Secondary Unannounced Care Inspection

Name of Service and ID:	**Masseerene Manor**
Date of Inspection:	**23 February 2015**
Inspector's Name:	**Heather Moore**
Inspection ID:	**IN020235**

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544

1.0 General Information

Name of Home:	Massereene Manor
Address:	6 Steeple Road Antrim BT41 1AF
Telephone Number:	028 9448 7779
E mail Address:	olive@hutchinsoncarehomes.com
Registered Organisation/ Registered Provider:	Ms Naomi Carey Mrs Janet Montgomery
Registered Manager:	Mrs Olive Hall
Person in Charge of the home at the time of Inspection:	Mrs Olive Hall
Categories of Care:	NH- LD , NH-LD(E,) RC-DE , NH-DE , NH-MP , NH-MP(E)
Number of Registered Places:	74
Number of Patients /Residents Accommodated on Day of Inspection:	63 Patients 8 Residents
Scale of Charges (per week):	£581.00 - £624.00 Nursing £461.00 Residential
Date and type of previous inspection:	21 March 2014 Primary Unannounced
Date and time of inspection:	23 February 2015: 09.10 - 13.45
Name of Inspector:	Heather Moore

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year are required.

This is a report of an inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being met.

3.0 Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

The Regulation and Quality Improvement Authority aims to use inspection to support providers in improving the quality of services, rather than only seeking compliance with regulations and standards. For this reason, annual inspection involves in-depth examination of a limited number of aspects of service provision, rather than a less detailed inspection of all aspects of the service.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the Provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)
- Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/Process

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

- discussion with the registered provider;
- discussion with the registered manager;
- discussion with staff;
- discussion with patients /residents individually and to others in groups;
- review of a sample of policies and procedures;
- review of a sample of staff training records;
- review of a sample of staff duty rotas;
- review of a sample of care records;
- observation during a tour of the premises; and
- evaluation and feedback.

5.0 Inspection Focus

During the course of the inspection, the inspector spoke with:

Patients/Residents	**10**
Staff	**8**
Relatives	**2**
Visiting Professionals	**0**

Questionnaires were provided by the inspector, during the inspection, to patients / residents, their representatives and staff to seek their views regarding the quality of the service.

Issued to:	**Number Issued**	**Number Returned**
Patients /Residents	**6**	**6**
Relatives / representatives	**0**	**0**
Staff	**9**	**9**

The inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

STANDARD 19 - CONTINENCE MANAGEMENT
Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Massereene Manor was first registered on 27 January 1997 and extended in 2011 with the addition of a further 24 beds. The home is a purpose built residence divided over two buildings, providing care in six separate units. The Broom hill unit is an additional new residential unit for persons with dementia.

The home is located close to Antrim town convenient to shops and community services. The home provides single bedroom accommodation, some of which have ensuite facilities. All beds in the Eden Hill and Maple Hill units provided ensuite facilities.

Access to the bedroom accommodation on the first floors is via a passenger lift and stairs. Day and dining rooms, bath/shower and toilet facilities are also available on both floors of the home. A kitchen, laundry and staff facilities are provided. A designated car park is available within the home grounds.

The home is currently registered to accommodate not more than 74 persons needing nursing care or social care in the following categories.

DE-Dementia
MP- Mental disorder excluding learning disability or dementia
MP- (E) Mental disorder excluding learning disability or dementia over 65 years.

The home is currently registered to provide Day Care for not more than four persons in this category each day.

The home's Certificate of Registration issued by the Regulation and Quality Improvement Authority (RQIA) was on display and accurately reflected the categories of care accommodated in the home on the day of inspection.

8.0 Summary

This summary provides an overview of the services examined during an unannounced care inspection to Massereene Manor which was undertaken by Heather Moore on 23 February 2015 from 09.10 to 13.45.

The inspection was facilitated by Mrs Olive Hamill Registered Manager who was available throughout the inspection. Verbal feedback of the issues identified during the inspection was given to the registered manager and the deputy manager at the conclusion of the inspection.

During the course of the inspection, patients and residents were consulted, a selection of records examined and a general inspection of the nursing home environment carried out as part of the inspection process.

