Marina Care Home
RQIA ID: 1423
Shore Road
Ballyronan
BT45 6JA

Inspector: Aveen Donnelly
Inspection ID: IN021823

Tel: 02879418770
Email: Marina.Manager@hc-one.co.uk

Unannounced Care Inspection
of
Marina Care Home

25 August 2015

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

1. Summary of Inspection

An unannounced care inspection took place on 25 August 2015 from 09.45 to 16.30.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

For the purposes of this report, the term 'patients' will be used to described 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 28 January 2015.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	7

The total number of requirements and recommendations above includes both new and those that have been 'restated'.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the 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: HC-One / Paula Keys	**Registered Manager:** Ailish Devlin
Person in Charge of the Home at the Time of Inspection: Teresa Boyd	**Date Manager Registered:** 24/03/2014
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: 26	**Weekly Tariff at Time of Inspection:** £470 to £593

3. Inspection Focus

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

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

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; and
- pre inspection assessment audit.

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with four patients, two care staff, two nursing staff, one domestic staff and two patient's visitors/representative.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP;
- staffing arrangements in the home;
- five patient care records;
- staff training records;
- staff competency and capability assessments for the nurse with responsibility for being in charge of the home;
- staff induction programme;
- complaints records;
- regulation 29 monitoring reports;
- policies for communication and end of life care; and
- 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 Marina Care home was an announced estates inspection dated 15 July 2015. The completed QIP was returned and approved by the estates inspector.

5.2 Review of Requirements and Recommendations from the last care inspection on 28 January 2015

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 14 (3) **Stated:** First time	The registered person must ensure that suitable arrangements are in place to provide a safe system for moving and handling patients.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager confirmed that all staff had completed training in moving and handling. A review of the regulation 29 monitoring reports evidenced that safe moving and handling practices had been monitored. We did not observe any incorrect moving and handling practices during the inspection.	

Requirement 2 **Ref**: Regulation 15 (e) **Stated:** First time	The registered person must ensure that the home only accommodates patients within the category of care for whom they are registered.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager confirmed that all patients were within the categories of care for which the home is currently registered.	
Requirement 3 **Ref**: Regulation **13(7)** **Stated:** First time	The registered person must ensure that suitable infection prevention and control arrangements are in place to minimise the risk and spread of infection.	**Partially Met**
	Action taken as confirmed during the inspection: Inspector confirmed that the home was generally clean. There was no evidence of un-laminated signage and alcohol gel dispensers were replenished. All staff were observed using this, before and after delivering patient care. All toilet brushes had been replaced following the last care inspection. Bathroom cords were covered with a wipe-able cover and the flooring in the treatment room had been replaced. However, there was evidence that incontinence pads were being stored in bathrooms. This was discussed with the deputy manager, who removed the pads before the end of the inspection. There was one heavily soiled bedpan observed on the floor of the sluice room on the ground floor. This was brought to the attention of the deputy manager, who ensured that the bedpan was removed. The sluice room was deep cleaned before the end of the inspection. Discussion with the registered manager confirmed that daily audits were carried out, to ensure that the home was clean. The registered manager provided assurances that the daily audits would be delegated to the nurse in charge, when the manager is on leave. This requirement has not been fully met and is stated for the second time.	

