Massereene Manor
RQIA ID: 1435
6 Steeple Road
Antrim
BT41 1AF

Inspector: Lyn Buckley
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Unannounced Care Inspection of Massereene Manor

9 March 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 9 March 2016 from 09:20 to 16:30 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.

For the purposes of this report, the term ‘patients’ will be used to described those living in Massereene manor 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 9 September 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	0	2

The details of the Quality Improvement Plan (QIP) within this report were discussed with the Registered Manager, Mrs Olive Hall, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person:	Registered Manager:
Massereene Manor Mrs Janet Montgomery and Mrs Naomi Carey – Responsible Persons.	Mrs Olive Hall
Person in Charge of the Home at the Time of Inspection: Mrs Olive hall – Registered Manager.	**Date Manager Registered:** 1 April 2005.
Categories of Care: NH – LD, LD (E), DE, MP and MP(E) RC – DE Day care - for 4 persons Maximum of 10 persons in category RC-DE. Maximum of 3 persons in categories NH- LD and LD(E).	**Number of Registered Places:** 74
Number of Patients Accommodated on Day of Inspection: 70	**Weekly Tariff at Time of Inspection:** £520 - £648

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 the registered nurses
- discussion with care staff and support staff
- discussion with patients and relatives
- a general inspection of the home environment which comprised of a review of a random selection of patient bedrooms, bathrooms and communal areas
- examination of a selection of care records
- examination of a selection of records pertaining to the inspection focus
- observation of care delivery
- 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 with RQIA since the previous care inspection
- the previous care inspection report
- the inspector's pre inspection assessment audit

During the inspection, the inspector met with 13 patients individually and with others in smaller groups; 11 care staff; one senior care assistant; four registered nurses (RNs) and three patient's visitors/representatives.

The following records were examined during the inspection:

- policies and procedure pertaining to the inspection focus and theme
- staff training records
- complaints records
- compliments records
- seven patient care records and care charts

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 9 September 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care (Same specialism) Inspection

Last Care Inspection Statutory Requirements		**Validation of Compliance**
There were no requirements made		
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 4.7 **Stated:** First time	The registered person should that the re-assessment/review of overdue assessments and care plans is completed by 30 November 2015. **Action taken as confirmed during the inspection**: Review of records and discussion with the registered manager and registered nurses confirmed that this recommendation had been met.	**Met**

Recommendation 2 **Ref**: Standard 35.6 **Stated:** First time	The registered person should ensure continued monitoring of 'overdue' assessments and care plans and as required take action to ensure that record keeping and care planning is effectively managed on a daily basis in accordance with DHSSPS minimum standards and professional standards as set by NMC. **Action taken as confirmed during the inspection**: Review of records and discussion with the registered manager confirmed that this recommendation had been met.	**Met**
Recommendation 3 **Ref**: Standard 5.3 **Stated:** First time	It is recommended that written evidence is maintained in patients/residents care records which indicate that discussions had taken place between the nurse patient/resident and or their representative in developing and agreeing care plans. **Action taken as confirmed during the inspection**: Review of records and discussion with registered nurses confirmed that this recommendation had been met.	**Met**
Recommendation 4 **Ref**: Standard 19.2 **Stated:** First time	The following best practice guidelines should be readily available to staff for reference and use when required. • NICE guidelines on the management of urinary incontinence in women; and • NICE guidelines on the management of faecal incontinence. **Action taken as confirmed during the inspection**: Discussion with the registered manager and staff confirmed that this recommendation had been met.	**Met**
Recommendation 5 **Ref**: Standard 19.2 **Stated:** First time	Monthly audits of patients who are incontinent should be undertaken and the findings acted upon to enhance continence care in the home. **Action taken as confirmed during the inspection**: Discussion with the registered manager and review of records confirmed that this recommendation had been met.	**Met**

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A procedure to direct staff regarding communication was available dated May 2015. Guidance on breaking bad news was also available to staff. Staff spoken with were aware of the availability of the home's policies, procedures and various guidance documents; for example Breaking Bad News (DHSSPS) and the DHSSPS Care Standards for Nursing Homes (April 2015).

