Ratheane Private Nursing Home
RQIA ID: 1431
58 Mountsandel Road
Coleraine
BT52 1JF

Inspector: Lyn Buckley
Inspection ID: IN022002

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# Unannounced Care Inspection
# of
# Ratheane Private Nursing Home

## 12 October 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 12 October 2015 from 10:25 to 16:15 hours.

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

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 Ratheane Private Nursing 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 14 December 2014.

### 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** | 0 | 3 |

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

## 2. Service Details

| | |
|---|---|
| **Registered Organisation/Registered Person:**<br>Ratheane.<br>Mr Brian Macklin and Mrs Mary Macklin – responsible persons. | **Registered Manager:**<br>Mrs Araceli Flores |
| **Person in Charge of the Home at the Time of Inspection:**<br>Mrs Araceli Flores – registered manager | **Date Manager Registered:**<br>2 September 2014 |
| **Categories of Care:**<br>NH- I, PH and PH(E)<br>RC – I, PH and PH(E)<br>Maximum of 16 persons within residential category. | **Number of Registered Places:**<br>79 |
| **Number of Patients Accommodated on Day of Inspection:**<br>72<br>Nursing 58<br>Residential 16 | **Weekly Tariff at Time of Inspection:**<br>£490 - £637 |

## 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:

- discussion with the registered manager
- discussion with a selection of staff on duty
- consultation with patients and relatives
- observation of care delivery
- observation of patient and staff interactions
- review of selected records
- tour of the home and review of a random selection of patient bedrooms, bathrooms and communal areas
- evaluation and feedback.

Prior to inspection the following records were analysed:

- notifiable events submitted since 1 January 2015
- the registration status of the home
- written and verbal communication received by RQIA since the previous care inspection
- the returned quality improvement plans (QIP) from the last care and estates inspection
- the previous care inspection report.

During the inspection, the inspector spoke with the 16 patients and met others in smaller groups. The inspector also spoke with one relative, three catering/housekeeping staff, one member of administration team, four care staff and two registered nurses.

The following records were examined during the inspection:

- evidence required to validate the previous care inspection QIP
- policies and procedures pertaining to the inspection themes
- nursing and care staff duty rotas from 21 September to 4 October 2015
- training records
- induction templates for nursing and care staff
- compliment records
- complaint records
- six patient care charts relating to repositioning and fluid intake/output charts
- four patient care records.

## 5. The Inspection

### 5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an announced estates inspection dated 9 June 2015. The completed QIP was returned and approved by the estates inspector with clarification or follow up required on some items.

The registered manager confirmed, during this inspection, that the issues detailed in the estates QIP in respect of the lift, gas safe requirements, fire doors, and records pertaining to fire drills had been actioned. Observation evidenced that fire doors were not propped or wedged open.

## 5.2 Review of Requirements and Recommendations from the Last Care Inspection

| Last Care Inspection Statutory Requirements | | Validation of Compliance |
|---|---|---|
| **Requirement 1**<br><br>**Ref**: Regulation 16 (1)<br><br>**Stated:** First time | The registered person must ensure that at the time of each patient/residents admission to the home, a nurse draws up an agreed care plan to meet the patients/residents immediate care needs.<br><br>**Action taken as confirmed during the inspection**:<br>Review of patient care records evidenced that this requirement had been met. | **Met** |
| **Requirement 2**<br><br>**Ref**: Regulation 16 (2)<br><br>**Stated:** First time | The registered person must ensure that care plans are kept under review and are put in place:<br><br>• in response to assessed need<br>• to incorporate recommendations made by other professionals.<br><br>Corresponding fluid intake charts should reflect individualised patient need and ensure the following:<br><br>• the total fluid intake for the patient over 24 hours<br>• an effective reconciliation of the total fluid intake against the fluid target established<br>• action to be taken if targets are not achieved<br>• a record of reconciliation of fluid intake in the daily progress notes.<br><br>**Action taken as confirmed during the inspection**:<br>Review of patient care records and discussion with nursing staff evidenced that this requirement, as stated had been met. A recommendation is made regarding the completion of records. Refer to section 5.5.3. | **Met** |

