Unannounced Follow Up Care Inspection Report

7 November 2019

Ratheane Private Nursing Home

Type of Service: Nursing Home
Address: 58 Mountsandel Road, Coleraine, BT52 1JF
Tel No: 028 7034 4299
Inspector: Gillian Dowds

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 65 patients.

3.0 Service details

Organisation/Registered Provider: Ratheane **Responsible Individuals:** Brian Macklin Mary Macklin	**Registered Manager and date registered:** Araceli Flores – 2 September 2014
Person in charge at the time of inspection: Ivy Moya (Sister)	**Number of registered places:** 65
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 43

4.0 Inspection summary

An unannounced care inspection took place on 7 November 2019 from 09.30 hours to 18.30 hours.

The inspection sought to assess progress with issues raised since the last care inspection on 2 July 2019.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	4

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ivy Moya, sister, as part of the inspection process. The timescales for completion commence from the date of inspection.

4.2 Action/enforcement taken following the most recent inspection dated 6 October 2019

The most recent inspection of the home was an unannounced inspection undertaken on 6 October 2019 due to information received to RQIA. Other than those actions detailed in the QIP no further actions were required to be taken following the previous inspection on 6 October 2019.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection the inspector met with seven patients, four patients' relatives and six staff members.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The inspector provided the registered manager with 'Have we missed you cards' which were then placed in a prominent position to allow patients and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision. Ten questionnaires were also left in the home to obtain feedback from patients and patients' representatives.

A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. No responses were received.

The following records were examined during the inspection:

- duty rota for all staff from 28 October to 17 November 2019
- staff training records
- incident and accident records
- three patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits/records.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

6.0 The inspection

6.1 Review of areas for improvement from previous inspection

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 5 (1) (a) (b) **Stated:** Second time	The registered person must provide revised individual agreements to each patient (or their representative) currently accommodated in the home, which reflect the correct fees and financial arrangements in place. A copy of the signed agreement by the patient or their representative and the registered person must be retained in the patient's records. Where the patient or their representative is unable to, or chooses not to sign the agreement, this must be recorded. The registered person must ensure that all written patient agreements comply with requirements under Regulation 5 of the Nursing Homes Regulations (NI) 2005 and Standard 4 of the DHSSPS Minimum Standards for Nursing Homes 2008.	**Met**
	Action taken as confirmed during the inspection: Review of records confirmed that this area for improvement was met.	
Area for improvement 2 **Ref**: Regulation 20 (1) (a) **Stated:** First time	The registered person shall ensure that at all times suitably qualified, competent and experienced staff are working at the home in such numbers as are appropriate for the health and welfare of the patients.	**Met**
	Action taken as confirmed during the inspection: The manager confirmed the planned increase in staffing levels and reviewed ongoing staff competency assessments. This area for improvement had been met.	

Area for improvement 3 **Ref**: Regulation 15 (2) (a) (b) **Stated:** First time	The registered person shall ensure that the assessment of patients' needs are kept under review in a timely manner and revised at any time when it is necessary to do so. This is in relation to ensuring: • care plans include the reason for fluid restriction • when a patient requires fluid restriction the daily fluid intake charts must highlight the volume of the fluid restriction. **Action taken as confirmed during the inspection**: Review of care plans and daily fluid intake charts confirmed that records now included the reason for fluid restriction.	**Met**
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 16 **Stated:** First time	The registered person shall ensure that the complaints procedure includes detail of all communications with the complainant; the results of any investigations; the actions taken; whether or not the complainant was satisfied with the outcome and how this level of satisfaction was determined. **Action taken as confirmed during the inspection**: Review of complaints records evidenced that these were satisfactory.	**Met**
Area for improvement 2 **Ref**: Standard 14.13 **Stated:** First time	The registered person shall ensure that where any service is facilitated within the home (such as, but not limited to, hairdressing, chiropody or visiting retailers) the person providing the service and the patient or a member of staff of the home signs the treatment record or receipt to verify the treatment or goods provided and the associated cost to each patient. **Action taken as confirmed during the inspection**: Records reviewed evidenced that the records were signed as required.	**Met**

Area for improvement 3 **Ref**: Standard 2.8 **Stated:** First time	The registered person shall ensure that any changes to the individual agreement are agreed in writing by the resident or their representative. The individual agreement is updated to reflect any increases in charges payable. Where the resident or their representative is unable to or chooses not to sign the revised agreement, this is recorded.	**Met**
	Action taken as confirmed during the inspection: Review of records/written correspondence evidenced that this has been met.	
Area for improvement 4 **Ref**: Standard 14.26 **Stated:** First time	The registered person shall ensure that an inventory of property belonging to each resident is maintained throughout their stay in the home. The inventory record is reconciled at least quarterly. The record is signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.	**Met**
	Action taken as confirmed during the inspection: Records reviewed following the inspection confirmed that this area for improvement has been met.	

6.2 Inspection findings

Staffing

The nurse in charge confirmed the planned staffing levels and that these levels could be altered to ensure the needs of patients were met. Discussion with staff also confirmed this. We reviewed the staff duty rota from 28 October 2019 to 17 November 2019 which confirmed the planned staffing levels were generally met. We also discussed the system in place to manage short notice absence.

We discussed with the regional manager the recent review of staff and plan to increase staffing levels during the morning shift. Staff stated that the only time the full complement of staff was not achieved was when a staff member reported in absence with late notice and no alternative cover could be sought.

Two patients spoken with said they felt there was not enough staff. One stated they had to wait an hour or more for a call bell to be answered. We discussed this with the sister and regional manager who agreed to address this and monitor call bell response going forward. An area for improvement was identified.

