Moneymore
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Moneymore
BT45 7QF

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Unannounced Care Inspection
of
Moneymore

25 January 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 25 January 2016 from 09.40 to 16.00 hours.

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

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 Moneymore 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 previous care inspection on 7 July 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	**1**	**5**

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

2. Service Details

Registered Organisation/Registered Person: Four Seasons Health Care	**Registered Manager:** Fionnuala Kidd
Person in Charge of the Home at the Time of Inspection: Fionnuala Kidd	**Date Manager Registered:** 17 July 2013
Categories of Care: RC-I, RC-PH(E), RC-MP(E), NH-I, NH-PH A maximum of 4 residential places. A maximum of 1 patient in category NH-PH.	**Number of Registered Places:** 41

Number of Patients Accommodated on Day of Inspection: 29	**Weekly Tariff at Time of Inspection:** £470-£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:

- discussion with the registered manager
- discussion with patients
- discussion with staff
- review of care records
- observation during an inspection of the premises
- evaluation and feedback.

The inspector met with six patients individually and with the majority of others in groups, three care staff, two registered nurses, two ancillary staff and two patient's visitors/representatives.

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 reports from inspections undertaken in this inspection year
- the returned quality improvement plans (QIPs) from inspection undertaken in this inspection year.

The following records were examined during the inspection:

- three patients' care records
- staff training records
- resources for staff in relation to resuscitation and palliative care
- staff meeting minutes
- residents' meeting minutes
- care record audits
- a selection of policies and procedures.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an announced estates inspection on 4 August 2015. The completed QIP was returned and approved by the estates inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 26.6 **Stated:** Second time	The following specified policies must be reviewed and updated as required and ratified by the responsible person: • Continence Care • Catheter care • Ileostomy and colostomy care • Digital rectal evacuation • Bowel Care	**Met**
	Action taken as confirmed during the inspection: The above policies had all been reviewed and placed in a file for staff to read. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 39 Criterion 9 **Stated:** First time	The registered manager should ensure that staff are made aware of guidance documents such as Nursing Midwifery Council (NMC) guidance and the Resuscitation Guidelines 2010 from the Resuscitation Council UK.	**Met**
	Action taken as confirmed during the inspection: The manager had compiled a resuscitation file for staff to include the up to date guidelines. This had been highlighted to staff at the staff meeting in August 2015. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 32 **Stated:** First time	Staff should receive training/supervision on the content of the new palliative care and end of life manual once completed to ensure they are knowledgeable regarding best practice in this aspect of care.	**Met**
	Action taken as confirmed during the inspection: The manager had compiled a palliative care resource file which included the new manual and up to date policies.	

	A palliative care workbook had been distributed to all staff and there was evidence that several of these had been completed and returned. Staff had also been required to undertake an e-learning module on palliative care and a number of staff had completed this course. This training was ongoing. This recommendation has been met.	
Recommendation 4 **Ref**: Standard 44 **Stated:** First time	An action plan should be submitted detailing the works to be undertaken and the timeframe for these works with the return of the QIP. **Action taken as confirmed during the inspection**: An action plan was submitted with the return of the previous QIP detailing the works to be completed. There was evidence that refurbishment works had been completed to include painting, repairs to doors and architraves, replacement of furniture and flooring and the refurbishment of three bath/shower rooms. The manager stated that new flooring was due to be put down in the dining room and the replacement of patients' bedroom furniture was ongoing. The home was generally presented to a good standard of hygiene and décor throughout. A rusted and loose handrail was noted in one bathroom which required replacement. Handrails had been ordered for the newly refurbished bathrooms and the manager agreed to order another handrail and replace this as soon as possible. This recommendation has been met.	**Met**

5.3 Additional Areas Examined

5.3.1. Comments of patients, patients' representatives and staff

As part of the inspection process patients, their representatives and staff were consulted and some comments received are detailed below.

Patients

Patients spoken with were generally satisfied with the care provided and commented on the kindness and attentiveness of the staff. They confirmed that staff responded to call bells promptly.

One patient was dissatisfied with the choices of pureed meals on offer. Kitchen staff, care staff and the manager all confirmed in discussion that alternatives would be made available if requested. In discussion with the manager it was agreed that patients should be informed that alternatives are available on request. A recommendation has been made in this regard.

One patient commented that they were not always kept informed about their care but did not wish the inspector to identify them. Advice was offered to the patient and the comment was passed on to the manager for her information and attention as required.

Comments from patients included:

"The staff are good and are looking after me."
"They are all very good here. The food is good – there is nearly too much!"
"You couldn't get better care."

On entering one patient's bedroom it was noted that they has spilled tea on their clothes as they were unable to drink from the cup provided. At the request of the inspector, a care assistant was able to provide an alternative, more suitable cup, the patient was assisted to change their clothes and a fresh cup of tea was provided. The minutes of a residents' meeting in September 2015 were reviewed and evidenced that the issue of suitable drinking cups had been raised by relatives. Evidence was available that more suitable cups had been provided for those patients who required them. However, the morning tea was served by the kitchen staff who were unaware of the patient's need for specialist equipment. In discussion with the manager it was agreed that kitchen staff should be made aware of the equipment required to enable patients to eat and drink independently. A recommendation has been made.