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|---|---|---|
| **Requirement 3**<br><br>**Ref**: Regulation 20 (1)<br><br>**Stated:** First time | The registered person should review staffing levels in the residential care unit to ensure there is sufficient staff on duty at all times to meet the assessed care needs of all residents. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Discussion with the registered manager, staff and review of duty rotas from 21 September to 4 October 2015 evidenced that this requirement had been met. | |
| **Requirement 4**<br><br>**Ref**: Regulation 27 (2) (c)<br><br>**Stated:** Second time | The registered person must review that the nurse call system to minimise unnecessary disruption and noise pollution for patients/residents. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Discussion with the registered manager confirmed that engineers had worked on the nurse call system following the last care inspection. Alterations had been made but had to be reversed as the volume was too low.<br><br>Observations during this inspection did not evidence excessive noise or disruption.<br><br>Discussion with patients did not raise any concerns in relation to the noise levels of the nurse call system.<br><br>In addition the registered manager confirmed that staff responses to nurse call bells were monitored by her and the deputy manager. Staff were aware of the importance of answering call bells promptly.<br><br>Any concerns raised by patients or relatives were discussed with senior managers and recorded in the complaints record and the responsible persons' quality monitoring report.<br><br>This requirement has been proactively managed and was assessed as met. | |

| Last Care Inspection Recommendations | | Validation of Compliance |
|---|---|---|
| **Recommendation 1**<br><br>**Ref**: Standard 30.1<br><br>**Stated:** First time | A recommendation has been made for the registered manager to review the excess hours worked by some staff members to ensure there is no negative impact on the health and safety of patients/residents or staff. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Review of duty rota for a two week period, discussion with the registered manager and staff confirmed that this recommendation had been met. | |

## 5.3 Standard 19 - Communicating Effectively

### Is Care Safe? (Quality of Life)

A policy and procedure on communicating effectively was available dated December 2010. The registered manager confirmed that the regional manager was undertaking a review of policies and procedures pertaining to the focus and theme. However, the revised policy was not available. It was agreed that the registered manager would inform RQIA by 19 October 2015 of the progress of the policy review and when it would be available. An email was received on 19 October 2015 which confirmed that the revised policy, dated April 2015, was now available in the home.

Regional guidelines on Breaking Bad News were available however staff were not aware of them or the Minimum Care Standards for Nursing Homes; standard 19. A recommendation was made.

The registered manager confirmed that training in communicating effectively with patients was planned for November/December 2015. Training dates were confirmed by email received on 23 October 2015.

Discussion with staff confirmed that they were knowledgeable of how to communicate effectively. Staff confirmed that they were aware of the importance of communicating effectively through their training and experience of caring for patients.

### Is Care Effective? (Quality of Management)

Care records examined reflected patients' individual needs and wishes regarding the end of life care. Recording within records included reference to the patients specific communication needs including any barriers to effective communications such as, language, cognitive ability, or sensory impairment.

There was evidence within care records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs. Relatives spoken with confirmed they were kept informed.

Staff consulted demonstrated their ability to communicate sensitively with patients and their families. It was evident that staff were aware of the individual needs of their patients.

**Is Care Compassionate? (Quality of Care)**

Observation of the delivery of care and many staff interactions with patients, evidenced that communication was compassionate and considerate of the patient's needs and that patients were treated with dignity and respect.

Patients who could verbalise their feelings on life in Ratheane Nursing Home commented positively in relation to the care they were receiving from staff and the attitude of staff. Patients who could not verbalise their feelings appeared, by their demeanour, to be relaxed and comfortable in their surroundings and with staff.

Positive comments were also viewed in letters and cards received by the home from relatives.

**Areas for Improvement**

It is recommended that staff are made aware of the regional guidance and minimum standard in relation to communicating effectively.

| **Number of Requirements:** | **0** | **Number of Recommendations**: | **1** |
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**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, as stated in section 5.3 these were under review and an email received on 19 October 2015 confirmed that the revised policies and procedures were available in the home; dated either April or May 2015.

The registered manager confirmed verbally and by email that palliative and end of life care training had been scheduled for all staff in November and December 2015.

