as confirmed during the inspection: Review of training records, evidenced that 13 staff had completed training in the identified areas and the remaining staff were scheduled to complete same. This recommendation has been met.	

Recommendation 3 **Ref**: Standard 20.2 **Stated:** First time	It is recommended that end of life care plans are developed to enhance the delivery of person centred care and reflect the patient's /patient representatives wishes.	**Met**
	Action taken as confirmed during the inspection: Review of three patient's care records evidenced that care plans have been further developed in this area of practice since the last care inspection and are ongoing. This recommendation has been met.	
Recommendation 4 **Ref**: Standard 46 **Stated:** First time	It is recommended that there is an established system to assure compliance with best practice in infection prevention and control within the home in regards to the issues identified in section 5.5.1.	**Not Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager evidenced that infection prevention and control is included as part of the Control System Tool completed at monthly intervals. A review of this document indicated that it was not robust enough to identify shortfalls in this area of practice. Issues identified at the previous care inspection had not been satisfactorily actioned. This recommendation has been stated for a second time.	
Recommendation 5 **Ref**: Standard 16 **Stated:** First time	It is recommended that records of all complaints include all communications with complainants; the result of any investigations; the action taken; whether or not the complainant was satisfied with the outcome; and how this level of satisfaction was determined. A recommendation has been made.	**Met**
	Action taken as confirmed during the inspection: Review of the complaints record evidenced that complaints management and recording was in accordance with legislation, care standards and policy and procedures. This recommendation has 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.

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 catheters (RCN), urinary and faecal management (NICE), information on stoma care and the use and application of continence products.

Discussion with staff and the registered manager confirmed that ten staff had completed training in 2014. Further training had been scheduled for 22 February 2016 and 13 staff were available to complete same, however, the trainer provider cancelled at short notice. The registered manager advised that this was currently being re-scheduled for 2016.

A review of training records and staff discussions evidenced that 13 staff had completed Stoma care training in 2015. Staff discussions evidenced that staff were knowledgeable in all aspects of stoma care management.

The registered manager advised that they are also a qualified Stoma Therapist and completed regular training updates for staff. This is commended.

Staff was 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 were a number of registered nurses trained and assessed as competent in urinary catheterisation. The registered manager advised that it was their intention to organise a training update for registered nurses in relation to the management of urinary catheterisation for continued professional development.

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

Is Care Effective? (Quality of Management)

Review of three patients care records evidenced that a continence assessment was in place for each patient. This assessment clearly identified the patient's individual needs. A care plan was in place to direct the care to meet the needs of the patients. The specific type of continence products the patient required was also recorded in all care records examined.

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. Assessments and care plans inspected for continence management did not refer to patients normal bowel patterns. A recommendation has been made. A review of bowel management records did evidenced that the Bristol Stool Chart was being referenced for recording however this was inconsistent. The registered manager gave an assurance to address this matter with staff and action appropriately.

Urinalysis was undertaken as required and patients were referred to their GPs appropriately.

At this inspection there were no patients with urinary catheters. A review of records pertaining to Stoma care management evidenced that the documentation was detailed to guide and direct staff in all aspects of care in this area of practice.

Review of patient's care records evidenced that patients and/or their representatives were informed of any changes to patient need and /or condition and actions taken.

Is Care Compassionate? (Quality of Care)

Discussion with the registered manager and staff confirmed were patients, or their families, have a personal preference for the gender of the staff providing intimate care their wishes would be respected.

Staff was 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 was polite and respectful and that their needs were met in a timely manner. Good relationships were evident between patients and staff.

Areas for Improvement

It is recommended that assessments and care plans include all aspects of continence management including bowel management.

Number of Requirements:	**0**	**Number of Recommendations**:	**2 ***

5.4 Additional Areas Examined

5.4.1 Quality of Nursing Care and Care Records

Care records in respect of one identified patient were examined and shortfalls were identified in relation to pressure and /or wound care management. A review of the care records evidenced that the patient had been admitted with wounds and a plan of care had been prescribed. There was no evidence that a body map had been completed at time of admission and there was lack of evidence that the dressings were carried out in accordance with the prescribed frequency. A review of records evidenced that some dressings had not been renewed in seven days. This was concerning given that the treatment plan advised that the dressing (s) were to be renewed every third day. These shortfalls could potentially have a direct impact on the delivery of safe effective care. An urgent actions record was issued at time of inspection and a requirement has been made.

A review of care records for the same patient evidenced that the assessment and care planning process had not being completed within the five days of admission to the home. Care plans had in some instances not being devised for over a four week period. A recommendation has been made in this regard.

5.4.2Staffing and Recruitment

Prior to the inspection the registered manager had advised RQIA that the home were having to use high levels of agency care staff due to operational matters and staff sickness. The registered manager advised at this inspection that this issue was being resolved. The registered manager confirmed that a number of care staff had returned to work and the home had successfully recruited care staff and final employment checks were being completed. A review of duty rotas for nursing and care staff and discussions with staff and management confirmed that staffing levels were appropriate to meet the needs of the patients.

The home continues to rely on the use of some agency care staff to cover shifts in the interim period and care staff are “blocked booked” as much as possible to ensure continuity of care for patients.

Discussions with staff on duty at time of inspection acknowledged the high use of agency care staff during this period of time however, advised that it had been managed effectively and had had no direct impact on care. Staff were knowledgeable that staff had been recruited and was due to commence employment.

5.4.3 Consultation with Patients and Staff

The inspector spoke with five patients individually and the majority of others in smaller groups, two registered nurses and three care staff.

Observations confirmed that patients who could not communicate due to their condition were relaxed and comfortable in their environment. There was evidence of good relationships between patients and staff. Staff were observed to attend to patients’ needs in a caring and sensitive manner.

Patients were complimentary regarding the care they received from staff and stated that they felt safe in the home. One patient stated that medications at night were not being administered in a timely manner and that this was having an impact on patients’ ability to retire to bed. This matter was discussed with the registered manager who gave an assurance to address this issue and practice. No other concerns were raised.

Staff spoken with were knowledgeable of their role and function in the home. Staff spoken with advised that the home delivered safe, effective and compassionate care and felt Bell Gray delivered high standards of quality care. As previously referred to in section 5.4.2 staff acknowledged that the home had encountered some previous problems with the availability of care staff however expressed that this situation had been managed effectively by management. No concerns were raised.

Areas for Improvement

A requirement has been made that any patients with pressure areas/wound management needs, has care and treatment delivered in accordance with their identified regime of care. All records pertaining to this area of practice should be completed accordingly.

Assessments and care records should be completed in accordance with the guidance cited in the Care Standards for Nursing Home, April 2015.

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

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Eileen Stanford, 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.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref:** Regulation 12 (1)(a)(b) **Stated:** First time **To be Completed by:** 25 February 2016	The registered person shall ensure that any patients with pressure areas/wound management needs, has care and treatment delivered in accordance with their identified regime of care. All records pertaining to this area of practice should be maintained appropriately to reflect the care and treatment given. An urgent actions record was issued. **Ref Section: 5.4.1**
	Response by Registered Person(s) Detailing the Actions Taken: The urgent actions record was actioned on the day of the inspection. All nurses are fully aware that pressure areas/wound management needs must be documented following delivery of care. Audits on the documentation have been commenced.
Recommendations	
Recommendation 1 **Ref**: Standard 46 **Stated:** Second time **To be completed by:** 4 April 2016	It is recommended that there is an established system to assure compliance with best practice in infection prevention and control within the home in regards to the issues identified. **Ref Section : 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: A works order has been issued,the property services officer has met with the contractors in the home and areas for repair identified.Following re-decoration a protective material will be applied to prevent further damage.
Recommendation 2 **Ref**: Standard 4 Criteria (1)(7) **Stated:** First time **To be Completed by:** 4 April 2016	It is recommended that continence assessments and care plans are completed to include all interventions required to manage patients' continence needs including bowel management. Records should include information relating to patients bowel types and patterns. **Ref Section: 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: All staff are fully aware that all continence assessments need to include all interventions required to manage residents' continence needs including bowel management. Records will include information relating to residents' bowel types and patterns.
Recommendation 3 **Ref**: Standard 4 Criteria 1	It is recommended that assessments and care plans are commenced on the day of admission and completed within five days of admission to the home. These criteria should be included in the auditing process and actioned accordingly.

Stated: First time **To be Completed by:** 4 April 2016	**Ref Section: 5.4.1** **Response by Registered Person(s) Detailing the Actions Taken:** All staff are aware that the assessments and care plans must be commenced on the day of admisson and completed within five days of admission to the home.This criteria will be included on the Admissions Checklist document and audited prior to day five post admission date

Registered Manager Completing QIP	.Eileen Stanford	**Date Completed**	01/04/16
Registered Person Approving QIP	Muriel Sands	**Date Approved**	01/04/16
RQIA Inspector Assessing Response	Sharon Loane	**Date Approved**	11/05/16

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