Unannounced Care Inspection Report
3 November 2016

Marina Care Home

Type of Service: Nursing Home
Address: Shore Road, Ballyronan, BT45 6JA
Tel no: 028 7941 8770
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Marina Care Home took place on 03 November 2016 from 09.00 to 16.30 hours.

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

The term 'patients' is used to describe those living in Marina which provides both nursing and residential care.

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	*2

*The total number of requirements and recommendations above includes one recommendation that has been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Una McTaggart, registered 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 undertaken on 30 August 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection. Refer to section 4.3.1

2.0 Service details

Registered organisation/registered person: Burnview Healthcare Ltd Mrs Briege Agnes Kelly	**Registered manager:** Mrs Una McTaggart (registration pending)
Person in charge of the home at the time of inspection: Mrs Una McTaggart	**Date manager registered:** Mrs Una McTaggart - application received - "registration pending".
Categories of care: NH-I, NH-DE, RC-I, RC-MP(E) 22 nursing 11 residential 1 identified patient in category NH-DE	**Number of registered places:** 33

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with seven patients, four care staff, one registered nurse, one domestic staff, three patients' representatives and two visiting professionals.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- six patient care records
- staff training records for 2016
- accident and incident records
- audits in relation to care records and falls
- complaints received since the previous care inspection
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- one staff recruitment and selection record.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 30 August 2016

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

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

4.2 Review of requirements and recommendations from the last care inspection dated 11 May 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 15 (2) (b) **Stated:** Second time	The registered persons must ensure that risk assessments are completed for all patients and that the assessment of the patient's need is kept under review and revised on a regular basis.	**Met**
	Action taken as confirmed during the inspection: Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and were reviewed as required.	
Requirement 2 **Ref:** Regulation 16 (1) **Stated:** Second time	The registered persons must ensure that comprehensive written care plans are prepared by registered nurses, in consultation with the patient and/or their representative.	**Met**
	Action taken as confirmed during the inspection: Review of patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. There was a system in place to ensure that patients and/or their representatives were involved in the care planning process.	

Requirement 3 **Ref**: Regulation 12 (1) (a)(b) **Stated:** First time	The registered persons must ensure that the treatment provided to each patient meets their individual needs and reflects current best practice. This relates specifically to the arrangements for managing accidents and incidents that occur in the home.	**Met**
	Action taken as confirmed during the inspection: A review of the accident and incident records confirmed that accurate records were maintained in relation to each incident.	
Requirement 4 **Ref**: Regulation 13 (1)(a) **Stated:** First time	The registered persons must ensure that the home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. It is therefore required that where nursing needs are identified care must be delivered to ensure individual patient needs are met. This refers particularly to the management arrangements of patients who are at risk of dehydration and require their total fluid intake to be monitored.	**Met**
	Action taken as confirmed during the inspection: Where patients were identified as being at risk of dehydration, there was evidence that the totals of food and fluid received were being monitored regularly.	
Requirement 5 **Ref**: Regulation 19 (3)(b) **Stated:** First time	The registered persons must ensure that complaints records are available for inspection at all times.	**Met**
	Action taken as confirmed during the inspection: A new system to record complaints had been implemented and there was evidence that complaints were being managed appropriately.	

Requirement 6 **Ref**: Regulation 30 (1) (c) **Stated:** First time	The registered persons must ensure that RQIA are notified appropriately, in regards to any serious injury that occurs in the home.	**Met**
	Action taken as confirmed during the inspection: A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 5.6 **Stated:** Third and final time	The registered manager should ensure that bowel function, reflective of the Bristol Stool Chart, should be recorded on admission as a baseline measurement and thereafter in the patients' daily progress records.	**Met**
	Action taken as confirmed during the inspection: A review of patient care records evidenced that bowel function, reflective of the Bristol Stool Chart, had been recorded on admission and thereafter in the patients' food and fluid intake charts and in the patients' daily progress records.	
Recommendation 2 **Ref**: Standard 32.1 **Stated:** Third and final time	The following policies and guidance documents should be developed and made readily available to staff: • a policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.* • a policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines which* should include the out of hours procedure for accessing specialist equipment and medication, referral procedure for specialist palliative care nurses and the management of shared rooms. • a policy on death and dying in line with current best practice, such as DHSSPSNI (2010) *Living Matters: Dying Matters* which should include the procedure for dealing with patients' belongings after a death.	**Met**