Regional guidelines regarding palliative and end of life care were available but staff were not aware of them or the minimum care standards for nursing homes; standards 20 and 32. A recommendation has been made previously in section 5.3.

Discussion with staff and a review of care records confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the manager, nursing staff and a review of care records evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

A protocol for timely access to any specialist equipment or medications was in place and discussion with nursing staff confirmed their knowledge of the protocol.

**Is Care Effective? (Quality of Management)**

A review of 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. There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered. Care records evidenced 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. There was evidence that referrals had been made to the specialist palliative care team and where instructions had been provided, these were evidently adhered to.

Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying and how the families would be supported during this time. Staff described how family member had stayed overnight in the home when their loved ones were dying.

A review of notifications of death to RQIA since the 1 January 2015 confirmed that any death occurring in the home was notified appropriately.

**Is Care Compassionate? (Quality of Care)**

Discussion with staff and a review of care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences regarding end of life care. Staff demonstrated an awareness of patients' expressed wishes and needs as identified in their care plan.

Staff spoken with demonstrated clearly their compassion for the patients, their relatives and friends. The inspector commended how staff interacted with patients and of the detailed knowledge demonstrated to ensure patients were afforded privacy, dignity and respect.

Staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death.

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. All staff spoken with informed the inspector of how they could provide support to families who were 'sitting with loved ones' who were dying.

Discussion with the registered manager, staff and a review of the compliments record, evidenced that arrangements in the home supported relatives when their loved one was dying. There was evidence within compliments/records that relatives had commended the management and staff for their efforts towards the family and patient. Some examples of comments made by relatives included:

"You put so much thoughtfulness into everything you do."

"Thank you for all your care and devotion in making … stay with you so happy and for the extra attention in the last few weeks."

"I would like to thank you [registered manager] and all the staff at Ratheane for the exemplary care my … received."

"This is a very sincere note of thanks to the staff of Ratheane who cared for my … The love, attention, care and support they gave… is just amazing."

**Areas for Improvement**

It is recommended that staff are made aware of the regional guidance and minimum standards in relation communicating effectively and palliative/end of life care.

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| **Number of Requirements:** | **0** | **Number of Recommendations:** *1 recommendation was made as stated under Standard 19 above | ***1** |

## 5.5 Additional Areas Examined

### 5.5.1 Consultation with Patients, Staff and Patient Representative/Relatives

**Patients**

The inspector met and spoke with 16 patients individually and with others in small groups. Patients were very complimentary regarding the standard of care they received, the attitude of staff and the food provided. There were no concerns raised with the inspector.

Eight questionnaires for patients were left with the registered manager for distribution and six were returned. Patient indicated that they were satisfied or very satisfied with the care and supported they received from staff and that the home delivered safe, effective and compassionate care. Comments recorded included:

"Ratheane is a very caring home, the staff are so kind and friendly…"
"everything is very satisfactory in Ratheane."
"I am always encouraged by the attending of staff."
"Staff always give me my pain relief when I request it."
"Staff all very friendly and helpful."

**Staff**

In addition to speaking with staff on duty eight questionnaires were provided for staff not on duty. The registered manager agreed to forward these to the staff selected. At the time of writing this report two had been returned. One was returned blank. The staff member who responded indicated that they had received training in relation to safeguarding, reporting poor practice/whistleblowing and patient consent. In addition the staff member indicted that they were satisfied or very satisfied that patients were treated with dignity and respect and that patients' needs and wishes were respected and met.

There were no additional comments recorded.

**Representatives/Relatives**

Eight questionnaires were provided for patient representatives/relatives and seven were returned. Comments recorded evidenced that five relatives were either satisfied or very satisfied with the care provided for their loved one.

Additional comments recorded included;

"Friendly and helpful staff. Good overall quality of care. High level of cleanliness."
"My … is very happy in her surroundings and staff deal with her in a very dignified manner."
"Staff are knowledgeable, timely and effective."
"My … is receiving quality care in the home. I am in the home most days…"
"First class nursing home."
"Very happy."

