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Unannounced Care Inspection of Clanrye

18 and 20 August 2015

The Regulation and Quality Improvement Authority
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1. Summary of inspection

An unannounced care inspection took place on 18 August 2015 from 10.00 to 14.00 and on 20 August 2015 from 10.00 to 13:15. The inspection was in response to concerns raised with RQIA by the Northern Health and Social Care Trust (NHSCT) on 13 August 2015.

On the day of the inspection the home was found to be delivering safe, effective and compassionate care. Areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) appended to this report.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005, the DHSSPS Residential Care Homes Minimum Standards (2011), NICE guidelines on the management of urinary incontinence in women (September 2013), NICE guidelines on the management of faecal incontinence (June 2007) and Guidance and Audit Implementation Network (GAIN) guidelines available for palliative care.

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1.1 Actions/ Enforcement taken following the last inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last inspection.

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	5	2

The details of the QIP within this report were discussed with the deputy manager Mrs Jennifer Moore as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service details

Registered Organisation/ Registered Person: Mrs Heather Margaret Leo	**Registered Manager:** Mrs Heather Margaret Leo
Person in charge of the home at the time of inspection: On 18 August 2015, Ms Karen Rice, Senior Care Assistant, until 11.00. Mrs Jennifer Moore, deputy manager, 11.00 to 14.00. On 20 August 2015, Mrs Jennifer Moore, deputy manager.	**Date manager registered:** 1 April 2005

Categories of care: RC-LD(E), RC-DE, RC-I, RC-MP(E)	**Number of registered places:** 17
Number of residents accommodated on day of inspection: 16	**Weekly tariff at time of inspection:** £470 plus £20 third party contribution

3. Inspection focus

The inspection sought to assess issues raised progress with the issues raised during and since the previous inspection and to determine if the following standard and theme has been met:

Standard 14: **The death of a resident is respectfully handled as they would wish.**
Theme: **Residents receive individual continence management and support.**

4. Methods/ Process

Prior to inspection we analysed the following records; notification reports and previous inspection report and information received from the Northern Health and Social Care Trust pertaining to safeguarding investigations.

During the inspection we met with 16 residents, five staff and two visiting relatives.

We inspected the following records; residents' care records, accident/ incident reports, complaints record, fire safety records, policies and procedures and aligned guidance available to the standards inspected.

5. The inspection

5.1 Review of requirements and recommendations from previous inspection

The previous inspection of the home was an unannounced estates inspection dated 22 May 2015. The completed QIP was returned and approved by the estates inspector.

5.2 Review of requirements and recommendations from the last care inspection

Previous Inspection Recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 20.6	The registered manager should ensure that the homes statement of purpose describes the arrangements of all restrictive practices which may be in use in the home with consideration of the Human Rights Act (1998). A copy should be forwarded to the care inspector which is fully compliant with Regulation 3.	**Met**
	Action taken as confirmed during the inspection: A copy of the home's amended statement of purpose was submitted to the care inspector. This was found to be satisfactory.	
Recommendation 2 **Ref**: Standard 27	The registered manager should ensure that actions taken effectively treat and eradicate mal-odours in a timely manner.	**Met**
	Action taken as confirmed during the inspection: There were no mal odours in the home on either date of inspection.	

5.3 Standard 14: The death of a resident is respectfully handled as they would wish

Is care safe? (Quality of life)

The deputy manager confirmed to us that residents can spend their final days of life in the home unless there are documented health care needs that prevent this.

An area of concern identified by the NHSCT was around end of life care provided to a resident who had been discharged from hospital. A separate investigation into the discharge arrangements from hospital was undertaken by the trust.

We reviewed the care records of this resident who had palliative care needs. The home did not have a care plan in place identifying how the palliative care needs would be met. There was no clear record of multi-disciplinary input and no written evidence of the involvement of district nursing services. Verbal assurances, however, were provided by the deputy manager that the home had instigated timely liaison with district nursing services and that the appropriate equipment and nursing supports had been supplied.

We found that progress records were maintained, but that these recorded there were interventions with fluid intake were against the prescribed Speech and Language Therapy (SALT) directions from the hospital. The care records confirmed that the resident's family was present in the days before the resident died. The family was noted to be pleased with the care provided to the resident at the end of life and had expressed their appreciation in the form of a card. These concerns identified by NHSCT have been investigated by the adult safeguarding team within the trust.

A requirement has been made that a comprehensive assessment of end of life care needs and a written care plan must be in place with clear direction and involvement with the aligned health care professionals.

We inspected a sample of compliment letters and cards. Some were received from families of deceased residents. In these correspondences there were messages of praise and gratitude to the home for the care provided to ill or dying residents.

The spiritual needs of the resident were clearly noted. In our discussions with the deputy manager and staff they confirmed to us that arrangements can be made to provide spiritual care for residents who are dying, if they so wish. Family members, friends, other residents and staff who may wish to offer comfort for a resident who is dying are enabled to do so, if the resident wishes. Following a death, the body of the deceased resident is handled with care and respect and in accordance with his or her expressed social, cultural and religious preferences. The news of the death of a resident is shared with fellow residents in a sensitive manner. Residents are given the option to attend the funeral.