Requirement 4 **Ref**: Regulation 27 (2) (b) (d) **Stated:** First time	The registered person must make suitable arrangements to ensure that the standard and monitoring of cleanliness throughout the home is maintained. This must include robust systems and processes that provide traceability and follow up on identified areas. The registered person must ensure that the refurbishment plan is reviewed and revised including realistic and appropriate timescales for the completion of works. A copy of the reviewed plan should be forwarded to RQIA with the completed QIP.	**Partially Met**
	Action taken as confirmed during the inspection: Inspector confirmed that with the exception of one identified issue observed in the ground floor sluice room, the home was clean. Infection control audits and daily cleaning schedules were reviewed. However, they were only carried out every three months. A new recommendation is made to ensure that infection control audits are carried out on a monthly basis. We observed that some refurbishment had taken place since the previous inspection. However a refurbishment plan was not submitted to RQIA and issues were also raised during the RQIA estates inspection on 15 July 2015. A condition survey for all floor and wall finishes and a works action plan to replace and refurbish wall and floor finishes is required to be completed on/before 26 October 2015. This requirement will be followed up by the estates inspector.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 25.12 **Stated:** Second time	It is recommended that the template used to record Regulation 29 visits is further developed to include a section that records staffing levels.	**Partially Met**
	Action taken as confirmed during the inspection: Inspector reviewed the Regulation 29 monitoring reports for the three months preceding the inspection. Two out of three reports included a review of the staffing levels. This was discussed with the registered manager who provided assurances that this matter would be addressed with the person designated to conduct the monitoring visit.	
Recommendation 2 **Ref**: Standard 19.2 **Stated:** First time	The registered person should ensure that the following guidance documents are sourced and made available to staff: • RCN continence care guidelines • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence.	**Met**
	Action taken as confirmed during the inspection: The continence guidance documents listed above were not in place. However, the registered manager ensured that these were in place before the end of the inspection.	
Recommendation 3 **Ref**: Standard 17.6 17.10 17.16 **Stated:** First time	The registered manager should ensure that all complaints are recorded and a process implemented to determine complainant' satisfaction with actions taken. Information should also be provided to complainants with regards to the process to follow should they remain dissatisfied.	
	Action taken as confirmed during the inspection: A review of the complaints records confirmed that all complaints were recorded and appropriate action had been taken.	

Recommendation 4 **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: Three patient care records were reviewed. Two out of three patients' continence assessments identified their daily bowel pattern, however the Bristol Stool Chart was not used to provide a baseline measurement. The care plans for continence did not consistently reflect the information that was identified in the patients' continence assessment and there was no evidence in the progress notes reviewed that the Bristol Stool Chart was used to record bowel motions. Considering that the three identified patients were identified as being prone to constipation and faecal incontinence, recording within records did not evidence that this was being monitored.	
Recommendation 5 **Ref**: Standard 34.3 **Stated:** First time	The registered manager should ensure that there is an identified nurse with day-to-day responsibility for monitoring compliance with infection prevention and control procedures and that the role and responsibility of this person is reviewed, to address the issues identified.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed that there was an identified infection control nurse, who completed hand hygiene and infection control audits. As discussed previously infection control audits were not completed on a monthly basis and a recommendation is made in this regard. Refer to Requirement 4 above.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy was available on communicating effectively which reflected current best practice, including regional guidelines on Breaking Bad News. The policy stated that "training in communication skill and the breaking of bad news must be provided to relevant members of staff." Training had not been provided on breaking bad news. However, discussion with the registered nurses and care staff confirmed that staff were aware of the sensitivities around breaking bad news and the importance of accurate and effective communication.

Discussion with registered nursing and care staff confirmed that they were knowledgeable regarding this policy and procedure. The registered manager confirmed that training was planned for all staff regarding end of life care. This training included the procedure for breaking bad news, as relevant to staff roles and responsibilities.

Is Care Effective? (Quality of Management)

The registered manager and two nursing staff consulted demonstrated their ability to communicate sensitively with patients and/or representatives when breaking bad news. Staff emphasised the importance of building caring relationships with patients and their representatives and the importance of regular, ongoing communication regarding the patient's condition. Care staff considered the breaking of bad news to be, primarily, the responsibility of the registered nursing staff.

However, five care records reviewed did not reflect patient individual needs and wishes regarding the end of life care and there was no evidence that options and treatment plans had been discussed or that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs. There was also no reference to the patient's specific communication needs and there was no evidence that the breaking of bad news was discussed with patients and/or their representatives.

Is Care Compassionate? (Quality of Care)

Observations of the delivery of care and staff interactions with patients confirmed that communication was well maintained and patients were observed to be treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients when required.

Discussion with four patients individually and with the majority of patients generally evidenced that patients were content living in the home.

One patient's representative also confirmed that they were kept informed of any changes to their relative's condition and of the outcome of visits and reviews by healthcare professionals.

Areas for Improvement

It is recommended that the arrangements for breaking bad news with patients and/or their representatives are discussed and documented as appropriate.

Number of Requirements:	**0**	**Number of Recommendations**: ***1 recommendation made is stated under Standard 32 below**	***1**

5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

Policies and procedures on the management of palliative and end of life care and death and dying were available in the home. However, these documents did not make reference to best practice guidance such as the GAIN Palliative Care Guidelines, November 2013. Other policies that were reviewed included the procedure for managing an unexpected death, spiritual care and cultural diversity.

There was also a folder that contained a symptom advice sheet for palliative care patients which included advice on pain control, nausea and vomiting, agitation and restlessness. Information on GAIN guidance was available in summary format. There was no formal protocol for timely access to any specialist equipment or drugs in place, however discussion with staff confirmed their knowledge of the procedure to follow should these be required.

Discussion with the registered manager confirmed that training on end of life care was planned for all staff. Course content regarding the planned training was available.

Discussion with two nursing staff and a review of five patient care records confirmed that:

- there were arrangements in place for staff to make referrals to specialist palliative care services; and
- staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

There was no specialist equipment, in use in the home on the day of inspection. Discussion with the registered manager confirmed that training in the use of syringe drivers would be accessed through the local healthcare trust nurse, if required. A folder was also available which included syringe driver information which was published by the Northern Health and Social Care Trust.

There was no palliative care link nurse identified, however the registered manager confirmed that they were in the process of nominating a registered nurse to undertake this role.

Is Care Effective? (Quality of Management)

A review of five patient care records evidenced that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain management and symptom management. However, there were no care plans completed for patients who were receiving palliative or end of life care and recording with records did not evidence discussion between the patient, their representatives and staff in respect of death and dying arrangements.

A key worker/named nurse was identified for each patient approaching end of life care.

Discussion with the manager and staff evidenced that environmental factors had been considered. Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. Through discussion with staff there was evidence that shared rooms were managed sensitively when one occupant was dying.

A review of notifications of death to RQIA during the previous inspection year identified that all deaths were reported appropriately.

Is Care Compassionate? (Quality of Care)

Discussion with staff evidenced that patients and/or their representatives had been consulted in respect of their social, cultural and spiritual preferences regarding end of life care and all staff consulted demonstrated an awareness of the patients' expressed wishes and needs. However, a review of five care records identified that spiritual needs were not addressed in any the patients' care plans.

Arrangements were in place in the home to facilitate, as far as possible, in accordance with the persons wishes, for family/friends to spend as much time as they wish with the person. Overnight stays were facilitated if there was a vacant room at the time and staff consulted described how refreshments and snacks would be provided to relatives during this time.

From discussion with the manager and staff, there was evidence that arrangements in the home were sufficient to support relatives during this time. Staff described how relatives of patients who had died in the home have continued to visit the home.

Discussion with the manager and a review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

One staff member consulted stated that it was the manager's role to attend patient funerals, however all other staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death and that they would ensure that the staff were always represented at a patient's funeral.

From discussion with the manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included more experienced staff supporting newer staff and time spent reflecting on the patients time spent living in the home.

Information regarding support services was available and accessible for staff, patients and their relatives. This information included an information leaflet from the Health and Social Care Bereavement Network and another leaflet entitled *Coping with Dying*. Information was also available from Marie Curie for carers and for people who were in the final stages of their lives.

Areas for Improvement

As previously discussed, 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 needs.

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.

