Milesian Manor
RQIA ID: 1436
9 Ballyheifer Road
Magherafelt
BT45 5DX

Inspector: Aveen Donnelly
Inspection ID: IN023947

Tel: 02879631842
Email: milesian-manor@hotmail.co.uk

Unannounced Care Inspection
of
Milesian Manor

9 December 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 09 December 2015 from 09.00 to 16.00.

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

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

For the purposes of this report, the term ‘patients’ will be used to described those living in Milesian 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 26 August 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 as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Milesian Manor Seamus P Higgins and Patrick Joseph Forbes	Registered Manager: Martha Therese O'Kane
Person in Charge of the Home at the Time of Inspection: Martha Therese O'Kane	**Date Manager Registered:** 1 April 2005
Categories of Care: NH-I, RC-I, NH-PH, NH-PH(E)	**Number of Registered Places:** 34
Number of Patients Accommodated on Day of Inspection: 34	**Weekly Tariff at Time of Inspection:** £593

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection.

4. Methods/Process

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

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with four patients, five care staff, two nursing staff and three patient's representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- a sample of fluid intake charts
- a sample of repositioning records
- staffing arrangements in the home
- four patient care records
- staff training records

- complaints records

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 26 August 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection on 26 August 2015.

<table>
<tr><th colspan="2">Last Care Inspection Statutory Requirements</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Requirement 1

Ref: Regulation 15 (2)

Stated: First time</td><td>Where a nursing assessment is made to monitor a patient’s daily fluid intake, then the patients daily (24hour) fluid intake must be recorded in their daily progress record to evidence that this area of care is being properly monitored and validated by the registered nurse.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Inspector confirmed that patient’s daily fluid intake records were recorded accurately. There was evidence that this was being validated by registered nurses in patients’ daily progress records.</td></tr>
<tr><td rowspan="2">Requirement 2

Ref: Regulation 16 (1)

Stated: First time</td><td>The registered persons must ensure that care plans are developed by registered nurses.</td><td rowspan="2">Partially Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of five care records confirmed that care plans were generally in place. However, there were a small number that were not updated/in place. Further detail is discussed in section 5.3. A new recommendation was made regarding care record auditing.</td></tr>
</table>

Requirement 3 **Ref**: Regulation 20 (2) (c) **Stated:** First time	Registered nursing staff should receive training in developing care plans. This training should also address the deficits in contemporaneous recording observed in this inspection, in accordance with NMC guidelines for record keeping and should include the legal aspects of care planning and record keeping.	**Met**
	Action taken as confirmed during the inspection: A review of training records evidenced that training in the development of care plans had taken place.	
Requirement 4 **Ref**: Regulation 27 (4) (b) **Stated:** First time	Precautions must be in place that minimise the risk of fire and protect patients, staff and visitors in the event of a fire. This refers specifically to the observed practice of fire doors being propped open.	**Met**
	Action taken as confirmed during the inspection: There was no evidence that bedroom doors were being propped open.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 19.3 **Stated:** Second time	It is recommended that regular audits of the management of patients and residents who are incontinent be undertaken and the findings acted upon to enhance already good standards of care.	**Met**
	Action taken as confirmed during the inspection: Continence audits were reviewed. Advice was given regarding the format of the audit tool.	

<table>
<tr>
<td rowspan="2">Recommendation 2

Ref: Standard 32.1

Stated: First time</td>
<td>The following policies and guidance documents should be developed and made readily available to staff:

A policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) Breaking Bad News.
A policy on communication which includes communication with patients who have cognitive impairments and sensory, cultural or language barriers.
A policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) Palliative Care Guidelines which should include the out of hours procedure for accessing specialist equipment and medication; the referral procedure for specialist palliative care nurses; and the management of shared rooms.
A policy on death and dying in line with current best practice, such as DHSSPSNI (2010) Living Matters: Dying Matters which should include the procedure for dealing with patients' belongings after a death.
</td>
<td rowspan="2">Met</td>
</tr>
<tr>
<td>Action taken as confirmed during the inspection:
The above policies were reviewed and all deficits identified were included.</td>
</tr>
<tr>
<td rowspan="2">Recommendation 3

Ref: Standard 32.1

Stated: First time</td>
<td>End of life arrangements for patients should be discussed and documented as appropriate, and include patients' wishes in relation to their religious, spiritual and cultural needs.</td>
<td rowspan="2">Met</td>
</tr>
<tr>
<td>Action taken as confirmed during the inspection:
A review of care records confirmed that end of life care arrangements were discussed with the patients' representatives. End of life care plans were in place, as appropriate and there was evidence that the religious and spiritual needs were included in the care plan.</td>
</tr>
</table>

<table>
<tr>
<td rowspan="2">Recommendation 4

Ref: Standard 16.11

Stated: First time</td>
<td>Records should be maintained of all complaints and these should include details of all communications with complainants; the result of any investigations; the actions taken; whether or not the complainant was satisfied with the outcome; and how this level of satisfaction was determined.