Staff spoken with said that they had time to care for patients and that they received regular training to ensure they had the skills to provide care and to help keep patients safe. Review of staff training records, for example manual handling, confirmed this.

One family member spoken with confirmed that staffing levels met the needs of their loved one and that the staff were knowledgeable of their loved one's needs and wishes, caring, kind and respectful.

As part of the inspection we also asked patients, family members and staff to provide us with their comments on staffing levels via questionnaires. None were returned.

Environment

We reviewed the home's environment including a selection of patients' bedrooms. There was a strong malodour in one bedroom and along one corridor. We discussed this with management following the inspection and assurances were provided that this had been addressed and would continue to be monitored. This will be reviewed at the next care inspection.

We noted that a room where oxygen is in use had no visible signage. This was highlighted to management who agreed to ensure a sign would be put in place. We saw thickening agents for patients were not securely stored in some bedrooms therefore an area for improvement was identified.

We observed when checking the brakes on beds that in most cases they were not in place. We discussed this and this was addressed at the time of inspection. A system is to be put in place to ensure brakes on the beds are checked. This will be reviewed at the next care inspection.

Care Delivery

We spoke with one family member regarding the delivery of care. They were complimentary regarding the care of their loved one and the staff attitude towards them, their loved one and other patients. They said that they were kept informed of any changes in their loved one's care and if they had a concern they would talk to the nurse in charge or the manager. We saw patients unable to express their opinion and views were relaxed and comfortable. Interactions between them and staff were observed to be respectful, caring and kind. Patients able to voice their views confirmed that they received good care and that staff were respectful, caring, kind and attentive.

We spoke with one patient who stated that they were not offered a shower. We reviewed patient shower charts which confirmed that showers had been offered and provided. Patients who initially refused a shower, were offered at a later time, however, this was not clearly documented and therefore an area of improvement was made.

Care Records

We reviewed the records for a patient who required enteral feed. We identified that this patient was receiving mouth care on a regular basis but this was not documented. An area for improvement was identified.

We reviewed three patient care records which evidenced that relevant risk assessments were completed when each patient was admitted. Care plans had been developed to manage the identified care needs. Risk assessments and care plans had been review at least every month however we did identify the following:

- conflicting information in a manual handling care plan and monthly evaluation of the care plan indicated different equipment in use
- fluid target was not recorded on one patient's care plan
- lack of oversight of supplementary records by registered nurses in daily and monthly evaluation of care.

In view of the findings two areas for improvement were identified.

We reviewed the records for patients with distressed reaction. We discussed with the nurse at this time about the assessment of the patient and possible reasons for the reaction. We identified that the evaluation of 'as required' medications administered during this time had not been done effectively. An area for improvement was identified.

Areas for improvement

Recording and oversight by registered nurses of supplementary care records, care records pertaining to manual handling care plan and fluid targets, and contemporaneous recording of supplementary care in regard to showers and mouth care. Call bell response times, storage of thickeners and management of distressed reactions.

	Regulations	Standards
Total number of areas for improvement	1	5

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ivy Moya, Sister, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 12 (1) (a) and (b) **Stated:** First time **To be completed by:** 15 January 2020	The registered person shall ensure that: • care plans reflect the correct manual handling equipment to be used for each patient as required • care plans are reflective of fluid targets for those patients who require a prescribed fluid target. Ref: 6.2
	Response by registered person detailing the actions taken: All care plans have been reviewed to reflect the correct manual handling equipment to be used for each individual patient as required. All care plans have been reviewed to reflect the fluid targets for those patients who require a preacribed fluid target. This is completed and reflected in the monthly evaluations.
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 12 January 2020	The registered person shall ensure that in regard to patient feedback that a system is in place to monitor call bell response times and necessary actions are taken if a delay is observed.
	Response by registered person detailing the actions taken: A manual system is in place to monitor call bell response times and necessary actions are taken if delays are observed. An electronic system is in the process of being set up, it should be completed by end of February 2020.
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 12 January 2020	The registered person shall ensure that fluid thickeners kept in the home are appropriately stored in a secure place. Ref: 6.2
	Response by registered person detailing the actions taken: All thickening agents are locked in the kitchen when not in use.

Area for improvement 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 10 January 2020	The registered person shall ensure that contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each patient in accordance with NMC guidelines. Registered nurses should have an oversight of supplementary care records. Ref: 6.2
	Response by registered person detailing the actions taken: Registered Staff have been reminded of their duty regarding documentation and the NMC guidance in relation to this. One to one supervision relating to each registered nurses understanding of the above is in progress and should be completed by the end of February 2020.
Area for improvement 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 10 January 2020	The registered person shall ensure that supplementary care records are recorded in an accurate, comprehensive and contemporaneous manner • this is in relation to but not limited to the recording of patients showers and recording of the provision of mouth care. Ref: 6.2
	Response by registered person detailing the actions taken: A review of the supplementary care records has been carried out particularly relating to: - showers - mouthcare Care staff have been reminded of the importance of accurately maintaining the supplementary records to include accurate record, times, dates and signatures the supplementary care records have been revised to include a sign off for the registered nurses on these records on a daily basis.
Area for improvement 5 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 10 January 2020	The registered person shall review and revise the management of distressed reactions as detailed in the report. Ref: 6.2
	Response by registered person detailing the actions taken: Staff training has been arranged for the 4th of February for 5 staff nurses who will then cascade the learning, in addition the Alzheimers society will carry out two sessions of training for staff and relatives on the 28th February focusing on distressed reactions and dementia. A guideline has been developed for staff to advice them of the actions to take when patients are feeling distressed.

Please ensure this document is completed in full and returned via Web Portal

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