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Unannounced Care Inspection of Victoria

9 February 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 9 February 2016 from 09.45 to 16.00.

The focus of this inspection was continence management which was underpinned by selected criteria from DHSSPS Care Standards for Nursing Homes, April 2015:

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, 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.

For the purposes of this report, the term ‘patients’ will be used to described those living in Victoria 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 12 May 2015

1.2 Actions/Enforcement Resulting from this Inspection

As a result of the inspection, RQIA were concerned that the quality of care and service within Victoria was below the minimum standard expected. The findings were reported to senior management in RQIA, following which a decision was taken to hold a serious concerns meeting. The inspection findings were communicated in correspondence to the Registered Person, Dr Robert Francis Alistair Lynas, and a meeting took place at RQIA on 16 February 2016. At this meeting an action plan was submitted by the registered person and registered manager as to how and when the concerns raised at the inspection would be addressed.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	5*	11*

*The total number of requirements and/or recommendations includes 1 requirement stated for the second time and four recommendations stated for the second time.

The details of the Quality Improvement Plan (QIP) within this report were discussed with Helen Chambers, 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: Belfast Health and Social Care Trust Dr Robert Francis Alistair Lynas & Mrs Helen Lynas	Registered Manager: Helen Chambers
Person in Charge of the Home at the Time of Inspection: Helen Chambers	**Date Manager Registered:** 1 April 2005.
Categories of Care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 33
Number of Patients Accommodated on Day of Inspection: 29	**Weekly Tariff at Time of Inspection:** Nursing - £593 - £636 per week Residential - £526 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, 8and 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 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 12 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, two 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
- quality audits including audits of care records, infection prevention and control and accidents
- Regulation 29 monthly monitoring reports

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 12 May 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref:** Regulation 17 (1) **Stated:** First time	The registered person must implement a robust system to review the quality of nursing and other services provided by the home. Audits should be present of the review of: • nursing care records • infection control procedures • accident records	**Partially Met**
	Action taken as confirmed during the inspection: Quality monitoring audits in relation to accidents had been completed on a monthly basis by the manager. However, the manager was unable to provide the evidence that audits in relation to infection prevention and control and care records had been completed from the date of the previous inspection. **This matter is raised for a second time as a consequence of this inspection**	
Requirement 2 **Ref:** Regulation 30 **Stated:** First time	The registered person must endure RQIA are informed of any accident or event which occurs in the home in accordance with the requirement of Regulation 30.	**Met**
	Action taken as confirmed during the inspection: The review of the accident record and incident notifications evidenced accident recording and incident reporting were in accordance with regulatory and best practice guidelines.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref:** Standard 4.9 **Stated:** First time	Nursing staff should adhere to professional standards in respect of care records. The registered person should monitor nursing staff adherence to NMC guidelines	**Not Met**
	Action taken as confirmed during the inspection: The review of patient care records did not evidence a consistent approach by nursing staff to the assessing, planning and review of care. The manager was unable to evidence that there was a systematic approach to the quality auditing of care records and that a robust approach to auditing had been implemented. **This matter is raised for a second time as a consequence of this inspection**	
Recommendation 2 **Ref:** Standard 19.6 **Stated:** First time	Training on communicating effectively should be provided for staff. The training should be in accordance with DHSSPS 'Breaking Bad News' regional guidelines.	**Not Met**
	Action taken as confirmed during the inspection: Training records did not evidence that this training had been provided for staff from the date of the last inspection. **This matter is raised for a second time as a consequence of this inspection**	
Recommendation 3 **Ref:** Standard 32.1 **Stated:** First time	Training on palliative and end of life care should be provided to staff. Training provided should be in accordance with regional guidance, for example, Gain Palliative Care Guidelines 2013.	**Not Met**
	Action taken as confirmed during the inspection: Training records did not evidence that this training had been provided for staff from the date of the last inspection. **This matter is raised for a second time as a consequence of this inspection**	

Recommendation 4 Ref: Standard 32.1 Stated: First time	Patients' care records should reflect that individuals' wishes regarding end of life care have been considered, as far as possible.	Not Met
	Action taken as confirmed during the inspection: Care records did not evidence that patients' wishes and/or preferences in respect of end of life care had been discussed. **This matter is raised for a second time as a consequence of this inspection**	

Areas for Improvement

One requirement and four recommendations have been stated for a second time as compliance could not be verified at the time of the inspection.

Number of Requirements:	1	Number of Recommendations:	4

5.3 Continence Management

Is Care Safe? (Quality of Life)

Policies and procedures to guide staff regarding the management of continence were not available at the time of the inspection. The registered manager stated copies of the regional and national guidelines were not available in the home. This was discussed with the registered manager and it was agreed an up to date policy in relation to continence management would be made available and shared with staff. The following regional and national guidelines would also be made for staff to reference:

- 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)

The registered manager should also implement a system to evidence the date the policy documentation had been read and by whom. A recommendation is stated.