The process for dealing with complaints should be reviewed to include how the staff records complaints in the absence of the registered manager.

The complaints record should always made available for inspection.</td>
<td rowspan="2">Met</td>
</tr>
<tr>
<td>Action taken as confirmed during the inspection:
The complaints record was available. Discussion with the registered manager and staff confirmed that the staff were aware of how to record complaints in the absence of the registered manager. There were no recorded complaints since the last inspection. However, the complaints policy reviewed confirmed that processes were in place, to ensure that the elements of this recommendation were met.</td>
</tr>
<tr>
<td rowspan="2">Recommendation 5

Ref: Standard 18.11

Stated: First time</td>
<td>Where restraint and/or restrictive practices are used, the patient and/or their representative should be invited to discuss and regularly review the consent form for continued use.</td>
<td rowspan="2">Met</td>
</tr>
<tr>
<td>Action taken as confirmed during the inspection:
A review of three patient care records confirmed that consent forms had been updated in consultation with the patients' representatives.</td>
</tr>
</table>

<table>
<tr><td rowspan="2">Recommendation 6

Ref: Standard 4.11

Stated: First time</td><td>The process for discussing care plans with patients and/or their representatives should be reviewed to ensure that they are facilitated to participate in all aspects of reviewing outcomes of care, on a regular basis.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of four patient care records confirmed that two patient representatives had been involved in the development of care plans. This was discussed with the registered manager, who provided assurances that a system was in progress to address this matter.</td></tr>
<tr><td rowspan="2">Recommendation 7

Ref: Standard 39

Stated: First time</td><td>The content of all training provided should be maintained in the home.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of the training file evidenced that the content of training was maintained.</td></tr>
</table>

5.3 Additional Areas Examined

Care Records

As discussed in section 5.2, the review of care records evidenced that care plans were generally in place/updated. However there were a small number of care plans and assessments that were not regularly updated. Discussion with the registered manager confirmed that care records were audited informally and there was no specified tool in place to evidence identified deficits. Advice was given regarding formalising the auditing process. A recommendation was made.

A review of three care records evidenced that despite care plans for pain management being in place, validated pain assessment tools had not been completed. Furthermore, two patients care records did not have continence/bowel assessments in place. This was discussed with the registered manager who agreed to address this matter. A recommendation was made.

Comments of Patients, Patient Representatives and Staff

All comments received were in general positive. Some comments received are detailed below:

Staff

'I feel good inside when I go home, knowing that I delivered good care'
'It is known as the best home in the area'
I am very happy here. It is all very good'
'I have no concerns. I am very happy'
'I treat all the patients like I would expect my own mother to be treated. If I saw anything even slightly wrong, I would not put up with it'
'Whatever the patients want, they get. If a patient wanted prawn cocktail, we would go up the town and get it for them'

Two staff members commented that absenteeism had been a problem. This was discussed with the registered manager, who confirmed that short notice absences were being managed as per the home's protocol. A review of the regulation 29 monthly monitoring reports also confirmed that this was being addressed.

Patients

'I have no reason to complain. Everything is alright'
'I have no complaints about the staff. They are very good'
'It's very good. I am respected and given choice regarding my day to day'
'I am happy. I get a fry every day. Wouldn't live without my fry'

Patients' representatives

'I am happy enough'
'I want to rave about the place. There is some difference in (my relative) since he was admitted here'
'The nurses are hands-on. They know everything about my (relative)'
'The food is excellent'
'Very good really. You couldn't get better'

Areas for Improvement

The registered manager should ensure that care records are audited, using a robust system that provides traceability of audit.

The registered manager should ensure that patient assessments are completed, as appropriate, in particular pain assessments and continence assessments.

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 the 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 35.3 **Stated:** First time **To be Completed by:** 06 February 2016	The registered manager should ensure that care records are audited, using a robust system that provides traceability of audit. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: The Registered Manager will ensure that care records are audited using a robust system that provides traceability of audit.
Recommendation 2 **Ref**: Standard 4.1 **Stated:** First time **To be Completed by:** 06 February 2016	The registered manager should ensure that patient assessments are completed, as appropriate, in particular pain assessments and continence assessments. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: The Registered Manager now ensures that patients assessments are completed.

Registered Manager Completing QIP	MARTHA O'KANE	**Date Completed**	01/02/2016
Registered Person Approving QIP	Patsy Forbes/Seamus Higgins	**Date Approved**	01/02/2016
RQIA Inspector Assessing Response	Aveen Donnelly	**Date Approved**	01/02/2016

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