Is care effective? (Quality of management)

Residents can spend their final days in the home unless there are documented health care needs to prevent this.

In our discussions with staff they confirmed that they would be able to recognise the possibility that a resident may die within the next few days or hours. Staff members were knowledgeable about obtaining multi-professional community supports. Whilst we found evidence that a care plan was not put in place for a former resident with palliative care needs, we were satisfied that in other instances, end of life care had been appropriately managed.

Is care compassionate? (Quality of care)

The home has policies and procedures pertaining to terminal and palliative care and death of a resident. These policies and procedures guide and inform staff on this area of care. There is associated guidance available for staff.

Training in this area of care has been provided to staff on 7 and 8 April 2015.

In our discussions with staff they demonstrated that they had knowledge and understanding of how to care for this area of need. Staff also advised us that there is a supportive ethos with the management in the home.

Areas for improvement

The standard was assessed as being partially met with one area of improvement identified. This was in relation to assessment and care planning of palliative care needs in consultation with district nursing services.

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

5.4 Theme. Residents receive individual continence management and support

Is care safe? (Quality of life)

Staff had received training in continence management during their induction. In our discussions with staff they also demonstrated knowledge and understanding of this area of care.

We inspected eight residents' care records and found that in all but one an individualised assessment and plan of care was in place relating to continence management and care. Issues of assessed need were referred to district nursing services. The district nurse, in consultation with the resident and the home, prescribed a plan of care. This plan of care included provision of continence aids.

From our observations we found there to be adequate supplies of aprons, gloves and hand washing dispensers.

In our discussions with staff, general observations and review of care records we identified that no residents had reduced skin integrity associated with poor continence management. There were no malodours noted during inspection of the premises.

Is care effective? (Quality of management)

The home had policies and procedures pertaining to the management of continence. There was also associated guidance and information available to staff.

Staff had received training in continence management. Staff were able to describe how identified issues relating to changing continence needs were reported to district nursing services for advice and direction.

Is care compassionate? (Quality of care)

From our discreet observations of care practices we found that residents were treated with care, dignity and respect when being assisted by staff. Continence care was undertaken in a discreet, private manner.

Areas for improvement

There were no areas of improvement identified with the theme inspected. We found continence management and care to be safe, effective and compassionate. The theme was assessed as being met.

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

5.5 Additional areas examined

5.5.1 Residents' views

We met with 16 residents in the home. In accordance with their capabilities, all residents expressed that they were happy with their life in the home, their relationship with staff, and the provision of meals.

Some of the comments included;

- "They are all kind to me"
- "I like it here. No problems"
- "Things are grand. This is a nice place to live"
- "I am very happy here. No complaints"
- "Everyone is very kind".

5.5.2 Relatives' views

We met with two visiting relatives. Each relative spoke positively about the care provided, the kindness and support received from staff, the provision of meals and the provision of activities.

5.5.3 Staff views/ questionnaires

We met with five staff of various grades. All spoke positively about the workload, teamwork, training, managerial support and staff morale. Staff informed us that they felt a good standard of care was provided to the residents.

Nine staff questionnaires were distributed for return. Four were returned in time for inclusion to this report. These confirmed positive feedback with no identified issues of concern raised.

5.5.4 Staffing levels

The staffing levels in the home on both days of inspection consisted of;

1 x deputy manager
2 x senior care assistants
1 x care assistant
2 x housekeeping staff
1 x cook

The staffing levels were deemed to be appropriate taking account of resident dependencies, the size and layout of the home and fire safety requirements.

5.5.5 General environment

We found the home to be clean and tidy, with good housekeeping arrangements in place. The general décor and furnishings were of a reasonable standard.

Residents' bedrooms were clean and comfortable and contained personal possessions.

A wardrobe in bedroom 9 had drawers that were broken. Access to the roof space in bedroom 12 was not secure and posed a potential risk. Two requirements were made in relation to the general environment.

A number of wardrobes throughout the home were not secured to the wall; this posed a potential risk of injury to a resident. These issues were identified on 18 August 2015, however, on inspection on 20 August 2015 we found that the wardrobes had been safely secured to the walls.

5.5.6 Accident/ incident reports

We inspected the accident/ incident reports which had been recorded and submitted to RQIA since the date of the previous care inspection. These were found to be appropriately managed and reported. A recommendation was made to include in the format of recording accidents / incidents confirmation that the resident's aligned care manager or trust representative is notified of the event.

5.5.7 Care practices

Discreet observations of care practises found that residents were treated with dignity and respect. Staff interactions with residents were found to be polite, supportive, friendly and warm. Care duties and tasks appeared organised and delivered at an unhurried pace. Residents were found to be comfortable, content and at ease in their environment and interactions with staff were positive.