Training and induction records were sampled and evidenced that staff had completed or had been asked to complete training in relation to communicating effectively.

Dementia awareness training was planned on a regular basis to ensure all grades of staff were up to date. This ensured that staff were skilled and knowledgeable of this area of practice. This level of dementia awareness training was commended by the inspector.

Is Care Effective? (Quality of Management)

Care records reviewed, included reference to the patient's specific communication needs and actions required to manage barriers such as language, culture, cognitive ability or sensory impairment. There was also evidence that patients and their representatives were included in discussions where appropriate.

Staff consulted clearly demonstrated their ability to communicate effectively and sensitively with patients and their relatives/representatives.

Review of care records evidenced that relatives, where appropriate, were kept informed of changes in the patient's condition. This was also confirmed during discussion with relatives.

Is Care Compassionate? (Quality of Care)

Observation of care delivery and interactions between patients and staff clearly demonstrated that communication was compassionate and considerate of the patients' needs.

Patients who could verbalise their feelings commented positively in relation to the care they received and in relation to the attitude of staff.

Patients unable to verbalise their feelings appeared, by their demeanour, to be relaxed and comfortable in their surroundings and with staff.

Areas for Improvement

There were no areas for improvement identified in relation to communicating effectively.

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

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 dated May 2015. These documents reflected best practice guidance such as the Gain Palliative Care Guidelines, November 2013.

Training records evidenced that staff were trained in the management of death, dying and bereavement. Nursing and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

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 registered manager and staff 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.

Review of patient care records evidenced the involvement of the patient's General Practitioner (GP) in decisions regarding 'advanced care planning'.

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. 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 where appropriate.

Discussion confirmed that management had made reasonable arrangements for relatives/representatives to be with patients who were ill or dying. Staff confirmed that relatives were supported with tea, coffee, meals and advice as required.

A review of notifications of death to RQIA during the inspection year 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 spoken with demonstrated an awareness of patient's expressed wishes and needs as identified in their care plan. Staff demonstrated clearly their compassion for patients, their relatives and friends.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

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. Staff informed the inspector of how they would provide support to families whose loved ones were dying.

From discussion with the registered manager and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives during this time. There was evidence within compliments/records that relatives had commended the management and staff for their efforts towards the family and patient.

Comments recorded by relatives included:

'My…was nursed for the final weeks of … life in Massereene Manor. I want to express the thanks and appreciation of the family for the extraordinary level of care…received'.

'We can't thank you enough for the way in which Massereene manor staff looked after our … for over 10 years. The level of care, the quality of provision, the love and the hugs give have been deeply appreciated and a constant source of reassurance for us'.

'Thank you for being so supportive to me. You were so kind.'

'We would like to say a big thank you for all the care you gave our …. Although only with you for a brief period we knew…was being well cared for'.

'I appreciated very much that day and night staff were represented at…funeral'.

Staff confirmed that they were given an opportunity to pay their respects after a patient's death by attending the funeral, if this was appropriate.

Areas for Improvement

There were no areas for improvement identified in relation to end of life and palliative care.

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

5.5 Additional Areas Examined

5.4.1 Consultation with Patients, Staff and Patient Representatives/Relatives

Patients

Thirteen patients were spoken with individually and others in small groups. Patients were complimentary regarding the standard of care they received, the attitude of staff, management and the food provided. There were no concerns raised with the inspector.

Ten questionnaires for patients were left with the registered manager for distribution. At the time of writing this report five were returned. Patients confirmed that that felt safe in the home, were confident that staff listened to them and that they were treated with dignity and respect. There were no concerns expressed.

Additional comments made included:

'I like living here with staff'.

'I wouldn't say a bad thing about any of them,[staff] I haven't met anyone that isn't nice'.

Staff

In addition to speaking with staff on duty, ten staff 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 three had been returned.

