Rylands
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Unannounced Care Inspection
of
Rylands

16 December 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 16 December 2015 from 09.45 to 16.45.

On the day of the inspection, areas for improvement and matters of concern were identified and are required to be addressed to ensure that care in the home is safe, effective and compassionate. These areas are set out in the Quality Improvement Plan (QIP) within this report. Please refer to section 1.2 below.

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 Rylands, 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 17 September 2015.

1.2 Actions/Enforcement Resulting from this Inspection

An urgent action record regarding the management of wound care and moving and handling practices was issued to the registered manager at the end of the inspection. These actions are required to be addressed without delay to ensure the safety and wellbeing of patients in the home.

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	3	*6

* The total number of requirements and recommendations above includes both new and those that have been 'restated'.

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

2. Service Details

Registered Organisation/Registered Person: Rylands Trevor Duncan and Karen Duncan	**Registered Manager:** Valerie Rutherford
Person in Charge of the Home at the Time of Inspection: Valerie Rutherford	**Date Manager Registered:** 24 March 2014
Categories of Care: NH-LD, RC-I, RC-MP(E), RC-PH(E), NH-I, NH-PH, NH-PH(E)	**Number of Registered Places:** 59
Number of Patients Accommodated on Day of Inspection: 56	**Weekly Tariff at Time of Inspection:** £485 to £652

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 five patients, five care staff, three nursing staff and six patients' representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- four personal care charts
- 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 Rylands was an unannounced care inspection dated 17 September 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 17 September 2015.

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref:** Regulation 20 (1)(c) **Stated:** Third time **To be Completed by:** 15 November 2015	The registered manager must ensure that all relevant staff have training in the management of dysphagia and are deemed competent in this. **This requirement was stated for the third and final time.** **Confirmation that all staff have been trained and deemed competent must be submitted with the returned QIP.**	**Met**
	Action taken as confirmed during the inspection: A review of staff training records confirmed that all relevant staff had received training and were deemed competent in the management of dysphagia.	
Requirement 2 **Ref:** Regulation 14 (5) **Stated:** First time **To be Completed by:** 15 November 2015	The registered persons must ensure that records are maintained in respect of lap belts, to ensure that they are released and repositioned on a regular basis throughout the day. This information must also be included in the patients' care plans, as appropriate.	**Met**
	Action taken as confirmed during the inspection: A review of care records relating to the release and repositioning of patient lap belts confirmed that records were maintained appropriately.	

Requirement 3 **Ref:** Regulation 29 (5) (a) **Stated:** First time **To be Completed by:** 15 November 2015	A copy of the regulation 29 monitoring reports must be retained in the home and available for inspection.	**Met**
	Action taken as confirmed during the inspection: The Regulation 29 monthly monitoring reports were available and retained in the home. A review of the monitoring reports confirmed that the visits were conducted on a regular basis.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 4.4 **Stated:** Second time **To be Completed by:** 15 November 2015	It is recommended that care plans clearly demonstrate the promotion of independence in line with patients' expressed wishes, regarding the time they wish to get up.	**Met**
	Action taken as confirmed during the inspection: A review of two patient care records confirmed that the rising and retiring time of patients was recorded in accordance with their expressed wishes.	
Recommendation 2 **Ref**: Standard 37.1 **Stated:** First time **To be Completed by:** 15 November 2015	Consideration should be given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times.	**Not Met**
	Action taken as confirmed during the inspection: Discussion with staff confirmed that daily personal care records, which included daily food and fluid intake records were generally maintained on a table in the dining room. However, on the day of inspection, there were 22 records observed on a chair in the dining room. This recommendation has not been met and was stated for the second time. Further detail regarding the meal time experience is discussed in section 5.3.	

Recommendation 3 **Ref**: Standard 46.2 **Stated:** First time **To be Completed by:** 15 November 2015	Personal protective equipment should be appropriately stored, to ensure compliance with best practice in infection prevention and control within the home.	**Met**
	Action taken as confirmed during the inspection: Personal protective equipment was observed to be stored appropriately.	

5.3 Additional Areas Examined

Health and welfare of patients

A review of the care record for a patient with a wound identified three gaps in relation to the recording of dressing changes. There was evidence of the Trust tissue viability nurse involvement and the care plan for wound care reflected the current regime of care required for dressing the wound. The registered nurse also confirmed the prescribed frequency; however, a review of the wound care records evidenced that wound care had not been delivered in accordance with the prescribed regime of care from 06 December 2015. Discussion with the registered manager and nursing staff confirmed that wound dressing regimens were directed by a board in the treatment room. Wound measurements taken on the day of inspection confirmed that there had been deterioration in the wound healing when compared to the previously recorded measurements. The process for auditing wounds was discussed with the registered manager, who confirmed that audits were conducted on a regular basis, however, the audits referred to, were not available for inspection. An urgent actions record was issued and a requirement was also made, to ensure that the patients' needs are assessed and that a treatment plan is developed and implemented accordingly and recorded to evidence all care provided, with particular reference to wound and/or pressure care management.

