Unannounced Care Inspection Report
21 April 2016

Richmond

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Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Richmond took place on 21 April 2016 from 10:30 to 16:30 hours.

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

Is care safe?
Concerns were identified in the delivery of safe care, specifically in relation to the management of fire safety risks. Records evidenced management were aware of the issues but had not effectively and consistently addressed practice deficits in the area. A requirement was made in relation to fire safety practices.

Is care effective?
There was evidence of positive outcomes for patients through the competent delivery of safe and effective care. However, one recommendation was made in relation to the accurate recording of care delivery on repositioning charts.

Is care compassionate?
Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. All patients spoken with were very complementary regarding the staffs' attitude and attentiveness to detail.

There was evidence of good communication in the home between staff, patients, relatives and other healthcare professionals. Patients were very complimentary of staff. There was evidence of patient, representative and staff consultation.

There were no areas for improvement identified in the delivery of compassionate care.

Is the service well led?
There was evidence of systems and processes in place to monitor the delivery of care and services within Richmond Nursing Home. In considering the findings of this inspection and that one requirement was made within the safe domain and one recommendation made within the effective domain; this would indicate the need for more robust management and leadership in the home.

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	1	1

Details of the QIP within this report were discussed with Mrs Sharon Ruth Radcliffe-Bryans, registered person, and the assistant manager as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result 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 dated 19 November 2015.

Other than those actions detailed in the previous QIP there were no further actions required.

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: Mrs Sharon Ruth Radcliffe- Bryans	**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 records:

- notifiable events since the previous 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 the inspector met with six patients individually and with others in smaller groups; two visitors/ representatives; three care staff, three nursing staff, the home's administrator and a quality monitoring consultant.

The following records were examined during the inspection:

- four patient care records including care charts
- staff roster 11-24 April 2016
- staff training matrix and planner for 2016
- one staff recruitment record
- complaints record
- incident and accident records
- record of quality monitoring visit carried out on behalf of the responsible individual
- records of audit
- minutes of staff meetings
- patient/ relative satisfaction survey April 2015.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 19 November 2015

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

There were no areas of concern which required follow up at this time.

4.2 Review of requirements and recommendations from the last care inspection dated 5 May 2015

There were no requirements made as a result of the last care inspection.

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 35 (3) **Stated:** First time	The registered person must ensure the availability and staff awareness of current and relevant minimum standards and practice guidance in relation to communicating effectively, breaking bad news and palliative/ end of life care.	**Met**
	Action taken as confirmed during the inspection: Observation and discussion with staff confirmed that this recommendation had been met.	

Recommendation 2 **Ref**: Standard 39 (4) **Stated:** First time	The registered person must ensure that training for staff in relation to communicating effectively, breaking bad news, palliative and end of life care is provided. Records of all learning in the home should be maintained in accordance with minimum standards.	**Met**
	Action taken as confirmed during the inspection: Review of training records and discussion with staff confirmed that this recommendation had been met.	
Recommendation 3 **Ref**: Standard 36 **Stated:** First time	The registered person must ensure that policies and procedure relating to communicating effectively, breaking bad news, palliative and end of life care are reviewed to reflect current minimum standards and regional guidance.	**Met**
	Action taken as confirmed during the inspection: Review of the policies and procedures listed in the recommendation confirmed that this recommendation had been met.	
Recommendation 4 **Ref**: Standard 4 (4) **Stated:** First time	The registered person must ensure that when specialist healthcare professionals issue recommendations, following a visit to a patient that the patient's care plans are reviewed to reflective the 'current' recommendations made and that the 'out of date' recommendations are archived.	**Met**
	Action taken as confirmed during the inspection: Review of patient care records and discussion with nursing staff confirmed that this recommendation had been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met.

A review of the staffing rota from 11 to 24 April 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives and staff 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.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Staff confirmed that they were provided with a mentor who assisted them to complete their induction programme. Review of one staff member's induction evidenced the record to be completed in full and signed/ dated appropriately.