	Action taken as confirmed during the inspection: Although updated policies were not available on the day of the inspection, the registered person forwarded the policies to RQIA, by email on 04 November 2016. A review of the policies evidenced that they had been reviewed in keeping with the above best practice guidelines.	
Recommendation 3 **Ref**: Standard 11 **Stated:** Third and final time	A record should be maintained to evidence the decision making process regarding the provision of activities and events for patients accommodated in the nursing home. This record should include the level of participation and enjoyment and the activities provided to patients who cannot or do not wish to partake in group activities.	**Met**
	Action taken as confirmed during the inspection: A review of the activities programme and related records, evidenced that each patient had a care plan regarding their interests and preferences in relation to activities. There was also evidence that the care plans had been regularly updated, to include the level of participation in group activities. The records also reflected the activities provided to patients who were not involved in group activities.	
Recommendation 4 **Ref**: Standard 4.1 **Stated:** Third and final time	The process for discussing care plans with patients and/or their representatives should be reviewed to ensure that they are facilitated to participate in all aspects of reviewing outcomes of care, on a regular basis.	**Met**
	Action taken as confirmed during the inspection: There was a system in place to ensure that patient care plans were developed in consultation with the patient and/or their representative.	

Recommendation 5 **Ref**: Standard 35.3 **Stated:** Second time	The registered manager should ensure that there are robust systems in place to discharge, monitor and report on the delivery of nursing care, in particular, the auditing processes in relation to care records.	**Met**
	Action taken as confirmed during the inspection: A review of the care record audits evidenced a system of regular auditing. Where shortfalls were identified, there was a system in place to ensure that follow up action had been taken.	
Recommendation 6 **Ref**: Standard 19.4 **Stated:** First time	The registered persons should ensure that the recruitment and selection processes are reviewed to ensure that there are robust systems in place, to address the deficits identified in this inspection.	**Partially Met**
	Action taken as confirmed during the inspection: Although a review of personnel records evidenced improvements in the recruitment and selection processes, a review of one personnel record evidenced that employment references had not been received in advance of the employees start date. This recommendation was partially met and has been stated for the second time.	
Recommendation 7 **Ref**: Standard 19.4 **Stated:** First time	The registered persons should ensure that records are retained, to evidence that staff have completed an induction programme.	**Met**
	Action taken as confirmed during the inspection: 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.	

Recommendation 8 **Ref**: Standard 19.4 **Stated:** First time	The registered persons should ensure that records in relation to adult safeguarding are maintained, to ensure that evidence of any investigation and/or outcome is recorded appropriately.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager confirmed that there had been no safeguarding incidents since the previous inspection. The manager was knowledgeable regarding regional safeguarding protocols and was able to describe how to record any potential concern.	
Recommendation 9 **Ref**: Standard 19.4 **Stated:** First time	The registered persons should ensure that registered nurses, are provided with training, as appropriate, on the nursing process. Evidence of the training provided, in whatever format, should be retained in the home.	**Met**
	Action taken as confirmed during the inspection: Review of training records evidenced that registered nurses had attended training on the nursing process.	
Recommendation 10 **Ref**: Standard 22.10 **Stated:** First time	The registered persons should ensure that falls are reviewed and analysed on a monthly basis to identify any patterns or trends and appropriate action taken.	**Met**
	Action taken as confirmed during the inspection: An audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls.	