Two relatives recorded concerns in relation to staff, staffing and communication. However, the inspection outcomes in relation to the expressed opinions of patients and relatives consulted, observation of staff interactions with patients and review of staffing levels; would not substantiate the views of the two respondents. Nonetheless, the concerns raised were discussed with the registered manager who agreed to communicate the details to senior management and record the action taken as part of the responsible individual's monthly monitoring visit.

### 5.5.2 Environment

A review of the home's environment was undertaken which included observation of a random sample of bedrooms, bathrooms lounge and dining rooms and sluices on each floor. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients were observed relaxing in their bedroom or in one of the lounge areas available. Patients were complimentary in respect of the home's environment.

### 5.5.3 Care Records

Review of four patients' assessments, care plans and daily evaluations evidenced that these care records were maintained in accordance with, regulatory, professional and minimum standards. The records also reflected the recommendations made by other healthcare professionals such as dieticians and GPs.

However, review of six care charts relating to repositioning and fluid intake/output evidenced that accurate records were not maintained. For example, some charts had no entries against the date, fluid output only was recorded and in relation to reposition charts staff consistently left the skin check section blank. Details were discussed with the registered manager who informed the inspector that a new reposition chart was under development which was expected to address the issues identified. A recommendation was made.

Observation evidenced that folders containing patient care charts were stored on small tables in each corridor. Following discussion with the registered manager, it was agreed that this information formed part of the patient's record and should therefore be held confidentially. A recommendation was made.

### 5.5.4 Staffing

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. The registered manager also confirmed that recruitment for full time staff was being undertaken. Interim arrangements to ensure consistency and continuity of care were in place. For example, if agency nursing or care staff were booked, it was in advance on a 'block booked' basis; agency staff were provided with an induction to the home from either the registered manager or the deputy manager and 'out of hours' support for staff was in place.

Review of duty rotas from 21 September to 4 October 2015 confirmed that the planned staffing levels were maintained.

During discussion, with staff, patients and one relative, there were no concerns regarding staffing levels made.

**Areas for Improvement**

It is recommended that nursing and care staff are aware of the requirements for record keeping in relation to care charts.

It is recommended that all patient information is held in a confidential manner to safeguard the privacy and dignity of patients.

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

## 6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Araceli Flores, registered 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 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

| Recommendations | |
|---|---|
| **Recommendation 1**<br><br>**Ref**: Standard 39.8<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>30 November 2015. | It is recommended that staff are made aware of the regional guidance and minimum standard in relation to communicating effectively and in relation to palliative and end of life care.<br><br>**Ref: Section 5.3 and 5.4** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>All staff nurses have completed the Northern Ireland Hospice 3 day training course on palliative care in 2014 and all feedback from families of residents who have passed away has been very positive about the care that their loved one received. We have however commenced update training on Palliative care to incorporate the care staff and this will include all Regional Guidelines including Breaking bad news, and how to communicate effectively. The dates are as follows: 29/10/15, 10/11/15, 17/11/15, 24/11/15, 30/11/15, 2/12/15, 8/12/15, 11/12/15. |
| **Recommendation 2**<br><br>**Ref**: Standard 4.9<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>30 November 2015 | It is recommended that nursing and care staff are aware of the requirements for record keeping in relation to care charts.<br><br>**Ref: Section 5.5.3** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>The fluid balance recording charts have been updated and robust auditing is put in place to monitor the recording of fluid and repositioning charts. Daily audits are carried out by Deputy manager and frequent short meetings are held to address the inconsistencies and why they occur in a means to ensure that all staff are adhering to the requirements placed on them. Dysphasia training and thickened fluid training was completed on 6th October 2015. |
| **Recommendation 3**<br><br>**Ref**: Standard 5.8<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>30 November 2015 | It is recommended that all patient information is held in a confidential manner to safeguard the privacy and dignity of patients.<br><br>**Ref: Section 5.5.3** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>All patient records have been removed from the small tables on the corridors. Records have been placed in each residents bedroom and filed away every other night in individual patient files located in the nurses station. |

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| **Registered Manager Completing QIP** | Araceli Flores | **Date Completed** | 01/12/15 |
| **Registered Person Approving QIP** | Mary Macklin | **Date Approved** | 01/12/15 |
| **RQIA Inspector Assessing Response** | Lyn Buckley | **Date Approved** | 01/12/15 |

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