Review of the training matrix/ schedule for 2016 indicated that training was planned to ensure that mandatory training requirements were met. Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training. Through observation and discussion staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding procedures.

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of records regarding the management of falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. Staff made use of a 'safety cross' to record when a fall occurred to raise staff awareness. The safety cross was displayed discreetly in the nursing office.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since 5 May 2015 confirmed that these were appropriately managed. Nursing staff confirmed their knowledge of the notification process to RQIA along with the process for making referrals to other healthcare professionals such as dieticians and speech and language therapists.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, the lounge and dining rooms. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients, representatives and staff spoken with were complimentary in respect of the home's environment.

The registered manager confirmed that a refurbishment programme was currently taking place. This had resulted in some issues with storage in the 'back corridor' being identified by the person undertaking the monthly monitoring visit conducted in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. Observation of the back corridor area evidenced that a range of patient equipment such as specialised wheelchairs and hoists as well as additional furniture items such as bookcases and chairs were stored along both walls of the corridor, obstructing the exit to the fire door.

In addition, a bookcase, a round metal patio table and a chair had been stored on the 'landing' area of the rear staircase leading to the fire exit.

Review of the Regulation 29 monitoring visit reports since November 2015 evidenced that the person undertaking these visits had identified the fire safety risk of storage in the 'back corridor' on the 10 November 2015 and had made a recommendation to address this matter. Subsequently the report for December 2015 evidenced that the concern had been addressed. However, the issue was again raised as a concern within the monitoring visits report dated 31 March 2016.

As a result of the inspection findings and because of the potential risk and impact on patient and staff safety it was emphasised to the registered manager and assistant manager that this corridor and staircase must be kept clear of obstruction, at all times, and compliance with fire safety practices monitored. This was followed up, post inspection, with an email sent to Mrs Bryans, registered person, requesting confirmation of the action taken immediately following the inspection. Confirmation of the action taken by the registered person was received, by email, on 25 April 2016.

However, following review of the Regulation 29 reports and the observations during the inspection a requirement was made in relation to fire safety practices.

Areas for improvement

A requirement was made in relation to the adherence to fire safety practices at all times and to ensure compliance monitoring is put in place.

Number of requirements	**1**	**Number of recommendations**:	**0**

4.4 Is care effective?

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was also evidence that risk assessments informed the care planning process. There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Care records accurately reflected the assessed needs of patients, and evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines.

Recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians were reflected within the care plans and evaluated daily by nursing staff following the delivery of the care. Nursing staff were aware of the referral arrangements to other healthcare professionals.

Supplementary care charts such as repositioning records were reviewed for four patients observed to be nursed in bed. Records generally identified the frequency of repositioning as prescribed within the patients' care plans. However, all four charts evidenced that the patient had not been repositioned for up to eight hours, between 15:00 and 23:00.

Discussion with nursing staff confirmed that the identified patients' pressure areas and skin were 'intact' and they believed that the care was delivered but not recorded accurately.

During feedback details were again discussed with the registered manager and assistant manager and a recommendation was made.

Discussion with staff confirmed that they were required to attend a handover report before commencing duty and that a staff meeting was held every Tuesday; records were maintained. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and/ or the registered manager. Staff voiced the opinion that the team worked well because management were approachable and available.

All grades of staff consulted, clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Discussion with the registered manager and review of records evidenced that patient and/ or relatives meetings were generally held every three months. Minutes were available. Patients confirmed that they attended meetings and were aware of the dates of the meetings in advance. However, patient and representatives spoken with expressed their confidence in raising concerns with the home's staff and management. Patients and representatives were aware of who their named nurse was and knew the registered manager. One patient, in respect of the assistant manager, stated 'I could talk to her about anything; she is what a nurse should be'.

Areas for improvement

A recommendation was made in relation to contemporaneous recording of repositioning records.