Discussion with staff confirmed that the majority of training was completed. Training records in respect of moving and handling were reviewed. The training statistics with regards to these areas were satisfactory. However, an incorrect moving and handling technique was observed, indicating that staff training in relation to moving and handling has not been fully embedded into practice. A review of care records also confirmed that a moving and handling assessment had not been completed for the identified patient, who had been incorrectly assisted to transfer position. An urgent action record was issued and a requirement was also made to ensure that suitable arrangements are in place to provide a safe system for moving and handling patients.

Mealtime experience

The serving of breakfast and mid-day meal were observed. Uncovered meal plates were observed being delivered to patient's bedrooms on four occasions. Staff consulted stated that they normally used plate covers, but that they did not use them if they were only delivering the meals in close proximity to the dining room. The hot cereal was not maintained at an appropriate temperature. It was observed on an unheated trolley, semi-covered with cling film. The desert was also not maintained at an appropriate temperature and was served on a tray alongside the main meal. It is recommended that each course is served separately.

Staff were also observed assisting patients to eat. There was little interaction between staff and patients, for example, two members of staff were observed not to speak with patients they were assisting with their meals. Napkins were used to clean patients' faces without prior permission from patients that staff could carry out this task. Staff were also observed to proceed to assist a second patient without any communication with the patient they had just finished assisting with their meal. One staff member was observed using a spoon to lift food that had fallen on the patient's person and proceeded to feed the patient with the same substance on the spoon. A number of meals were served in a lounge that was adjacent to the main dining room. Staff did not appear to anticipate patients' needs in this room. This was evident where one patient had fallen asleep in the middle of eating their meal, before staff provided assistance. This was discussed with the registered manager and responsible person during feedback. Following the inspection, information on staff training was submitted to RQIA, regarding food safety training. In this submission, the registered manager confirmed that assisting patients with dietary intake and communication were included in the staff's induction programme and that plans were in place to address the identified matters through group supervision. A requirement was made to ensure that the serving of meals is reviewed to address in particular that meals are served in a timely manner and at a temperature which is in accordance with the nutritional guidelines. The provision of appropriate supervision to patients during mealtimes and issues in relation to respect and dignity, when assisting patients to eat must be included in this review. Advice was also given regarding the auditing of the mealtime experience.

Care Records

The 24 hour daily fluid intake records for four patients were reviewed and were generally recorded consistently. There was a system in place for monitoring the total fluid intake and discussion with the registered manager and registered nurses confirmed that this was used to communicate the fluid intakes of all patients to oncoming staff. This is to be commended. The registered manager was advised to amend this process to include the registered nurses signature.

Four patients' personal care records for the seven days preceding the inspection were reviewed. The review identified gaps in recording of information. This was evident in three patient's care records where the personal care delivered was not recorded on six dates. Therefore there was no evidence that the patients' hygiene needs had been met on these dates. This was discussed with the registered manager. Given that the inspection did not raise any concerns with regards to the personal hygiene of patients, a recommendation was made to ensure that the registered manger monitors the completion of personal care records.

A review of three care records identified that assessments and care plans were generally well maintained. However, there were no care plans in place for one identified patient three days after admission. This was concerning given that the identified patient was assessed as being at high risk of falling and also had a high risk level assessed using the Malnutrition Universal Screening Tool (MUST). This was discussed with the registered manager, who stated that the registered nurse had intended to complete the care plans on the day of inspection. Confirmation was received by email, to RQIA on 17 December 2015 that the relevant care plans were in place following the patient's assessed need. A recommendation was made to ensure that the development of patients' assessments and care plans are conducted within five days of admission. Patients' needs should be monitored, to ensure that prioritisation is given to the assessments and care plans that need to be completed within this timeframe and that care plans are put in place immediately when the patient is deemed to be at a high risk.

The review of care records also identified that although falls risk assessments and bowel assessments were regularly updated, the breakdown of how the total score was ascertained could not be evidenced. There was also evidence of contradictory risk levels in one patient's assessments. The patient was identified as being at 'low risk' of falling whereas the moving and handling assessment identified that the patient was at 'high risk' of falling. This was discussed with the registered manager who provided assurances that the format for both forms would be amended. A recommendation was made in this regard and includes the need for training to be provided as relevant to staff's roles and responsibilities.

Categories of Care

One patient was calling out loudly in a bedroom and was observed to be agitated with staff and the inspector. Staff confirmed that the patient had a confirmed diagnosis of dementia. Discussion with the registered manager regarding the placement of this identified patient confirmed that the patient's dementia associated care needs were not the prevailing need at the time of admission. However, there was no evidence that a care plan had been developed for behaviour management and there was also no evidence that staff had proactively referred the patient for specialist assessment. This was discussed with the registered manager and advice was given regarding the ongoing assessment of the patient's circumstances, taking account of the impact their behaviour may have on other patients residing in the home, the competency and capability of staff and the overall nature and philosophy of the services provided in the home. Following the inspection, the registered manager confirmed by email, that 17 out of 72 staff had received training regarding the management of behaviours that challenge. RQIA also received an application to vary the registration of the home on 05 January 2016. However, a recommendation was made to ensure that arrangements for patients with a confirmed diagnosis of dementia are kept under regular review. The review process should also include consideration of the support and/or alternative arrangements when it becomes apparent that the existing placement is no longer able to meet the patient's increased or increasing dementia care needs. This review should also address the training needs of staff, as deemed appropriate.

Personnel Records

A review of one identified member of staff's personnel record evidenced that an induction programme had not been completed following the change of employment status. A recommendation was made in this regard.

Comments by Patients, Patients' Representatives and Staff.

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

Staff

'Everything is ok here. I have had all my training done'
'I have no concerns'
'I am happy here'
'I am well supported here'
'I am happy. I have no concerns at all about the care the patients get'

Patients

'It's very good. The food is good and I couldn't say anything against the place'
'It's very good, surely'
'The nurses are very good'

Patients' Representatives

'I am happy enough. They are very good to her here'
'She is quite contented and loves the (food)'
'We have no concerns. The staff are very pleasant'
'I visit at different times and I have never seen anything untoward'
'It is all very good. If I had a problem, I would go to (the manager)'
'I have no concerns. It is very nice'

Environment

A general tour of the home was undertaken which included review of a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout.

Areas for Improvement

As previously stated, a requirement was made, to ensure that the patients' needs are assessed and that a treatment plan is developed and implemented accordingly and recorded to evidence all care provided, with particular reference to wound and/or pressure care management. Wound care audits should also be maintained in the home and made available for inspection at all times.

Suitable arrangements must be in place to ensure that moving and handling practices in the home are safe.

The serving of meals must be reviewed to address in particular, that meals are served in a timely manner and at a temperature which is in accordance with the nutritional guidelines. The provision of appropriate supervision to patients during mealtimes and issues in relation to respect and dignity, when assisting patients to eat must be included in this review.

The registered manager should monitor the patients' personal care records, to ensure that deficits identified during this inspection are addressed.

The progression of care plan development in the five day period following patient admission to the home should be monitored to ensure that prioritisation is given to the assessments and care plans that need to be completed within this timeframe.

The format of the falls risk assessment and bowel assessment forms should be further developed to provide a clear breakdown of the scores ascertained each time the assessments are updated. Training should be provided as relevant to staff's roles and responsibilities.

The appropriateness of patients' placements within the home should be kept under regular review, in particular, patients who have a confirmed diagnosis of dementia. The review process should also include consideration of the support and/or alternative arrangements when it becomes apparent that the existing placement is no longer able to meet the patient's increased or increasing dementia care needs. This review should also address the training needs of staff, as deemed appropriate.

An induction programme should be completed for all newly employed registered nurses.