Activities were in place for those residents who choose to partake. Other residents were found to be content in pursuing pastimes of choice, such as reading, going out to the town or knitting.

The choice of music on the radio in one of the lounges was found to be of an inappropriate genre for residents' age group and taste. A recommendation was made to review this provision.

5.5.8 Fire safety

We reviewed the home's most recent fire safety risk assessment, dated 24 March 2015. This assessment had corresponding evidence that recommendations made, including Personal Emergency Evacuation Plans (PEEPs) were in the process of being addressed.

Fire safety training, including fire safety drills, was maintained and up to date.

We observed no obvious risks within the environment in terms of fire safety, such as wedging open of doors.

5.5.9 Complaints

A review of the record of complaints and discussions with the deputy manager confirmed that expressions of dissatisfaction are taken seriously and managed appropriately.

5.5.10 Restrictive practices

An area of concern identified by the NHSCT was around the locking of bedroom doors.

We found that there were locks on all but one of the residents' bedroom doors. Keys were used to access residents' bedrooms. Keys were easily accessible to staff. Five residents held the keys to their own bedrooms. In order to exit the door from the inside, the locking mechanism was via a snib lock. For a resident to exit their bedroom, they need a degree of mental ability to understand the lock mechanism and some manual dexterity to turn the lock.

We examined the locking mechanisms of the inside of the bedroom doors and found these to be easily opened. There were comprehensive, up to date assessments for each resident of their individual understanding and physical ability to exit bedrooms. We also observed residents gaining access to and exiting from their bedrooms.

In our discussions with one resident we found that the resident had good access throughout the home and was able to attend to shopping and social needs in the town when she wished.

5.5.11 Care plans

We reviewed the care plans of eight residents. Seven of these contained comprehensive detail of residents' holistic needs. The care records confirmed that issues of assessed need were accompanied by a care plan and that outcomes for residents were recorded. Referral to the appropriate healthcare professionals was recorded. We found that the preferred rising and retiring times for all residents were fully documented.

One resident admitted to the home approximately eight weeks prior to the inspection, had no written care needs assessment or care plan completed by the home. We found this to be unsatisfactory in terms of meeting this resident's needs. A requirement was been made in relation to this.

Areas for improvement

There were areas of improvement identified with these additional areas inspected.

Number of requirements:	3	**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 the Deputy Manager Mrs Jennifer Moore 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.

6.5 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, Residential Care Homes Regulations (Northern Ireland) 2005.

6.6 Recommendations

This section outlines the recommended actions based on research, recognised sources and the DHSSPS Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.7 Actions taken by the Registered Manager/ Registered Person

The QIP should be completed by the registered person/registered manager and 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 RQIA's office 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 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 home.

Quality Improvement Plan	
Statutory requirements	
Requirement 1 **Ref:** Regulation 13(1)(b) **Stated:** First time **To be completed by:** 27 August 2015	A comprehensive detailed assessment and care plan must be put in place for any resident receiving palliative care. This assessment and care plan must be in consultation with district nursing services. Details of this requirement need to be clearly stipulated in the home's policy and procedure on palliative care. All staff must be informed of same. **Response by Registered Person(s) detailing the actions taken:**
Requirement 2 **Ref:** Regulation 18(2)(c) **Stated:** First time **To be completed by:** 27 August 2015	The wardrobe in bedroom 9 must be repaired. **Response by Registered Person(s) detailing the actions taken:**
Requirement 3 **Ref:** Regulation 27(2)(t) **Stated:** First time **To be completed by:** 27 August 2015	The open access to the roof space in bedroom 12 must be safely secured. **Response by Registered Person(s) detailing the actions taken:**
Requirement 4 **Ref:** Regulation 15(2)(a) **Stated:** First time **To be completed by:** 27 August 2015	All residents must have an up to date assessment of care needs in place. **Response by Registered Person(s) detailing the actions taken:**

Requirement 5 **Ref:** Regulation 16(1) **Stated:** First time **To be completed by:** 27 August 2015	All residents must have an up to date comprehensive care plan in place, based on assessed needs.
	Response by Registered Person(s) detailing the actions taken:

Recommendations	
Recommendation 1 **Ref**: Standard 20.15 **Stated:** First time **To be completed by:** 21 August 2015	In the format of recording accidents / incidents it should be clearly recorded that the resident's aligned care manager or trust representative was notified of the event.
	Response by Registered Person(s) detailing the actions taken:
Recommendation 2 **Ref**: Standard 13.2 **Stated:** First time **To be completed by:** 21 August 2015	The choice of music genre played in the communal areas needs to be appropriate for the residents' age group and taste.
	Response by Registered Person(s) detailing the actions taken:

Registered Manager completing QIP		**Date completed**	
Registered Person approving QIP		**Date approved**	
RQIA inspector assessing response		**Date approved**	

Please ensure the QIP is completed in full and returned to care.team@rqia.org.uk from the authorised email address