As a result of the previous inspection conducted on 21 March 2014 three requirements and three recommendations were issued. These were reviewed during this inspection and found to be complied with. Details can be viewed in the section immediately following this summary.

Discussion with the registered manager, a number of staff, patients and residents and review of four patients care records revealed that continence care was well managed in the home.

Staff were trained in continence care on induction, additional continence training was provided on the 9 April 2014. Catheterisation training was also provided on the 26 January 2015.

Inspection of the home policies and procedures confirmed that polices were in place on the management of continence; however there were no NICE guidelines on urinary or faecal incontinence. A recommendation is made in this regard.

Examination of four care records confirmed a satisfactory standard of documentation. Comprehensive reviews of both the assessment of need and the care plans were maintained on a regular basis and as required in all of the care records reviewed. However inspection of care plans revealed the absence of written evidence that discussion had taken place between the nurse, patient/resident and/or their representative in regard to planning and agreeing nursing interventions.

A regular review of the management of patients and residents who were incontinent was not undertaken. A recommendation is made that a monthly audit is undertaken and the findings are acted upon to enhance continence management.

The patients/residents were well presented and those that were able to communicate commented positively on the care provided. Refer to section 11.5 for further details about patients and residents.

A tour of the home was undertaken and a number of patients' and residents' bedrooms, communal areas, dining areas and bathroom and toilet facilities viewed the home presented as clean warm and comfortable.

Based on the evidence reviewed, presented and observed the level of compliance with this standard was assessed as substantially compliant.

Three recommendations are made. These recommendations are detailed in the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, and residents registered provider, registered manager, deputy manager registered nurses and staff for their assistance and co-operation throughout the inspection process.

The inspector would also like to thank the patients, residents and staff who completed questionnaires.

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	16(2)(a)(b)(c)(d)	The registered person must ensure that the patients' plan of care is available to the patient and or their representative is consulted and informed of any revision to the plan of care. • The registered persons must ensure improved systems are in place to ensure that patients and fluid records are in place are being effectively recorded at all times. • The registered person must ensure Braden scores and body mapping records are reviewed and accurately reflect changes.	Inspection of four patients care records confirmed that patients' care records were reviewed and updated in accordance with their assessed /changing needs. • Examination of a sample of patients fluid balance records confirmed that these charts were completed appropriately and were recorded over a 24 hour period. • Examination of four care records confirmed that patients Braden assessment charts and body mapping records were recorded on a monthly basis or more often if deemed appropriate.	Compliant
2	13(7)	The registered person must ensure that worn and torn seating unable to be effectively cleaned has been repaired or replaced.	Discussion with the registered manager confirmed that any torn seating had been repaired or replaced since the previous inspection.	Compliant

3	14(6)	The registered person must ensure that on any occasion on which a patient is subject to restraint the registered person must record the circumstances, including the nature of the restraint. The use of wedges is considered as a form of restraint and circumstances of their use should be recorded in keeping with best practice. Where appropriate evidence of consultation should be recorded from the patient or their representative.	Review of two patients care records confirmed that appropriate evidence of consultation with the patient's representative in the use of bed wedges were maintained appropriately in the patients care records.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	5.3	It is recommended that care plans are updated to reflect the recommendations of visiting health care professionals.	Inspection of four patients care records confirmed that care plans reflected recommendations of health care professionals.	Compliant
2	25.13	The quality of services provided is evaluated on at least an annual basis, a report prepared and follow–up action taken. Key stake holders are involved in the process. It is recommended that systems are developed to evidence that patients and relatives have access to this report.	On the day of inspection the home's annual quality report was available in the reception of the home for patient/residents and their representatives to read.	Compliant
3	26.2	It is recommended that the policy on restraint is updated to include reference to Human Rights Legislation.	Inspection of the home's polices and procedure confirmed that a policy on restraint was available which included reference to Human Rights Legislation.	Compliant

8.1 Follow up on any issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care.

However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required: this may include an inspection of the home.