4.3 Inspection findings

4.3.1 Management of Accidents and Incidents

RQIA had previously reviewed the evidence available in respect of a serious adverse incident (SAI's) that had been investigated by the Northern Health and Social Care Trust and a requirement had been made in this regard. A review of the accident and incident records confirmed that there were accurate records maintained in relation to each incident; falls risk assessments and care plans were consistently completed following each incident; and care management and patients' representatives were notified appropriately. The review of the

records evidenced that the recommendations made by the Northern Health and Social Care Trust, in relation to the SAI had been embedded into practice. A notice was displayed at the nurses' station, alerting agency staff to the reporting requirements in relation to accident management. Consultation with staff also confirmed that they were knowledgeable regarding the arrangements for managing accidents and incidents that occur in the home.
A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

An audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. Advice was given in relation to the need to refine the timeframe in which falls had occurred, to enable improvements in identifying exactly when patients fell.

4.3.2 Care Records

As discussed in section 4.2, two requirements had been made in relation to the completion of risk assessments and the development of patient care plans. A review of the patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process and there was a system in place to ensure that the care plans were developed in consultation with the patient and/or their representative.

Records in relation to the management of wounds/pressure ulcers indicated that when a patient was identified as being at risk of developing a pressure ulcer, a care plan was in place to direct staff on the management of this risk. Where a patient had been readmitted to the home, there was evidence that the staff recorded the exact time that body maps had been completed. This evidenced that the body map had been completed within the six-hour recommended timeframe, in keeping with the National Institute of Clinical Excellence (NICE) guidelines. This is good practice and is commended.

Wound assessments and care plans were updated every time the wound dressings were changed and there was evidence that recommendations made by the tissue viability nurse specialist (TVN), had been adhered to.

Where patients were identified as being at risk of dehydration, there was evidence that the totals of food and fluid received were being monitored regularly. A review of patient care records evidenced that patients' total daily fluid intakes were consistently recorded in the daily progress notes. This is good practice and is commended.

A review of patient care records evidenced that continence assessments had been completed on admission and this included the patients' individual bowel pattern, reflective of the Bristol Stool Chart. Staff also recorded patients' bowel movements on the patients' food and fluid charts and in the daily progress records.

Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day. Referrals were made to relevant health care

professionals, such as GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of the patient's poor nutritional intake.

Patients who were identified as requiring a modified diet, had the relevant choke risk and malnutrition risk assessments completed and patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans. However, a review of supplementary care records, which includes repositioning records evidenced that patients were not repositioned according to their care plans. In three patients' repositioning records, gaps of up to six hours were evident, in recording position changes. Although pressure relieving mattresses were in place for all three patients, the gaps in repositioning were evidenced specifically on the night shift. This posed a risk to the patient's health and welfare. A requirement has been made in this regard.

4.3.3 Care Practices

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner.

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.

We observed the lunch time meal in the dining room. The atmosphere was quiet and tranquil and patients were encouraged to eat their food.

We saw a list of activities on the ground floor that included a variety of activities. As discussed in section 4.2, social care plans were in place to provide information to staff to ensure that patients' social care needs were met individually.

4.3.4 Consultation

During the inspection we met with seven patients, four care staff, one registered nurse, one domestic staff, three patients' representatives and two visiting professionals. We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. Four staff and one patient's representative had returned their questionnaires, within the timeframe for inclusion in this report. Some comments received are detailed below:

Staff

"The care is good".
"The patients are treated very well".
"Care is given with the utmost care and attention".
"The patients are treated very good".
"I like doing what makes the patients happy and the basic care is very good".
"It is very good, there is nothing wrong ever".

One staff member commented that additional staff was needed. Whilst there was no evidence that there was any impact on patient care, the staff member stated that it was difficult to 'get to

patients when you should'. Observations on the day of the inspection confirmed that care was delivered in a timely manner. No other complaints were raised in relation to the staffing levels.

Patients

"It could be better, it could be worse".
"It is alright here".
"I am fine, almost anything is good here".
"Very good really".
"They are very good to me".
"I am mostly treated ok".