Patients' representatives

Two patients' representative spoke with the inspector and commented positively on the care provided in the home. One representative commented that staff had also been very caring towards them as well as their loved one. Good relationships were evident between the staff and the visitors to the home.

Staff

Staff were generally happy working in the home and raised no concerns. One care assistant commented that they loved their work. Relationships between patients and staff were observed to be relaxed and friendly and staff were responding promptly to patient's needs.

5.3.2. Medicines management

On entering one patient's bedroom it was noted that several tablets and a liquid medication had been spilled on the floor. The manager and staff nurse were informed. On a review of the care records it was clear that this patient required supervision with their medications. It was evident that best practice in medicines management had not been adhered to and there was a risk that the patient's medications could have been omitted. The manager agreed to ensure that the patient received their outstanding medication and to complete a medicines incident notification to RQIA. In addition, the manager stated that she would raise this at the staff supervision session planned for later in the week. A requirement has been made in regard to the safe administration of medicines.

5.3.3. Care Documentation

One patient was observed to have a wound dressing in place and a review of their care records was undertaken. It was noted that the care plan had not been updated to reflect the current dressings in use nor was the wound review chart completed to document the condition of the wound at each dressing change. On discussion with a registered nurse it was evident that they were knowledgeable about the patient's wound care needs. According to the registered nurse the wound had been redressed that morning by the night staff and the wound dressing was observed to be clean and intact. A photograph had been taken of the wound that morning but there was no documentary evidence that the dressing had been done. A recommendation has been made that staff document the condition of wounds contemporaneously and in accordance with best practice guidelines.

It was noted that one patient was sitting on a chair which did not appear to be suitable for their needs. A review of this patient's care record could not evidence that their seating needs had been appropriately assessed or that any referral had been made to the occupational therapist (OT). The manager agreed to complete an OT referral that day and a recommendation has been made that confirmation that this referral has been made is sent with the return of the QIP.

In addition, it was noted that not all risk assessments and care plans had been completed within the required timeframe of five days post admission. A recommendation has been made in this regard.

Areas for Improvement

Number of Requirements:	**1**	**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 Fionnuala Kidd, 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 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

Statutory Requirements	
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be Completed by:** 1 February 2015	The registered person shall make suitable arrangements for the safe administration of medicines. Registered nurses must be aware of the plan of care for each patient and ensure that a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, is made in accordance with NMC standards for medicines management. **Ref: Section 5.3.2**
	Response by Registered Person(s) Detailing the Actions Taken: This was adderssed with all registered nurses under supervision. The administration of medication to residents under the NMC code of conduct and how also to report an incident.
Recommendations	
Recommendation 1 **Ref**: Standard 12, criteria 6 and 13 **Stated:** First time **To be Completed by:** 25 February 2016	Patients should be offered a choice of pureed meals and be made aware that alternative pureed options are available upon request. **Ref: Section 5.3.1**
	Response by Registered Person(s) Detailing the Actions Taken: All residents are offered a choice of meals daily and this is recorded. Residents can also change their mind before the meals are served and another meal of their choice will be served. This will be added to the menu choice form. Also this will be addressed at resident and relative meetings.
Recommendation 2 **Ref**: Standard 12, criterion 16 **Stated:** First time **To be Completed by:** 25 February 2016	The registered person should ensure that all staff, including kitchen staff, are made aware of the equipment required for each patient to enable them to eat and drink as independently as possible. **Ref: Section 5.3.1**
	Response by Registered Person(s) Detailing the Actions Taken: All staff in the kitchen and care staff were made aware of the personalised crockery of the residents. This has been advised to kitchen staff via a written and signed supervision.

Recommendation 3 **Ref**: Standard 4, criteria 8 and 9 **Stated:** First time **To be Completed by:** 25 February 2016	Records of wound care delivery should be maintained contemporaneously and in accordance with best practice guidelines in wound management. **Ref: Section 5.3.3**
	Response by Registered Person(s) Detailing the Actions Taken: All nurses were made aware of the need to complete wound care delivery though best practice guidleines. This will be checked and signed weekly by the home manager.
Recommendation 4 **Ref**: Standard 4, Criterion 4 **Stated:** First time **To be Completed by:** With the return of the QIP	A referral should be made to the occupational therapist in regards to the seating arrangements for one named patient. Confirmation that this referral has been made should be sent with the return of the QIP. **Ref: Section 5.3.3**
	Response by Registered Person(s) Detailing the Actions Taken: A referral has been sent to OT on 25.01.2016 to enable the resident to be considered for a specialised chair.
Recommendation 5 **Ref**: Standard 4, Criterion 1 **Stated:** First time **To be Completed by:** 25 February 2016	A detailed plan of care should be generated from a comprehensive, holistic assessment and drawn up with each patient. The assessment should be commenced on the day of admission and completed within five days of admission to the home. **Ref: Section 5.3.3**
	Response by Registered Person(s) Detailing the Actions Taken: Staff nurses were all reissued with the policy , of initial assessments to be completed on admission. New admissions will be checked and signed by the manager to verify.

Registered Manager Completing QIP	Fionnuala Kidd	**Date Completed**	24.02.2016
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	25.02.16
RQIA Inspector Assessing Response	Karen Scarlett	**Date Approved**	01.03.2016

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

Please provide any additional comments or observations you may wish to make below: