The Regulation and Quality Improvement Authority

Marina Care Home
RQIA ID: 1423
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Ballyronan
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Inspector: Aveen Donnelly
Inspection ID: IN021833

Unannounced Care Inspection of Marina Care Home

18 January 2016

1. Summary of Inspection

An unannounced care inspection took place on 18 January 2016 from 10.00 to 17.00 hours.

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 describe those living in Marina Care Home 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 25 August 2015.

1.2 Actions/Enforcement Resulting from this Inspection

An urgent action record regarding nursing risk assessments, care plans and repositioning records was issued to the manager at the end of the inspection. These actions are required to be addressed without delay to ensure the safety and wellbeing of patients in the home.

As a result of the inspection, RQIA were concerned that the quality of care and service within Marina Care Home was below the minimum standard expected. The inspection findings were discussed with senior management in RQIA. It was agreed that the matters of concern should be communicated in correspondence to the regional manager for follow up as a matter of priority. A preliminary action plan was submitted to RQIA on 22 January 2016 and a final action plan was then submitted on 28 January 2016. RQIA can confirm that the action plan has been reviewed and accepted. 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	4	*6

*The total number of recommendations above includes both new and those that have been 'restated'. Four recommendations were made for the second time. One recommendation was carried forward for future inspection.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the applicant manager as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: HC-One Limited Paula Keys	**Registered Manager:** Teresa Boyd
Person in Charge of the Home at the Time of Inspection: Teresa Boyd	**Date Manager Registered:** Registration pending
Categories of Care: NH-DE, NH-I, RC-I, RC-MP(E)	**Number of Registered Places:** 42
Number of Patients Accommodated on Day of Inspection: 25	**Weekly Tariff at Time of Inspection:** £470 - £593

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection.

4. Methods/Process

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

Prior to inspection the following records were analysed:

- 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. The inspector also met with four patients, five care staff, one registered nurse and three patient's representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- six patient care records
- staff training records
- complaints records
- policies for communication and end of life care
- policies for dying and death and palliative and end of life care.

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 25 August 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection on 25 August 2015.

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 13 (7) **Stated:** Second time	The registered person must ensure that suitable infection prevention and control arrangements are in place to minimise the risk and spread of infection. This refers specifically to the cleanliness of the sluice on the ground floor and to the storage of incontinence products in bathrooms throughout the home.	**Met**
	Action taken as confirmed during the inspection: The sluice room on the ground floor was observed to be clean. There was no evidence that incontinence pads were being stored inappropriately. There were no other concerns raised regarding the prevention and control of infection.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 46.3 **Stated:** First time	Infection control audits should be completed on a monthly basis.	**Met**
	Action taken as confirmed during the inspection: A review of infection control records confirmed that audits were completed on a regular basis. There were no concerns identified regarding infection control procedures.	

Recommendation 2 **Ref**: Standard 5.6 **Stated:** First 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.	**Not Met**
	Action taken as confirmed during the inspection: A review of five patient care records evidenced deficits in the completion of bowel assessments. Two continence assessments had not been updated in six months; two had not been completed; and one did not reference the Bristol Stool chart. This recommendation had not been met and was stated for the second time.	
Recommendation 3 **Ref**: Standard 32.1 **Stated:** First time	End of life arrangements for patients should be discussed and documented as appropriate and include patients' wishes in relation to their religious, spiritual and cultural need. Arrangements for breaking bad news with patients and/or their representatives should also be discussed and documented as appropriate.	**Carried forward for future inspection**
	Action taken as confirmed during the inspection: This recommendation was not examined and has been carried forward for review at a future inspection.	

Recommendation 4 **Ref**: Standard 32.1 **Stated:** First 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.	**Not Met**
	Action taken as confirmed during the inspection: A review of the end of life care policy, issued to the organisation in September 2015, did not evidence that the policy had been updated to include the above matters. This recommendation had not been met and was stated for the second time.	