Two of the three respondents confirmed that had received training in safeguarding vulnerable adults, whistleblowing/reporting poor practice and end of life care. One staff member recorded that they had not yet received training in end of life/ palliative care but had received training in the management of distressing symptoms at end of life. Another staff member indicated that during supervision with senior staff they were asked about what training they would like to attend or 'gain from'. Staff also confirmed that that they were either satisfied or very satisfied that care was safe, effective and compassionate.

Additional comments made included:

'Olive Hall is an amazing and fair manager'.

'I have worked in this home for [a number of years], I find it to be very homely, dedicated manager Olive and new deputy… make sure it's made homely and what the residents want the residents get'.

Representatives/Relatives

The inspector spoke with three relatives during this inspection. Relatives were satisfied with the care their loved one's received and complimentary regarding the attitude of staff, the environment, food provided and management. There were no concerns raised with the inspector.

Ten questionnaires were provided for representatives/relatives. The registered manager agreed to distribute these. At the time of writing this report nine had been returned. The respondents indicated that they were either satisfied or very satisfied with the care received by their loved one.

Additional comments recorded by eight respondents included:

'The residents are treated with great respect and the staff are very good at maintaining a very high standard regarding dignity'.

'The level of care is outstanding…'

'Myself and the family are very happy with the care given to my … It gives me and my family great peace of mind, knowing …is so well cared for'.

'Masserene Manor provides great care to both patients and families'.

'The care is very loving and sensitive and means the family's mind is at peace now.'

5.4.2 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 storage spaces.

The home was found to be warm, well decorated, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts.

5.4.3 Management of complaints

Review of the home's complaint record evidenced that complaints were recorded and managed in accordance with the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for nursing Homes (April 2015) and the DHSSPS complaints procedure. Complaints were also referred to the relevant staff member within the Trust area responsible for the admission of the patient involved. This is good practice.

5.4.4 Records and record keeping

Review of care records, including care charts for repositioning and fluid intake/output, evidenced that care records were generally 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, in one unit patient records and information were not maintained in a confidential and secure manner. When this was brought to the attention of the RN, the records were moved to a more secure location. Details were discussed with the registered manager during feedback. A recommendation has been made.

Observation of the lunch time meal in one unit revealed specific patient needs regarding assistance from staff. Staff were knowledgeable regarding the patient's needs and the support required. However, the patient's care plan for nutrition/eating and drinking did not reflect the patient's needs nor the care delivered.

Care plans for 'spirituality' in some units were found to be generic and basic while in other units the care plan were patient centred and reflected the patient's specific needs, wishes and preferences. During discussion it was evident that the management team had identified that care planning content could be improved in relation to individualised care and support. A recommendation has been made.

Areas for Improvement

A recommendation was made in relation to maintain patient records in a confidential and secure manner.

A recommendation was made in relation to the improvement of care planning process to ensure care plans were individualised and supported the care needs of the patient.

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 Olive Hall, 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 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

Recommendations	
Recommendation 1 **Ref**: Standard 6.6 **Stated:** First time **To be Completed by:** 10 April 2016	Patient records should be maintained in a confidential and secure manner at all times. Ref: Section 5.4.4. **Response by Registered Person(s) Detailing the Actions Taken:** Nursing staff have been advised to maintain the Nursing records in a confidential manner in relation to tidying information away from Nurse Stations.
Recommendation 2 **Ref**: Standard 4 **Stated:** First time **To be Completed by:** 30 April 2016	The care planning process should be improved to ensure care plans were individualised and supported the care needs of the patient. Ref: Section 5.4.4. **Response by Registered Person(s) Detailing the Actions Taken:** The Nursing Care plan was reviewed to reflect a person- centred plan of nursing care. The Nursing Team have used this example to reflect on and build on each individual care plan.

Registered Manager Completing QIP	Olive Hall	**Date Completed**	28/4/16
Registered Person Approving QIP	Janet Montgomery	**Date Approved**	28/4/16
RQIA Inspector Assessing Response	Lyn Buckley	**Date Approved**	09/05/2016

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