Discussion with staff and the registered manager failed to confirm that training relating to the management of urinary and bowel continence care had been completed for all staff. However two clinical nurse facilitators from the local health care trust provided five members of staff with the management of catheter care during the time of the inspection. Further dates for similar training have yet to be identified for the remaining staff. A recommendation is stated.

A link nurse for continence management had not been identified.

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. The review of fluid intake recording and repositioning confirmed that staff were diligent in this area.

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 did not evidence that a continence assessment was in place in the care records. Only one care record had a completed continence assessment. A comprehensive continence assessment which includes faecal incontinence should be completed for all patients. A recommendation for a completed assessment schedule regarding continence management is subsumed into requirement 2, of this report, in respect of the completion of patient's assessment of need. Care plans were 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. However, the completion of a robust continence assessment should inform the corresponding care plan to ensure the effective and appropriate delivery of continence care.

There was evidence in the patients' care records that the continence care plans were reviewed on a monthly basis. However, the review of patient care records evidenced that registered nurses were not care planning using a specific, measurable and person centred approach. For example, the progress records of the patient's response to planned care stated, 'incontinence care given' and 'care of incontinence'. The inspector provided other examples during feedback and the manager agreed that these statements were not 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 of bowel movements. However, care staff were not using the Bristol Stool chart as a reference source. A recommendation is stated. Nursing staff stated patients' bowel function is monitored on a daily basis by care staff who maintain an individual record and report to the nurse on duty. However, there was no evidence in patients progress records that nursing staff were monitoring and evaluating patients' bowel function. A recommendation is stated.

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

Review of patient's care records did not evidence that patients and/or their representatives were informed of changes to patient need and/or condition and the action taken. A recommendation is stated.

Is Care Compassionate? (Quality of Care)

Discussion with the registered manager confirmed that when 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.

Areas for Improvement

It is recommended that the relevant policy documentation and regional guidance is made available for staff's reference. Evidence should be maintained to verify that staff have read the documentation.

It is recommended that further staff training is sought for all staff who have not yet received training on continence management.

A recommendation that all patients have a continence assessment completed has been subsumed into requirement 2 of the quality improvement plan of this report.

It is recommended that staff reference the Bristol Stool chart when recording patient's bowel function.

It is recommended that nursing care records evidence that registered nurses are monitoring and evaluating patients' bowel function.

It is recommended that evidence should be present that patients' representatives have been informed of any change in care needs.

Number of Requirements:	**0**	**Number of Recommendations**:	**5**

5.4 Additional Areas Examined

5.4.1. Nursing Care Records

The review of three patients care records evidenced a number of concerns. The concerns were in relation to the use of restrictive practice, palliative care and wound care management.

Restrictive practice

A patient was observed sitting in a specialised chair which restricted mobility. There was no evidence within the patient's care record that the use of restrictive practice had involved consultation with the multidisciplinary team prior to it being used as outlined in best practice. There was no evidence that the patients and/or their representatives had been consulted in relation to the use of restrictive practice. A recommendation is made.

Palliative care

The review of one patient's care record did not evidence that the palliative care needs and wishes of the patient had been discussed and planned for. A care plan in respect of the patient's palliative needs was not present.

This had been a recommendation of the inspection of 12 May 2015. A recommendation had also been made, at this time, that training regarding palliative and end of life care should be provided for staff. The review of staff training records did not evidence this training had been provided. This recommendation has been stated for a second time.

Wound care management

The review of one patient's care record did not evidence that wound care management was being undertaken in accordance with best practice (NICE) guidelines. Wound care documentation was not appropriately maintained. A recommendation is stated.

Records and record keeping

There was a lack of evidence that registered nurses were completing and maintaining patients care records, as detailed above, in accordance with NMC guidelines. This was also a recommendation of the previous inspection of 12 May 2015. This recommendation is stated for a second time. Requirements have been made regarding the assessment of patient need and care planning.

Governance and management arrangements

Concerns were raised in relation to the completion of the monthly monitoring reports as required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. A review of these reports evidenced that the last available report was dated March 2015. A requirement is stated.

5.4.2. Safe working practices

A number of third party bedrails were observed to be in use. Discussion with the registered manager confirmed that a system to check the positioning of the bedrails was in use however the system was not in accordance with DHSSPS guidance document 'Safe use of Bedrails' November 2012. This document was forwarded to the manager following the inspection. A recommendation is stated..

5.4.3. Patients Views

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

Some patients' comments received are detailed below:
'The staff are so good.'
'It's very good.'
'Couldn't be better.'
'The food is delicious.'
'Staff are wonderful.'
'Staff look after me very well.'

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

Some staff comments received are detailed below:
'I really like it here.'
'I work for an agency and I like coming here to work.'
'I really enjoy it here.'