Recommendation 5 **Ref**: Standard 11 **Stated:** First 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.	**Not Met**
	Action taken as confirmed during the inspection: A review of the records pertaining to activity provision in the home confirmed that records were not appropriately maintained, in line with this recommendation. For example, the diary that was used to document activities included entries such as '1:1' accompanied by the patient's name or 'group discussion' followed by the participants names. There was no evidence that activities had been recorded from 07 January to the day of the inspection. This recommendation had not been met and was stated for the second time.	
Recommendation 6 **Ref**: Standard 4.1 **Stated:** First 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.	**Not Met**
	Action taken as confirmed during the inspection: Five patient care records were reviewed. There was no evidence that patients and or their representatives were consulted regarding the development of care plans. Refer to section 5.3 for further comment regarding patient care records.	

Recommendation 7 **Ref**: Standard 39 **Stated:** First time	Update training regarding infection control and safeguarding vulnerable adults should be monitored by the registered manager. **Confirmation that all staff have received this training should be submitted to RQIA with the returned QIP.**	
	Action taken as confirmed during the inspection: A review of training records confirmed that 30 out of 42 staff had completed training in safeguarding of vulnerable adults and infection control. There was evidence that the remaining staff had been assigned dates to complete the e-learning training programme and this was being monitored by the manager.	**Met**

5.3 Additional Areas Examined

Care Records

Five patient care records were reviewed. The review of patient care records identified that assessments and care plans were not completed consistently, following admission. In two patient care records, there was no evidence that assessments had been completed. It was also concerning that one patient had care plans in place despite having had any assessments completed. An urgent action record was issued and a requirement was also made. The manager confirmed to RQIA on 19 January 2016 that the assessments were completed.

The reviewed care records also evidenced that one identified patient did not have care plans updated 28 days after admission. Care plans were also not in place for two patients who had received antibiotic therapy. An urgent action record was issued and a requirement was also made. The registered manager confirmed to RQIA on 19 January 2016 that the care plans were completed.

A review of three patients' care records did not evidence that wound care documentation was adequately maintained. The review identified that a wound assessment had not been completed for a patient who had surgical wounds, nor was there any evidence that the wounds had been monitored. Another patient had a care plan in place for the treatment of a stage 2 pressure ulcer; however there was no wound assessment in place. A review of the regulation 29 monthly monitoring report for December 2015 evidenced that this was identified. However, there was no evidence that the identified shortcomings had been addressed. Repositioning records were not available. An urgent action record was issued and a requirement was also made. The registered manager confirmed to RQIA on 19 January 2016 that repositioning records were in place.

A review of the patient care records also identified that three patients who had been admitted for respite care in December 2015 did not have adequate care plans completed. For example, one patient was admitted to the home for 19 days. There were no assessments or care plans completed during this period. Two other patient records evidenced that care plans had not been developed, in line with the assessed need, in the 15 -21 day period following admission. This was concerning given that one patient was receiving anticoagulant therapy and had been treated for an infection.

Care File Audits

The process of auditing care records was discussed with the manager who responded that care records are audited on a regular basis. However, a review of the audit records evidenced that the deficits identified during this inspection had been identified, however there was no collective evidence available that where deficits were identified of the follow up with the registered nurse, to ensure that shortcomings were addressed. The auditing of care records should ensure that all sections of patients/residents assessment of need are completed and that care plans are developed. Evidence should be present that management verify the remedial action has been completed. A requirement was made.

Staff, Patients and Patients' Representatives' Comments

All comments received were positive in general. Some comments received are detailed below:

Staff

'I have no concerns'
'I can honestly say, I am very happy here'
'It's all fine here, happy enough'
'It's lovely to see that sometimes the staff pop in to check on the patients, when they are on their day off'
'It can be very busy. The patients' needs are always met'

Patients

'They are doing alright'
'It is grand. Sometimes I have to scold (the staff) to get my bed made, but I know that they are busy'
'It is pretty good – reasonable enough'
'I couldn't say anything (bad) about them'

One patient commented that there were delays of up to 30 minutes in having the call bell answered. Discussion with the manager and review of the maintenance records confirmed that this matter had been reported three times in the ten day period preceding the inspection. This was discussed with the manager who stated that the home was waiting for a part to repair the call bell. The manager provided assurances that an alternative call measure would be put in place in the interim. Confirmation was received by email on 19 January 2016, that the identified call bell had been repaired.

Patients' Representatives

'We have no concerns really. Sometimes they are busy, but every nursing home is'
'I have no concerns'
'It's all fine. We have no concerns'

Environment

A general tour of the home was undertaken which included review of 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.

Areas for Improvement

Risk assessments and care plans for all patients must be completed and kept under review and revised on a regular basis.

Repositioning records must be maintained for all patients who are assessed as being at a high risk of pressure sore development. Wound observation charts must also be completed at the time wounds are being dressed and dressing changes and observations of wound healing must be recorded in the progress notes and in the patients care plan.

The registered manager must review the current system of care record auditing, to ensure that there are robust systems in place to discharge, monitor and report on the delivery of nursing care.

Number of Requirements:	4	**Number of Recommendations:**	1

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the 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 15 (2) (b) **Stated:** First time **To be Completed by:** 15 March 2016	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. **An urgent actions record was issued.** **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: All care plans have been audited fully last month and any deficits addressed Care plans are checked the day following admission to ensure that they are compliant. Care plans are also checked as part of resident of the day for compliance
Requirement 2 **Ref:** Regulation 16 (1) **Stated:** First time **To be Completed by:** 15 March 2016	The registered persons must ensure that comprehensive written care plans are prepared by registered nurses, in consultation with the patient and/or their representative. **An urgent actions record was issued.** **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: All care plans have been audited and updated. Residents are there relatives are encouraged to be part of this process if they wish
Requirement 3 **Ref:** Regulation 13 (1)(a) **Stated:** First time **To be Completed by:** 15 March 2016	It is required 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, in particular, focus must be made on the maintenance of repositioning records for all patients who are assessed as being at a high risk of pressure sore development. **An urgent actions record was issued.** **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Any resident who is identified as being at high risk of pressure damage has a reposition chart in place.Those residents who have pressure damage have a wound care plan in place.

Requirement 4 **Ref:** Regulation 19(1)(a) Schedule 3 (3)(K) **Stated:** First time **To be Completed by:** 15 March 2016	The registered person must ensure that record keeping is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance including: • wound observation charts must be completed at the time wounds are being dressed • dressing changes and observations of wound healing must be recorded in the progress notes • care plans must be updated to reflect changes in wound treatment **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Wound charts are being updated at time of intervention, same documentated in daily notes and care plans updated to reflect any changes
Recommendations	
Recommendation 1 **Ref:** Standard 5.6 **Stated:** Second time **To be Completed by:** 15 March 2016	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. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Bristol stool charts are in files and all bowel motions are documented in daily progress notes
Recommendation 2 **Ref:** Standard 32.1 **Stated:** First time **To be Completed by:** 15 March 2016	End of life arrangements for patients should be discussed and documented as appropriate and include patients' wishes in relation to their religious, spiritual and cultural need. Arrangements for breaking bad news with patients and/or their representatives should also be discussed and documented as appropriate. **Carried forward from previous inspection.** **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: End of life care plans are in place for those residents/relatives who have chosen to discuss this

Recommendation 3 **Ref**: Standard 32.1 **Stated:** Second time **To be Completed by:** 15 March 2016	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 **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: A local protocol will be devised for each of the above which will incorporate current best practice. These will be discussed with staff at meetings and will be available for staff to refer to.
Recommendation 4 **Ref**: Standard 11 **Stated:** Second time **To be Completed by:** 15 March 2016	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. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Supervision with both activities therapists has been completed with clear discussion regarding the above requirements
Recommendation 5 **Ref**: Standard 4.1 **Stated:** Second time **To be Completed by:** 15 March 2016	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. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Review of care plans with relatives/residents are in care files and are up to date. Residents and relatives are also involved in reviewing their care plan as part of the resident of the day process.
Recommendation 6 **Ref**: Standard 35.3	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.

Stated: First time	**Ref: Section 5.3**
To be Completed by: 15 March 2016	**Response by Registered Person(s) Detailing the Actions Taken:** Care plans are being reviewed daily to ensure compliance

Registered Manager Completing QIP	Teresa Boyd	**Date Completed**	03.03.2016
Registered Person Approving QIP		**Date Approved**	8/3/2016
RQIA Inspector Assessing Response		**Date Approved**	21/03/2016

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