Number of Requirements:	**0**	**Number of Recommendations:**	**2**

5.5 Additional Areas Examined

Care Practices

Activities were not observed on the day of inspection due to annual leave. This was discussed with the deputy manager and with the registered manager, who provided assurances that a programme of activities was in place. A review of the regulation 29 monthly monitoring reports for the three months preceding the inspection identified that the provision of activities within the home had been monitored. Records of activities were reviewed. In the four weeks of records reviewed, there were only four entries recorded. Two entries did not identify the names of patients who had participated and there was no record of the patients' level of engagement/enjoyment. There was also no evidence regarding the provision of activities for patients who were confined to their bedrooms or those who did not wish to participate in group activities. A recommendation is made to address this.

Care Records

A review of five patient care records identified that four patients and/or their representatives had not been involved in discussions regarding the patients care plans. This was discussed with the registered manager who agreed to address this. A recommendation is made.

Staff Training

A review of staff training records identified that update training in infection control and safeguarding of vulnerable adults was not up to date for a number of staff. A review of the regulation 29 reports confirmed that this was being monitored and there was evidence that progress had been made between monitoring visits. This was discussed with the registered manager who agreed to amend the staff induction programme, to ensure that the staff were aware of the e-learning modules that were required to be completed. A recommendation is made to address this.

Questionnaires

As part of the inspection process we issued questionnaires to staff, patients and their representatives.

Questionnaire's issued to	Number issued	Number returned
Staff	10	9
Patients	5	5
Patients representatives	5	1

All comments on the returned questionnaires were in general positive. Some comments received are detailed below:

Staff

'To me the care is excellent'
'Mass is not regularly provided. This is greatly missed by the patients'
'End of life care is excellent and residents dignity is maintained throughout'
'The patients are not short of love and affection. When family and friends are not always about, we are always here'
'The nurses are good at keeping me informed'

Patients

'I feel the home is the best'
'They make (my relatives) feel welcome and if necessary, give them food'
'They are brilliant, the carers are very good and the food is very good'
'They are fine. They run up and down'

Patients' representatives

'A friendly and caring atmosphere is there all the time. Staff are always there when needed to speak to about (my relatives) needs'
'They are very good at keeping me informed'
'Care seems very good'

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered managers 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 and the Residential Care Homes Minimum Standards, August 2011. 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 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 any 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(7) **Stated:** Second time **To be Completed by:** 22 October 2015	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. **Ref Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: infection control audit now been completed monthly. Also staff nurses now completing walkarounds in home managers absence.
Recommendations	
Recommendation 1 **Ref:** Standard 46.3 **Stated:** First time **To be Completed by:** 22 October 2015	Infection control audits should be completed on a monthly basis. **Ref Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Now been completed monthly by infection control nurse
Recommendation 2 **Ref:** Standard 5.6 **Stated:** Second time **To be Completed by:** 22 October 2015	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: supervisions carried out with care staff and staff nurses and all existing residents care files renewed.
Recommendation 3 **Ref:** Standard 32.1 **Stated:** First time **To be Completed by:** 22 October 2015	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. **Ref Section 5.3 and 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: end of life care plan devised and to be included in care plans.

Recommendation 4 **Ref**: Standard 32.1 **Stated:** First time **To be Completed by:** 22 October 2015	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 to section 5.3 and 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: These are all in place and accessible for staff.
Recommendation 5 **Ref**: Standard 11 **Stated:** First time **To be Completed by:** 22 October 2015	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 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: Activity planner now been completed.
Recommendation 6 **Ref**: Standard 4.1 **Stated:** First time **To be Completed by:** 22 October 2015	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 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: careplans are discussed with resident and relative and same to be documented as highlighted.

Recommendation 7 **Ref**: Standard 39 **Stated:** First time **To be Completed by:** 22 October 2015	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.** **Ref Section 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: Training stats are at overall 93% now and induction adapted to reflect that infection control and safeguarding be completed as a priority.

Registered Manager Completing QIP	Ailish Devlin	**Date Completed**	10/10/15
Registered Person Approving QIP	Paula Keys	**Date Approved**	10/10/15
RQIA Inspector Assessing Response	Karen Donnelly	**Date Approved**	23/10/15

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