Number of Requirements:	**3**	**Number of Recommendations:**	**5**

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager and the responsible person 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 and the Residential Care Homes Minimum Standards, August 2011. 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	
Statutory Requirements	
Requirement 1 **Ref:** Regulation 13 (1) (a)(b) **Stated:** First time **To be Completed by:** 13 February 2016	The registered person must ensure that the identified patient's needs are assessed and that a treatment plan is developed and implemented accordingly and recorded to evidence all care provided, with particular reference to wound and/or pressure care management. An urgent actions record was issued. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: A treatment plan for wound care was developed and implemented with immediate effect for the identified resident. This plan also evidences all care provided. Trained staff also must document twice daily in the resident's progress notes in regards to the wound and when the dressing is due to be renewed. This information is also given over at each handover.
Requirement 2 **Ref:** Regulation 14 (3) **Stated:** First time **To be Completed by:** 13 February 2016	The registered person must ensure that suitable arrangements are in place to provide a safe system for moving and handling patients. An urgent actions record was issued. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Staff have been reminded through training, staff meetings and supervision, the importance of ensuring that all residents are transferred safely and appropriately as per their risk assessments and careplans. Trained staff must also ensure that all appropriate risk assessments and careplans are included in the patient's records.
Requirement 3 **Ref:** Regulation 12 (4)(a)(b) **Stated:** First time **To be Completed by:** 13 February 2016	The registered person must review the serving of meals to ensure that: • meals are served in a timely manner to meet patients' needs • meals are served at a temperature which is in accordance with the nutritional guidelines • staff provide appropriate supervision to patients during mealtimes The deployment of staff at mealtimes and issues in relation to respect and dignity, when assisting patients to eat, must be included in this review. An audit of the mealtime experience should also be used to assist in identifying deficits and improvements in this area. **Ref: Section 5.3**

	Response by Registered Person(s) Detailing the Actions Taken: Following the inspection the Dining Room Experience was reviewed and changes implemented to ensure that all meals are served in a timely manner to meet patients' needs. Staff ensure that residents are being assisted as required to ensure that all food is being served at the correct temperature. Each course is being served separately and all meal plates are appropriately covered. Hot food is served at a temperature in accordance with Nutritional Guidelines. Porridge is being served from the Bain Marie on request. Through staff meetings and supervision staff have been reminded of ensuring that respect and dignity is maintained at all times including during the dining room experience. The registered manager has been conducting audits of the dining room experience and improvements have been made accordingly.

Recommendations	
Recommendation 1 **Ref**: Standard 37.1 **Stated:** Second time **To be Completed by:** 13 February 2016	Consideration should be given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Confidential patient information is stored in the dining room in a lidded trolley.
Recommendation 2 **Ref**: Standard 35.3 **Stated:** First time **To be Completed by:** 13 February 2016	The registered manager should audit the patients' personal care records, to ensure that deficits identified during this inspection are addressed. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: The registered manager monitors personal care records regularly. Any deficits are brought immediately to the attention of the appropriate staff and the importance of good documentaion highlighted.
Recommendation 3 **Ref**: Standard 4.1 **Stated:** First time **To be Completed by:**	The progression of care plan development in the five day period following patient admission to the home should be monitored to ensure that prioritisation is given to the assessments and care plans that need to be completed within this timeframe. **Ref: Section 5.3**

13 February 2016	**Response by Registered Person(s) Detailing the Actions Taken:** The careplanning process is prioritised and implemented from admission for all new patients. Careplans are based on the assessments carried out on each patient and this is completed withn 5 days from admission.
Recommendation 4 **Ref**: Standard 39.4 **Stated:** First time **To be Completed by:** 13 February 2016	The format of the falls risk assessment and bowel assessment forms should be further developed to provide a clear breakdown of the scores ascertained each time the assessments are updated. Training should be provided as relevant to staff's roles and responsibilities. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Falls risk assessments and bowel assessments have been further developed and appropriate staff have been trained in the completion of the forms and also their responsiblities highlighted to them in regards to ensuring that careplans reflect scores from assessments.

Recommendation 5 **Ref**: Standard 17.4 **Stated:** First time **To be Completed by:** 13 February 2016	The appropriateness of patients' placements within the home should be kept under regular review, in particular, patients who have a confirmed diagnosis of dementia. The review process should also include consideration of the support and/or alternative arrangements when it becomes apparent that the existing placement is no longer able to meet the patient's increased or increasing dementia care needs. This review should also address the training needs of staff, as deemed appropriate. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Appropriateness of patients placements are kept under regular review and in particular patients who have a confirmed diagnosis of dementia and can present with challenging behaviour. Dementia training has been arranged for staff to assist them in the management of dementia patients and to give them a better understanding in challlenging behaviour.

Recommendation 6 **Ref**: Standard 39.1 **Stated:** First time **To be Completed by:** 13 February 2016	An induction programme should be completed for all newly employed staff. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: An induction programme is implemented on all newly appointed members of staff. Induction programmes should be completed within 4 weeks of commencing work.

Registered Manager Completing QIP	V Rutherford	**Date Completed**	04/02/16
Registered Person Approving QIP		**Date Approved**	04/02/16.
RQIA Inspector Assessing Response		**Date Approved**	

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

RQIA Inspector Assessing Response	Aveen Donnelly	**Date Approved**	05/02/2016