The Regulation and Quality Improvement Authority

Parkview
RQIA ID: 1254
Glencairn Road
Forthriver Road
Belfast
BT13 3PU

Inspector: Bridget Dougan
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Unannounced Care Inspection of Parkview

10 March 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 10 March 2016 from 11.30 to 16.30 hours.

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.

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 11 June 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	0	3

The details of the Quality Improvement Plan (QIP) within this report were discussed with the applicant manager, Ms Gillian Finlay, 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: Four Seasons Healthcare Maureen Claire Royston	Registered Manager: Gillian Finlay
Person in Charge of the Home at the Time of Inspection: Gillian Finlay	**Date Manager Registered:** 18 March 2015
Categories of Care: RC-LD(E), NH-DE, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 71
Number of Patients Accommodated on Day of Inspection: 62	**Weekly Tariff at Time of Inspection:** £593

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 registered 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, 12 patients were spoken with individually and the majority of others in small groups. Four care staff and two 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
- three 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 11 June 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection 11 June 2015

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 27 **Stated:** First time	The registered person must minimise risks to patient health and safety with the following actions; 1. Review all current wall lights in patient's bedrooms to repair, replace and / or relocate current fittings to minimise risks of patient / staff injury. 2. The dementia garden should be made suitable for patient access with risks from uneven coarse gravel suitably minimised. 3. The sewage issues which impact upon the main communal garden should be investigated and actioned as required. An action plan should be returned with the return of the QIP to demonstrate the time frames for all work to be commenced and completed.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and review of the environment evidenced that the wall lights had been replaced, the patients garden completed and sewage issues had been resolved.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 46 **Stated:** First time	It is recommended that the registered manager establish a daily quality assurance process which examines the general hygiene of all areas of the home including sluice rooms, communal bathroom areas and store rooms to minimise risks of hazards to patients.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that a quality assurance process had been developed to ensure the general hygiene of the home. All areas of the home were found to be clean and tidy at the time of this inspection.	

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:

- Urinary incontinence (NICE)
- Faecal Incontinence (NICE)
- Continence care in Care Homes (RCN)
- Four Seasons Healthcare continence care guidelines.

Discussion with the registered manager and a review of the training records confirmed that two registered nurses were trained in 2014 and assessed as competent in urinary catheterisation and further training has been planned for April 2016. Registered nurses and care staff had received 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.

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.

Two continence link senior carers had been identified for the home and one was available for a discussion during the inspection.

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.

While the continence assessment clearly identified the patient's incontinence needs, the specific type of continence product assessed to meet the needs of the patient was not recorded. A recommendation has been made.

Braden pressure ulcer assessments and Malnutrition Universal Screening Tool (MUST) risk assessments had been completed and consistently reviewed on a monthly basis within all three patients care records.

Continence care plans had been reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, and patients' dignity were addressed in the care plans inspected. Care plans did not specify the actual product required to meets the needs of the patient. Reference was not made to the Bristol Stool Chart when recording patients' bowel movements. A recommendation was made.

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

A number of entries in patient's care records were illegible. There was also evidence that an alteration had been made and the nurse's name, signature and date had not been included. This was discussed with the registered manager and a recommendation has been made.

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 and actions had been implemented as per the advice given.

The target fluid intake for patients with a urinary catheter had been recorded in their incontinence assessment; however this was not included in their care plans. While progress notes made reference to fluid intake and output, they were not specific with regard to the amounts. There was inconsistency in the recording of fluid balance charts. A recommendation has been made in this regard.

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

Assessments and care plans should include all interventions required to manage patients' continence needs and should include but not limited to; bowel patterns and type (reference Bristol Stool Chart) and continence products required.

Where fluid balance charts are in place (for example for patients with urinary catheters), target fluid intake amounts should be recorded in patients care plans, fluid balance charts should be accurately recorded and the amount of patients intake and output recorded in daily progress notes and action taken to address deficits.

The registered manager must ensure that registered nurses are aware of their responsibilities with regard to record keeping. Handwriting in patients care records should be legible and any amendments made in accordance with Nursing and Midwifery Council guidelines.

Number of Requirements:	0	Number of Recommendations:	3

5.4 Additional Areas Examined

5.4.1 Consultation with Patients, Patient Representatives and Staff

Twelve patients and six staff were consulted as part of the inspection process. The feedback received indicated that safe, effective and compassionate care was being delivered.

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 very well looked after"
- "I do like it here"
- "the staff are all good and kind to me"

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

Some staff comments received is detailed below:

- "We have been working here a long time and are very happy with the standard of care provided to our residents"
- "the training and everything is very good. I'm happy working here"
- "there is very good team work in this home"

No concerns were raised.

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 Ms Gillian Finlay, 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.

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

Recommendations	
Recommendation 1 **Ref**: Standard 4 (1) **Stated:** First time **To be Completed by:** 30 April 2016	The registered manager should ensure that assessments and care plans include all interventions required to manage patients' continence needs and should include but not limited to; bowel patterns and type (Bristol Stool Chart) and continence products required. **Reference: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Care staff to use the Bristol stool chart when documenting bowel motions. Each residents care plan is to state the individual continence products used to meet their needs. Care Plans to be reviewed by 30th April.Spot checks to be carried out on continence records.
Recommendation 2 **Ref**: Standard 4 (7) **Stated:** First time **To be Completed by:** 31 March 2016	The registered manager should ensure that where fluid balance charts are in place (for example for patients with urinary catheters), target fluid intake amounts should be recorded in patients care plans. Fluid balance charts should be accurately recorded and the amount of patients' intake and output recorded in daily progress notes and action taken to address deficits. **Reference: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Nursing staff informed that Residents Care plans are to state target fluid intake. Reference is to be made in the daily progress notes as to if this has been achieved and how any deficit was adressed. Spot checks and audits are to be carried out in April to check compliance.
Recommendation 3 **Ref**: Standard 4 (6) **Stated:** First time **To be Completed by:** 31 March 2016	The registered manager must ensure that registered nurses are aware of their responsibilities with regard to record keeping. Handwriting in patients care records should be legible and any amendments made in accordance with Nursing and Midwifery Council guidelines. **Reference: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: All nursing staff reminded of NMC code of practice in relation to Keeping clear and accurate records relevant to your practice. Unit managers to check documentation to make sure it is legible. For staff with poor handwritting the option of having care plans and risk assessments typed out is available.

Registered Manager Completing QIP	Gill Finlay	**Date Completed**	7/4/16
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	27.04.16

RQIA Inspector Assessing Response	Bridget Dougan	**Date Approved**	28/04/16

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