There were no issues/concerns raised with RQIA since the previous inspection such as complaints or safe guarding investigations.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support.	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of four patients'/residents' care records revealed that bladder and bowel continence assessments were undertaken for these patients and residents. The bladder and bowel assessments and the care plans on continence care were reviewed and updated on a monthly or more often basis as deemed appropriate monthly. The promotion of continence, skin care, fluid requirements and patients' and the resident's dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients and residents were referred to their GPs as appropriate. Review of care records revealed that there was no written evidence held of patient/resident and their relatives' involvement in developing and agreeing care plans. A recommendation is made in this regard. Discussion with staff and observation during the inspection revealed that there were adequate stocks of continence products available in the home.	Substantially compliant
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The following policies and procedures were in place: • continence management/incontinence management; • catheter care. The following guideline documents were not in place:	Substantially compliant

• Nice Guidelines on faecal incontinence; and • Nice Guidelines on urinary incontinence for women. A recommendation is made that these guideline documents are available and accessible to staff for reference and used as required.	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not applicable.	Not applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care and a number of registered nurses had been trained in male catheterisation. Staff were knowledgeable about the important aspects of continence care including privacy, skin care and reporting any concerns. The registered manager informed the inspector that currently monthly reviews of patients and residents who were incontinent were not undertaken in the home. A recommendation is made that monthly audits are undertaken and the findings acted upon to enhance continence management.	Substantially compliant

Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

11 .0 Additional Areas Examined

11.1 Care Practices

During the inspection the staff were noted to treat the patients and residents with dignity and respect. Good relationships were evident between patients, residents and staff.

Patients and residents were well presented with their clothing suitable for the season.

Staff were observed to respond to patients' and residents' requests promptly.

11.2 Patients' Residents' and Relatives comments

During the inspection 10 patients and residents were spoken to individually and others in groups. Six patients/residents completed questionnaires. A number of patients and residents were unable to express their views verbally. These patients and residents indicated by positive gestures that they were happy living in the home.

Examples of patients' and residents' comments were as follows:

- "I am happy."
- "It's alright."
- "I enjoy living here."
- "Massereene Manor is the type of home all the other homes should strive to be."

Relatives comments

The inspector spoke to two relatives on the day of inspection.

Examples of relatives comments were as follows:

- "I am very pleased with the standard of care in the home; all the staff here are excellent."
- "I cannot speak highly enough of the care here, it's very good."

11.3 Staffing

On the day of inspection the number of registered nurses and care staff rostered on duty were in line with legislation for the number of patients and residents currently in the home.

The inspector spoke to a number of staff during the inspection. Nine staff completed questionnaires. No issues or concerns were brought to the attention of the inspector.

Examples of staff comments were as follows:

- "There is good team work here."
- "Yes we have enough continence products."
- "I enjoy my work."
- "Yes I have had training in Safe Guarding Adults."
- "All the residents are well looked after."
- "We have a high standard of care here."

- “Yes I had an induction when I commenced work.”

11 .4 Environment

A tour of the home was undertaken and a number of patients’ and residents’ bedrooms, communal areas, dining areas, and bathroom and toilet facilities viewed. The home was clean comfortable and maintained to a high standard.

12 .0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Olive Hall Registered Manager and Ms Laura Moon Deputy Manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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.

Enquiries relating to this report should be addressed to:

Heather Moore
The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS

Quality Improvement Plan

Unannounced Secondary Inspection

Massereene Manor

23 February 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Olive Hall Registered Manager and Ms Laura Moon Deputy Manager either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers/managers should note that failure to comply with regulations may lead to further enforcement and/or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider/manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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.

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 (NI) 2005

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
		No requirements were made as a result of this inspection			

Recommendations

These recommendations are based on the Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.3	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. **Ref: 19.1 Section10**	One	Primary Nurses are currently progressing towards compliance in relation to this recommendation.	One Month
2	19.2	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 • NICE guidelines on the management of faecal incontinence. **Ref: 19.2 Section 10**	One	NICE guidelines are currently readily available.	One Month
3	19.4	Monthly audits of patients who are incontinent should be undertaken and the findings acted upon to enhance continence care in the home. **Ref: 19.4 Section10**	One	Whilst individual continence assessments are in place, we are currently working towards devising a monthly audit.	One Month

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person/identified responsible person:

Name of Registered Manager Completing QIP	Olive Hall
Name of Responsible Person / Identified Responsible Person Approving QIP	Janet Montgomery

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	Heather Moore	12/03/2015
Further information requested from provider			