Patients' representatives

"'(My relative) always says that he is happy here".
"It is a jolly place, we are very happy here".
"We are very pleased".
"We are very pleased, especially since the new manager came".

Visiting Professionals

"Everything is fine".
"Things are much better here now. The staff are reporting everything they should be reporting".

4.3.5 Governance and Management Arrangements

The manager commenced employment in the home on 1 June 2016 and the application for registration as registered manager was submitted to RQIA. The home has recently recruited registered nurses and the manager explained that when these staff commence, the home will have its full complement of nursing staff. In the interim, the manager has been carrying out nursing duties and agency staff have also been employed, to cover registered nurses' shifts.

The manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the week commencing 25 October 2016 evidenced that the planned staffing levels were adhered to. There was a system in place to identify the person in charge of the home, in the absence of the manager.

The review of validation evidence linked to the previous QIP, confirmed that action had been taken to improve the effectiveness of the care. All those consulted with, commented positively regarding the manager's leadership style and described her as being 'very approachable'. Staff consulted with described the manager and responsible person as being 'on the ball' and being 'very supportive'. The manager demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Discussion with manager and observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was displayed appropriately. The conditions of the registration certificate provided for the care of one identified patient who required dementia nursing care. Given that this identified patient no longer resided in the home, advice was given in relation to the process for having the

registration certificate amended. A certificate of public liability insurance was current and displayed.

As discussed in section 4.2, discussion with the 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, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

As discussed in section 4.2, there had been no safeguarding incidents reported since the previous inspection. Although all staff consulted with were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding, the adult safeguarding contact details were not available to all staff members. This was discussed with the manager. A recommendation has been made in this regard.

Discussion with the manager 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 were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. Areas for improvement were identified in the format and content of the monthly quality monitoring reports and the registered persons was referred to the provider guidance on conducting quality monitoring visits, which is available on the RQIA website.

4.3.6 Environment

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

A requirement has been made that the patients who are at risk of developing pressure sores and require regular repositioning are repositioned, in keeping with their care plan.

A recommendation has been made that the contact details for adult safeguarding are readily available and prominently displayed for staff to access.

Number of requirements	1	Number of recommendations	1

5.0 Quality improvement plan

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

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

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

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

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

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 13 (1) (a) **Stated:** First time **To be completed by:** 30 December 2016	The registered persons must ensure that the home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. It is therefore required that where nursing needs are identified care must be delivered to ensure individual patient needs are met. This refers specifically to the repositioning records of patients who are at risk of developing pressure sores and require regular repositioning, in keeping with their care plan. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: All staff have been made aware of the importance of documentation in each individual residents turning charts. This is to reflect that the intervention has been carried out. Supervision of this very important activity has been carried out by the Home Manager and each staff member has signed a training sheet.The importance of good observation and reporting to the nurse in charge of the shift for any change in skin colour is paramount in the prevention of skin breaking down.
Recommendations	
Recommendation 1 **Ref**: Standard 19.4 **Stated:** Second time **To be completed by:** 30 December 2016	The registered persons should ensure that the recruitment and selection processes are reviewed to ensure that there are robust systems in place, to address the deficits identified in this inspection. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Our recruitment policy clearly states that we do not employ a new staff member without receipt of 2 references both of which should be of average/good rating (if the previous estalishment policy is that they give factual e.g. confirmationof dates starting and leaving we have no choice but to accept this, however we must examine and queiry any gaps in employement.
Recommendation 2 **Ref**: Standard 13 **Stated:** First time **To be completed by:** 30 December 2016	The registered persons should ensure that the contact details for adult safeguarding are readily available and prominently displayed for staff to access. **Ref: Section 4.3.5**
	Response by registered provider detailing the actions taken: Presently we are complying with the new policy for Adult Safeguarding Prevention, Protection in Partnership which will give the nurse in charge

	access to the person to contact. A champion nusre is already identified and lead nurses will have champion person as their advisor.

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

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews