Unannounced Care Inspection Report
3 April 2017

Richmond

Type of Service: Nursing Home
Address: 19 Seafront Road, Cultra, BT18 0BB
Tel No: 028 9042 6558
Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Richmond took place on 3 April 2017 from 10:05 to 15:15 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

Discussion with patients evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. However a recommendation was made that staffing levels are reviewed from 18:00 hours to ensure patients' needs are met.

Staff spoken with confirmed that they were required to attend mandatory training. Staff demonstrated their knowledge, skill and experience necessary to fulfil their role, function and responsibilities in general and specifically in relation to adult safeguarding.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and generally reviewed as required. However, deficits regarding the process of assessment, care planning and review were evidenced and discussed with the nursing staff and a requirement was made.

Review of records pertaining to accidents/incidents since 16 January 2017 confirmed that accidents and incidents were managed appropriately. However, it was evident that RQIA had not been notified of at least five accidents/incidents in accordance with regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. A requirement was made.

Concerns were raised regarding the day to day management of fire safety precautions as a number of fire exit routes were partially obstructed. This issue had been raised with the home previously and the requirement is now stated for a second time, In addition the provider was required to attend a serious concerns meeting at RQIA following the inspection.

Is care effective?

Care records generally reflected the assessed needs of patients; and where appropriate, recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT), occupational therapist (OT), physiotherapists and/or dieticians were included in the care plan. One care plan relating to SALT recommendations did not reflect the most recent SALT visit – nursing staff agreed to address this matter. Records pertaining to the management of wounds were evidenced to be maintained to a good standard.

Observations and feedback from patients evidenced that call bells were answered promptly and requests for assistance were responded to in a calm, quiet and caring manner.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

Effective communication with patients and their representatives was evident. Patients consulted confirmed that they received “good care” and that the staff were “kind and attentive”.

There were no areas for improvement identified in this domain.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated knowledge of patients’ wishes and preferences. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Patients and staff confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

There were no areas for improvement identified in this domain.

Is the service well led?

Discussion with staff evidenced that there was a clear organisational structure within the home. Staff easily described their role and responsibility in the home. In discussion, patients were also aware of the roles of the staff in the home and to whom they should speak to if they had a concern.

Discussion with the nurse in charge and review of records evidenced that the home was operating within its registered categories of care.

Based on the inspection outcomes as detailed in the preceding domains, it was evident that improvements were needed in respect of the day to day management of fire safety precautions; however, the care delivered was observed to be safe, effective, compassionate and well led. Compliance with the requirements and recommendations made will further enhance the quality of care, treatment and services provided.

There were no areas for improvement identified in this domain.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	*3	1

*The total number of requirement includes a requirement stated for a second time. Refer to section 4.2 and 4.3 for details.

Details of the Quality Improvement Plan (QIP) within this report were discussed with the registered nurse (RN) in charge of the home, Alex Gioneaga and Mr Jeremey Bryans, administrator, as part of the inspection process. The timescales for completion commence from the date of inspection.

Following the inspection the registered provider/manager was contacted and asked to attend a serious concerns meeting at RQIA to provide assurances that the areas of concern identified in relation to fire safety were being addressed. Following this meeting, on 12 April 2017, RQIA were provided with assurances that the concerns had been addressed in full and that a management plan was in place to ensure compliance.

Enforcement action resulted from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 21 November 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Richmond Nursing Home Ltd Mrs Sharon Ruth Radcliffe-Bryans	**Registered manager:** Mrs Sharon Ruth Radcliffe-Bryans
Person in charge of the home at the time of inspection: Alex Gioneaga	**Date manager registered:** 1 April 2005.
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 35

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events 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 plan (QIP) from the previous care inspection
- the previous care inspection report.

During the inspection we spoke with nine patients individually and greeted others in small groups. We also met with three care staff, two registered nurses, one staff member from housekeeping and two staff from catering.
In addition questionnaires were provided for distribution by the administrator; eight for patients and 10 for relatives and 10 for staff not on duty during the inspection.

The following information was examined during the inspection:

- three patient care records
- patient repositioning records
- handover records and daily task allocation sheets
- four patients' additional care charts including repositioning charts, food and fluid intake charts
- staff duty rotas from 26 March to 8 April 2017
- one staff recruitment record
- incident and accident records
- consultation with patients and relatives
- reports of quality monitoring visits undertaken on behalf of the registered provider/manager for December 2016 and January 2017
- the patient register.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 21 November 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 21 April 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 27(4) **Stated:** First time	The registered person must ensure that fire safety practices are adhered to at all times and that compliance monitoring is in place. **Action taken as confirmed during the inspection**: Following the previous care inspection the registered person confirmed, by email, on 25 April 2016 and in the returned QIP that a process/system was in place to monitor compliance with fire safety practices. At the commencement of this inspection it was observed that the fire exit route to the rear of the ground floor was again obstructed as was the rear kitchen/laundry corridor. Details in relation to the findings are discussed section 4.3 This requirement is now stated for a second time.	**Not Met**
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 4.9 **Stated:** First time	The registered person should ensure contemporaneous recording of repositioning records. **Action taken as confirmed during the inspection**: Review of patient repositioning records evidenced that this recommendation had been met.	**Met**

4.3 Is care safe?

The nurse in charge confirmed the planned daily staffing levels for the home. A review of the staffing rota evidenced that the planned staffing levels were adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. However review of the duty rotas and discussion with staff confirmed that staffing levels were reduced over the afternoon/evening period to one nurse and four care assistants for 35 patients from 18:00 hours; until night staff come on duty. Staff described difficulties in meeting patients' needs in a timely manner and in particular over the tea time period as approximately 45% of patients accommodated, on the day of the inspection, required assistance to eat and drink. A recommendation was made that staffing levels are reviewed from 18:00 hours to ensure patients' needs are met.

Staff spoken with confirmed that they were required to attend mandatory training. Staff demonstrated their knowledge, skill and experience necessary to fulfil their role, function and responsibilities in general and specifically in relation to adult safeguarding.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and that these assessments were generally reviewed regularly. However, concerns regarding the process of assessment, care planning and review were discussed with the nurse in charge as follows:

- one patient's record did not contain any risk assessments or care plans. While RQIA acknowledge that the DHSSPS Care Standards for Nursing Homes – Standard 4.1 states that the assessment was to be "completed within five days of admission to the home;" it was concerning that no risk assessments or care plans had been undertaken on the day of admission given the complex needs of the patient
- a second patient's care records indicated serious concerns regarding the safe use of bed rails. Nursing staff had recorded on 2 April 2017 that the patient had attempted to "climb over" the bedrails. There was no evidence that nursing staff had reviewed the bedrail risk assessment and no care plan was in place to manage the use of the bedrails. Details were discussed with the nurse in charge who agreed to monitor the patient, review the bedrail risk assessment to determine if their use was still appropriate and to contact the patient's care manager. A requirement was made

Review of records pertaining to accidents/incidents since 16 January 2017 confirmed that accidents and incidents were managed appropriately. However, from the records reviewed it was evident that RQIA had not been notified of at least five accidents/incidents in accordance with regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. The information was shared with the registered provider/manager by telephone who agreed to review accident records back to 1 June 2016 and to submit retrospective notifications as required; a requirement was made.

A review of the premises was undertaken and included observations of a number of bedrooms, bathrooms, lounge/s, dining rooms and storage areas. The home was found to be warm and clean throughout. Housekeeping staff were commended for their efforts.

Observations and discussion with staff evidenced that infection prevention and control measures were adhered to with the only exception in relation to storage in bathrooms. Following discussion a variation application to change the use of a bathroom was submitted to RQIA. If approved, this change of use should assist in addressing storage concerns.

At the commencement of this inspection it was observed that the fire exit route to the rear of the ground floor was again obstructed as was the rear laundry/kitchen corridor. The rear exit route was obstructed by a ping pong table and a large garden chair/swing and stand. Staff were unsure how long the items had been stored in this position. In addition storage boxes were observed to be stacked in the rear laundry/kitchen corridor leading to the fire exit.

The nurse in charge advised the inspector she would arrange for the corridors to be cleared However, at the conclusion of the inspection the ping pong table had still not been removed.. A telephone call to the home on 6 April 2017 confirmed that the ping pong table had now been removed.

A notice/memo to staff was displayed in the nurses' station to remind staff to keep fire exits and routes clear and a daily task record identified a staff member to this on a daily basis. However, given the inspection findings RQIA were concerned regarding the effectiveness and management of fire safety.

As the management team were not available, during the inspection, due to leave arrangements, the nurse in charge and the administrator were advised that the corridors must be maintained clear of obstruction and that nursing staff must record the action they had taken to ensure fire safety practices were adhered to.

It was evident that the previous requirement had not been met and following discussion with RQIA's senior management the registered provider/manager was contacted on 10 April 2017, when she was returned from leave, and asked to attend a serious concerns meeting in RQIA to provide assurances that the areas of concern identified in relation to fire safety would be addressed.

At this serious concerns meeting, on 12 April 2017, RQIA were provided with assurances that the concerns had been addressed in full and that a management plan was in place to ensure compliance.

Details of the inspection findings and the serious concerns meeting assurances were also shared with the senior estates inspector and the Northern Ireland Fire and Rescue Service (NIFRS).

Areas for improvement

A recommendation was made that staffing levels are reviewed from 18:00 hours to ensure patients' needs are met.

A requirement was made that risk assessments and associated care plans are regularly reviewed and revised at any time when it is necessary to do so having regard to any change of circumstances.

A requirement was made that accidents/incidents occurring in the home are notified to RQIA in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 – regulation 30.

A requirement was stated for the second time in relation to the management of fire safety practices

Number of requirements	3	**Number of recommendations**	1

4.4 Is care effective?

Care records generally reflected the assessed needs of patients; and where appropriate, recommendations prescribed by other healthcare professionals such as TVN, SALT,OT, physiotherapists and/or dieticians were included in the care plan. One care plan relating to SALT recommendations did not reflect the most recent SALT visit – nursing staff agreed to address this matter. Records pertaining to the management of wounds were evidenced to be maintained to a good standard. A requirement has been made in relation to review of risk assessments and care plans; refer to section 4.3 for details.

Registered nurses were aware of the local arrangements and referral process to access other healthcare professionals.

Observations and feedback from patients evidenced that call bells were answered promptly and requests for assistance were responded to in a calm, quiet and caring manner.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Records were maintained in accordance with Regulation 19 (1) (a), Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005. Supplementary care charts such as repositioning/food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements.

Staff confirmed that they were kept informed of changes or concerns regarding patients' needs through the verbal and written handover reports at the beginning of their shift

Staff stated that there was 'good teamwork'; this was evidenced through discussion and observation of interactions throughout the inspection process. Each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the manager. All grades of staff consulted demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

Effective communication with patients and their representatives was evident on a one to one basis as recorded in the care records. Patients consulted confirmed that they received "good care" and that the staff were "kind and attentive".

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated knowledge of patients' wishes and preferences. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Patients and staff confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

Consultation with patients individually and with others in smaller groups, confirmed that living in Richmond was a positive experience. Patients said that they enjoyed sitting in the lounge or their bedroom, that the care they received was good and that the choice and quality of the food was “excellent. All advised that the staff “were great”. It was evident that patients knew staff and the management team well.

In addition to speaking with patients and staff during the inspection, RQIA provided questionnaires for distribution after the inspection. Eight were issued for patients and 10 for relatives/representatives and staff. At the time of writing this report, none had been returned within the timeframe specified. Any comments from patients, patient representatives and staff in returned questionnaires received, after the issue of this report, will be shared with the registered provider/manager for their information and action as required.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.6 Is the service well led?

Discussion with staff evidenced that there was a clear organisational structure within the home. Staff easily described their role and responsibility in the home. In discussion, patients were also aware of the roles of the staff in the home and to whom they should speak to if they had a concern.

Staff were knowledgeable of the complaints and adult safeguarding processes commensurate with their role and function.

The home’s registration certificate was up to date and displayed appropriately. A valid certificate of public liability insurance was displayed. Discussion with the nurse in charge and review of records evidenced that the home was operating within its registered categories of care.

Review of records evidenced that quality monitoring visits were completed on a monthly basis by a person independent of the home. This is good practice. An action plan was generated to address any areas for improvement. Copies of the reports for February and March 2017 were not available on the day of the inspection. However, the registered provider/manager provided RQIA with evidence on 12 April 2017 that the reports had been completed.

Areas relating to governance and quality control will be reviewed during the next care inspection.

Based on the inspection outcomes as detailed in the preceding domains, it was evident that improvements were needed in respect of the day to day management of fire safety precautions; however, the care delivered was observed to be safe, effective, compassionate and well led. Compliance with the requirements and recommendations made will further enhance the quality of care, treatment and services provided.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the nurse in charge of the home, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP via RQIA web portal for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 27 (4) **Stated:** Second time **To be completed by:** Immediate action required.	The registered person must ensure that fire safety practices are adhered to at all times and that compliance monitoring is in place. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: The items were removed during the inspection before the inspector left. Notices put in place to remind all staff and delivery people not to leave items in this space. All staff reminded to keep these areas clear and to be vigilant while on each shift. Night staff record this on nightly fire check sheet.
Requirement 2 **Ref:** Regulation 15 (2) **Stated:** First time **To be completed by:** 15 May 2017	The registered provider must ensure that risk assessments and associated care plans are regularly reviewed and revised at any time when it is necessary to do so having regard to any change of circumstances. **Section 4.3**
	Response by registered provider detailing the actions taken: All RN staff reminded to update risk assessments as change occurs as well as monthly updates. This is monitored in monthly Care Plan Audits.
Requirement 3 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** 15 May 2017	The registered provider must ensure that accidents/incidents occurring in the home are notified to RQIA in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 – regulation 30. Accidents/incidents dating back to 1 June 2016 should be reviewed and retrospective notifications submitted as required. Refer to RQIA's guidance; A Statutory Notification of Incidents and Deaths: Guidance for Registered Providers and Managers of Regulated Services, July 2015, which is available on the web site www.rqia.org.uk **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: All retrospective notifications have been submitted to RQIA and any accidents/incidents since date of inspection also submitted. RN staff aware of this.

Recommendations	
Recommendation 1 **Ref**: Standard 42 **Stated:** First time **To be completed by:** 15 May 2017	The registered provider should ensure that staffing levels are reviewed from 18:00 hours to ensure patients' needs are met. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Staffing levels are continually reviewed to ensure residents' needs are met.

Please ensure this document is completed in full and returned via RQIA web portal

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