5.4.4. Registration Categories

At the previous inspection in May 2015, the registered manager gave assurances that an application for variation of registration would be submitted to RQIA. The application was in relation to three residential beds and has not yet been received by RQIA. If the registered manager wishes to continue to provide residential care an application for this category must be submitted to RQIA without delay. A requirement is stated.

Areas for Improvement

A requirement is stated to ensure that all patients received a comprehensive and detailed assessment of need which is used to inform the care planning process.

A requirement is stated to ensure that patient care plans are detailed and comprehensive in content, drafted in conjunction with the patient / and or their representative and based upon the findings of a professional assessment of need.

A requirement has been made that the Regulation 29 monthly monitoring reports are completed and retained in an up to date manner in the home and are available for viewing and/or inspection.

A requirement is stated that an application for variation of registration is submitted to RQIA in relation to residential beds with all due haste.

A recommendation is stated regarding the safe use of third party bedrails, in accordance with guidance issued by DHSSPS.

A recommendation is stated that wound care management is undertaken in accordance with best practice (NICE) guidelines and the relevant documentation is maintained.

Number of Requirements:	4	Number of Recommendations:	2

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Helen Chambers, 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

Statutory Requirements	
Requirement 1 **Ref:** Regulation 17 (1) **Stated:** Second time **To be Completed by:** 1 April 2016	The registered person must implement a robust system to review the quality of nursing and other services provided by the home. Audits should be present of the review of: • nursing care records • infection control procedures • accident records audits are established **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: • NURSING CARE RECORDS WILL BE AUDITED MONTHLY. • INFECTION CONTROL AUDIT COMPLETED. • ACCIDENT AUDITS ARE IN PLACE. AUDITED MONTHLY. EVIDENCE AVAILABLE
Requirement 2 **Ref:** Regulation 15 (2) **Stated:** First time	The registered person shall ensure that the assessment of patients' needs is fully completed and evidence of regular review is present. Assessments of need must include continence assessment. **Ref: Section 5.4.1**
To be Completed by: 1 April 2016	**Response by Registered Person(s) Detailing the Actions Taken:** MONTHLY AUDITS ARE NOW RETAINED AT THE FRONT OF PATIENTS INDIVIDUAL NOTES TO EVIDENCE REVIEW. ALL ASSESSMENTS WILL BE PART OF AUDIT
Requirement 3 **Ref:** Regulation 16 **Stated:** First time	The registered person shall ensure that the written nursing plan of any patient is in accordance with assessed need and kept under review. **Ref: Section 5.4.1**
To be Completed by: 1 April 2016	**Response by Registered Person(s) Detailing the Actions Taken:** PLAN OF CARE WRITTEN AS PER ASSESSMENTS WILL ALSO BE AUDITED MONTHLY. MANAGERS AUDIT WILL ~~REFLECT~~ REFLECT THIS.

Requirement 4 **Ref:** Regulation 29 **Stated:** First time **To be Completed by:** 1 April 2016	The registered person shall ensure an unannounced monthly visit to the home is undertaken, a report is written of the visit and is available to view on request. The monthly reports will be retained concurrently. **Ref: Section 5.4.2** **Response by Registered Person(s) Detailing the Actions Taken:** MONTHLY UNANNOUNCED VISITS WILL TAKE PLACE AND RECORDS RETAINED FOR INSPECTION - LAST VISIT 8-3-2016
Requirement 5 **Ref:** Regulation 3 (1) Schedule 1 **Stated:** First time **To be Completed by:** 1 April 2016	The registered person shall that patients are not admitted to the home outside of the current statement of purpose and registered categories of care. An application for variation to the registered categories of care in respect of the addition of residential care should be submitted with all due haste. **Ref: Section 5.4.5** **Response by Registered Person(s) Detailing the Actions Taken:** COMPLETED AND POSTED 5-3-2016
Recommendations	
Recommendation 1 **Ref:** Standard 4.9 **Stated:** Second time **To be Completed by:** 1 April 2016	It is recommended that nursing staff should adhere to professional standards in respect of care records. The registered person should monitor nursing staff adherence to NMC guidelines. **Ref: Section 5.2** **Response by Registered Person(s) Detailing the Actions Taken:** REGISTERED MANAGER WILL AUDIT THESE RECORDS AS PART OF MONTHLY CARE RECORD AUDIT TO ENSURE NMC GUIDELINES ARE ADHERED TO
Recommendation 2 **Ref:** Standard 19.6 **Stated:** Second time **To be Completed by:** 1 April 2016	It is recommended that training on communicating effectively should be provided for staff. The training should be in accordance with DHSSPS 'Breaking Bad News' regional guidelines. **Ref: Section 5.2** **Response by Registered Person(s) Detailing the Actions Taken:** THIS TRAINING WAS PROVIDED FOR NURSING STAFF 15-3-2016

