Tennent Street
RQIA ID: 1302
Sandringham Suite
1 Tennent Street
Belfast
BT13 3GD

Inspector: Heather Sleator
Inspection ID: IN021718

Tel: 028 9031 2318
Email: tennent.street@fshc.co.uk

Unannounced Care Inspection
of
Tennent Street – Sandringham Suite

28 January 2016

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 28 January 2016 from 09.45 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: Heath Care
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. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

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 20 May 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	1

The details of the Quality Improvement Plan (QIP) within this report were discussed with Jackie Cairns, 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 Health Care Dr Maureen Claire Royston	**Registered Manager:** Jacquelyn Cairns
Person in Charge of the Home at the Time of Inspection: Jacquelyn Cairns	**Date Manager Registered:** 1 April 2005.
Categories of Care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 17
Number of Patients Accommodated on Day of Inspection: 17	**Weekly Tariff at Time of Inspection:** £593 per week

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, criterion 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, criterion 4**

4. Methods/Process

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

- discussion with the registered manager
- discussion with patients
- discussion with three patient representatives
- discussion with staff on duty during the inspection
- review of a selection of records
- observation during a tour of the premises
- evaluation and feedback

Prior to inspection the following records were analysed:

- inspection report and quality improvement plan (QIP) from the previous care inspection on 20 May 2015
- incident reports submitted in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005

During the inspection, the inspector met with approximately 15 patients, three care staff, ancillary staff and one registered nurse.

The following records were examined during the inspection:

- policies and procedures pertaining to the inspection focus
- staff duty rota
- three patient care records
- staff training records

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an announced estates inspection dated 8 December 2015. The completed QIP was returned and approved by the specialist inspector.

5.2 Review of Requirements and Recommendations from the last care inspection dated 20 May 2016

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref:** Standard 32.1 **Stated:** First time	A system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the organisation, in respect of communicating effectively and palliative and end of life care.	**Met**
	Action taken as confirmed during the inspection: A reference folder in respect of palliative and end of life care was available in the unit for staff to access. The folder contained the organisations most recent updated policies regarding communicating effectively and palliative and end of life care. Policy documentation had been read by all staff and their signature and date of reading was stated.	
Recommendation 2 **Ref:** Standard 44.1 **Stated:** First time	A programme of redecoration should be implemented. A gradual programme of the refurbishment of communal areas, for example, lounge and dining area should also be implemented and in conjunction with the redecoration of the home.	**Met**
	Action taken as confirmed during the inspection: The lounge, dining room and corridors had been repainted from the time of the last inspection. New soft furnishings had also been purchased.	

Areas for Improvement

There are no areas for improvement within the review of requirements and recommendations from the last care inspection.

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

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 organisational, regional and national guidelines. Information within the reference folder included:

- Improving Continence Care for Patients (RCN)
- Continence Care in Care Homes (RCN)
- Catheter Care (RCN)
- Guidance on the management of indwelling urinary catheters (SHSCT)
- Urinary Incontinence (NICE).

There was evidence of guidance documentation made available for staff to read. A signature sheet was also available to evidence the date the information had been read and by whom.

Discussion with staff and the registered manager confirmed that training relating to the management of the urinary and bowel continence care had been completed by 14 staff in July 2015 and stoma care management training had been scheduled for 29 January 2016. The registered manager also informed the inspector that there was support, and training opportunities from the local health and social care trust, if staff required an update in their training of catheterisation and/or the management of stomas. Two registered nurses had their competency verified in respect of male catheterisation in August 2015.

There was an identified link nurse for continence management.

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 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 in the care records. The assessment which was reviewed identified the patient's individual continence needs. A care plan was in place to direct the care to meet the needs of the patients. Care plans included information regarding the specific type of continence aid required.

There was evidence in the patients' care records that the assessment 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. Care plans referred to patients normal bowel patterns and care staff maintained a record using the Bristol Stool chart of bowel movements. Nursing staff stated patients' bowel function is monitored on a daily basis by care staff who maintain an individual record. However, there was no evidence in patient's progress records that nursing staff were monitoring and evaluating patients' bowel function. A recommendation has been made.

Fluid targets had been identified within the patient care records and any shortfall of these targets was clearly recorded to include actions taken to address the shortfall.

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

The management of urinary catheters was reviewed. Registered nurses (RNs) spoken with were knowledgeable regarding the management of urinary catheters and the rationale for the use of urinary catheters. Urinary catheters were only inserted on the instructions of the patient's GP or consultant.

Care plans relating to the management of urinary catheters did contain information regarding the frequency of changing the catheter in accordance with the type and evidenced based practice and that 'catheter care' was to be provided.

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

Is Care Compassionate? (Quality of Care)

Discussion with the registered manager confirmed where patients or their families have a personal preference for the gender of the staff providing intimate care their wishes would be respected, as far as possible. Arrangements were in place for the deployment of staff, if required, to ensure that patients' wishes were adhered to.

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

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

Patients who could not verbally communicate appeared well presented and displayed no signs of distress. The patients appeared comfortable in their surroundings.

Areas for Improvement

Evidence should be present in patient care records that nursing staff monitor patients' bowel function.

Number of Requirements:	**0**	**Number of Recommendations**:	**1**

5.4 Additional Areas Examined

5.4.1. The Environment

An observational tour of the home confirmed a high standard of cleanliness and hygiene was evident. All areas of the home were viewed and discussions were held with housekeeping staff. Staff were very clear as to their role and had an organised approach to their duties.

The corridors, lounge and dining room had been repainted and new soft furnishings had been purchased. New flooring had also been purchased for the dining room and it was stated that it was due to be laid in the near future. The home was well presented.

5.4.2. Patient and Representatives Views

During the inspection process, 15 patients, three care staff, one ancillary staff member and one registered nurse were consulted with to ascertain their personal view of life in Sandringham unit. The feedback from the patients, representatives and staff indicated that safe, effective and compassionate care was being delivered.

Patients expressed their satisfaction with the care afforded to them by staff.

Comments included:
'I love it here.'
'It's brilliant in here.'
'I love the staff; they would do anything for you.'

Three relatives met with the inspector. The relatives were very happy with the environment of the home and with the care and approach of staff stating, "they look after the patients very well and do everything they can."

Areas for Improvement

There were no areas for improvement identified.

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

6. Quality Improvement Plan

The issue identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Jackie Cairns, 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 4.9 **Stated:** First time **To be Completed by:** 15 March 2016	The registered person shall ensure registered nurses evidence the monitoring of patients bowel function in care records. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Registered nurses now evidence the monitoring of patients bowel function in the daily progress notes

Registered Manager Completing QIP	Jackie Cairns	**Date Completed**	23.2.2016
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	24.02.16
RQIA Inspector Assessing Response	Heather Sleator	**Date Approved**	24.02.16

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