Number of requirements	**0**	**Number of recommendations**:	**1**

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. All patients spoken with were very complementary regarding the staffs' attitude and attentiveness to detail.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

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.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

A detailed two week activity programme was in place. Discussion and observations confirmed that patients had received a copy of the programme as well as a copy being available on the notice board in the foyer. Review of the programme and discussion with the activity therapist and patients evidenced that patient's views were sought regarding the programme and the content of the activity. The activity therapist demonstrated enthusiasm and motivation to ensure a positive and enjoyable experience was achieved for each patient through participation in planned activities and events. While patients all expressed enjoyment regarding individual sessions; particular favourites were the 'Afternoon Tea Party' and the visit from a tiny horse. Photographs viewed showed patients and staff enjoying a spread of finger food and pastries elegantly presented in the usual afternoon tea party tradition; and patients and staff petting the tiny horse who was 'house trained'.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. As stated in section 4.4 one patient in respect of the assistant manager said, 'I could talk to her about anything; she is what a nurse should be'.

To ensure patients, relatives and staff were consulted with, in relation to the quality of service provision and care, the registered manager had employed a quality monitoring consultant who conducted regular audits such as the environment and completion of care records. As discussed later in section 4.6 the outcomes from these audits were recorded and deficits responded to. In addition the owner/ provider who is also the registered manager had opted to have Regulation 29 visits conducted by an independent person rather than conducting them herself. This is good practice and beneficial in assuring patients, relatives and staff that the home is operated to promote the quality of care and experience.

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 the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion, patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussion with the registered manager and assistant manager; and observations evidenced that the home was operating within its registered categories of care.

Policies and procedures were indexed, dated and approved by the registered person. Staff confirmed that they had access to the home's policies and procedures.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Staff were knowledgeable of the complaints process

Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients confirmed that they were confident that staff/ management would address any concern raised by them appropriately.

Discussion with staff and review of training records evidenced that staff were required to attend/ completed mandatory training. Monitoring was in place to ensure compliance with mandatory requirements. Staff also confirmed that additional training was made available to ensure staff met the assessed needs of patients.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. A review of notifications of incidents to RQIA since the last care inspection also confirmed that these were managed appropriately.

Discussion with staff and the quality monitoring consultant and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits undertaken included care records, infection prevention and control, environment and incidents/ accidents. Nursing staff stated clearly that they thought the care record audit to be particularly effective. Examples of the care record audit outcomes were viewed within the care records reviewed.

Management confirmed that the results of audits were analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice. However, a recommendation was made in relation to the contemporaneous recording of repositioning records as detailed in section 4.4 which audits had not identified. It was discussed, during feedback, that management should consider the inclusion of additional care charts within the care record audit.

Monitoring visits were undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. Records from November 2015 to 31 March 2016 were reviewed and discussed with, the registered manager. As stated in section 4.3 concerns were raised following the observation of the 'back corridor', the rear staircase leading to the fire exit and review of the records. Regulation 29 reports and observations during this inspection evidenced that management were aware of the issues but had not effectively and consistently addressed practice deficits in the area. A requirement was made.

These findings and the potential risk and effect on patient safety were considered in relation to this domain; and would indicate the need for more robust management and leadership in the home.

Areas for improvement
*A requirement was made in section 4.3 in relation to the adherence to fire safety practices at all times and to ensure compliance monitoring is in place.

*A recommendation was made in section 4.4 in relation to the contemporaneous recording of repositioning records.

Number of requirements	***1**	**Number of recommendations**:	***1**

5.0 Quality improvement plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Sharon Ruth Radcliffe-Bryans, Registered Person, 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on 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 person may enhance service, quality and delivery.

5.3 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.

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 service. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/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 person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 27(4) **Stated:** First 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 4.3 and 4.6
	Response by registered person detailing the actions taken: Evening RN is responsible for ensuring this is monitored daily and this was actioned with immediate effect on 21 April 2016. This was observed by the Estates Inspector on 28 April 2016.
Recommendations	
Recommendation 1 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** Immediate action required.	The registered person should ensure contemporaneous recording of repositioning records. Ref: Section 4.4 and 4.6
	Response by registered person detailing the actions taken: This is monitored daily by the RN in charge.

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

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