Recommendation 3 **Ref:** Standard 32.1 **Stated:** Second time **To be Completed by:** 1 April 2016	It is recommended that training on palliative and end of life care should be provided to staff. Training provided should be in accordance with regional guidance, for example, Gain Palliative Care Guidelines 2013. **Ref: Section 5.2** **Response by Registered Person(s) Detailing the Actions Taken:** TRAINING TOOK PLACE 15·3·2016. THIS TRAINING WAS PROVIDED BY STAFF NURSING LTD.
Recommendation 4 **Ref:** Standard 32.1 **Stated:** Second time **To be Completed by:** 1 April 2016	It is recommended that patients' care records should reflect that individuals' wishes regarding end of life care have been considered, as far as possible. **Ref: Section 5.2** **Response by Registered Person(s) Detailing the Actions Taken:** NURSES ARE NOW WORKING THROUGH BHSCT DOCUMENT WITH THEIR PATIENTS WHOSE CARE IS PALLIATIVE. (✓ ADVANCE STATEMENT)
Recommendation 5 **Ref:** Standard 36 **Stated:** First time **To be Completed by:** 1 April 2016	It is recommended that policy documentation and professional guidelines in relation to continence management are made available for staff. Management should implement a system to evidence staff have read the documentation. **Ref: Section 5.3** **Response by Registered Person(s) Detailing the Actions Taken:** ALL RELEVANT POLICY AND GUIDELINES ARE RETAINED ON FILE AND STAFF DATED SIGNATURES ARE RECORDED AS EVIDENCE.
Recommendation 6 **Ref:** Standard 39.4 **Stated:** First time **To be Completed by:** 1 April 2016	It is recommended that further staff training is sought for all staff who have not yet received training on continence management. **Ref: Section 5.3** **Response by Registered Person(s) Detailing the Actions Taken:** STAFF NURSING LTD HAVE BEEN ASKED TO PROVIDE THIS TRAINING DATE AS YET NOT CONFIRMED. FURTHER TRAINING WILL BE GIVEN BY BHSCT 4-4-16 AT EVERTON COMPLEX

Recommendation 7 **Ref:** Standard 4.8 **Stated:** First time **To be Completed by:** 1 April 2016	It is recommended that staff use the Bristol Stool chart as a reference when reporting on patients bowel function. **Ref: Section 5.3** **Response by Registered Person(s) Detailing the Actions Taken:** PATIENTS BOWEL FUNCTION IS NOW REFERENCED WITH BRISTOL STOOL CHART. THIS HAS BEEN IN PLACE FROM 10-2-2016
Recommendation 8 **Ref:** Standard 4.7 **Stated:** First time **To be Completed by:** 1 April 2016	It is recommended that evidence is present in patient care records of the monitoring and evaluating of patients' bowel function by registered nurses. **Ref: Section 5.3** **Response by Registered Person(s) Detailing the Actions Taken:** NURSES REFER TO PATIENTS BOWEL FUNCTION RECORD ON A DAILY BASIS. MONITORING OF SAME IS RECORDED IN DAILY PROGRESS NOTES
Recommendation 9 **Ref:** Standard 4.2 and 4.11 **Stated:** First time **To be Completed by:** 1 May 2016	It is recommended that evidence is present on patient care records of the involvement/consultation with patients and/or representatives in the planning of care. **Ref: Section 5.3** **Response by Registered Person(s) Detailing the Actions Taken:** NURSING STAFF ARE NOW ASKING THEIR PATIENTS AND OR THEIR REPRESENTATIVES TO SIGN EACH CAREPLAN TO EVIDENCE PATIENT INPUT AND AGREEMENT WITH THEIR PLAN OF CARE

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Recommendation 10 **Ref:** Standard 4.8 **Stated:** First time **To be Completed by:** 1 April 2016	A recommendation is stated that wound care management is undertaken in accordance with best practice (NICE) guidelines and the relevant documentation is maintained. **Ref: Section 5.4.1** **Response by Registered Person(s) Detailing the Actions Taken:** A separate wound management file is in use. Documentation is in accordance with best practice.
Recommendation 11 **Ref:** Standard 47.1 **Stated:** First time **To be Completed by:** 1 April 2016	It is recommended that the use of third party bedrails is monitored in accordance with DHSSPS guidelines. **Ref: Section 5.4.3** **Response by Registered Person(s) Detailing the Actions Taken:** Bedrails (third party) are monitored as per guidelines Records are maintained.

Registered Manager Completing QIP	[signature]	**Date Completed**	17-3-2016
Registered Person Approving QIP	R.T. Alistanhun	**Date Approved**	14-3-16
RQIA Inspector Assessing Response		**Date Approved**	

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

RQIA Inspector Assessing Response	Heather Sleator	Date Approved	30/03/16