Unannounced Care Inspection

Name of Establishment:	**Rathmena**
RQIA Number:	**1454**
Date of Inspection:	**13 January 2015**
Inspector's Name:	**Karen Scarlett**
Inspection ID:	**17072**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Rathmena
Address:	26 Rathmena Gardens Ballyclare BT39 9HU
Telephone Number:	028 9332 2980
Email Address:	rathmena.m@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Healthcare Mr James Mc Call
Registered Manager:	Mrs Wendy McMaster
Person in Charge of the Home at the Time of Inspection:	Mrs Wendy McMaster
Categories of Care:	NH-PH, NH-PH(E), RC-I, NH-LD, NH-LD(E), NH-I
Number of Registered Places:	29
Number of Patients Accommodated on Day of Inspection:	24 (21 nursing and 3 residential)
Scale of Charges (per week):	£526.00 - £540.00
Date and Type of Previous Inspection:	1 October 2013, primary unannounced inspection
Date and Time of Inspection:	13 January 2015 09.35 – 15.10
Name of Inspector:	Karen Scarlett

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 nurse manager
- Discussion with staff
- Discussion with patients individually and with others in groups
- Consultation with relatives
- 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 plans
- Observation during an inspection of the premises
- Evaluation and feedback

5.0 Consultation Process

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

Patients/Residents	9 individually and others in groups
Staff	6
Relatives	5
Visiting Professionals	0

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

Issued To	Number Issued	Number Returned
Patients/Residents	0	0
Relatives/Representatives	3	1
Staff	10	0

6.0 Inspection Focus

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible person/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

However, due to workload pressures and contingency measures within the Regulation Directorate, the themes/standards within the self-assessment were not inspected on this occasion.

This 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

Rathmena Private Nursing Home is situated in a quiet residential area of Ballyclare. Patients' facilities are on the ground floor with staff facilities on the first floor.

Bedroom accommodation is provided in double and single rooms. There is a large communal lounge and a dining area. Toilet, bathroom and shower facilities are also provided.

The home is surrounded by landscaped gardens and a patio area for patients is provided at the rear of the home. Car parking is available at the front and side of the home.

The home is part of Four Seasons Health Care Ltd. The home is registered to accommodate twenty nine persons, and to provide nursing and residential care for persons under the following categories of care: -

Nursing Care

I	Old age not falling into any other category
LD	Learning disability under 65 years
LD (E)	Learning disability over 65 years
PH	Physical disability other than sensory impairment under 65 years
PH (E)	Physical disability other than sensory impairment over 65 years

Residential Care

I	Old age not falling into any other category

8.0 Executive Summary

The unannounced inspection of Rathmena Care Home was undertaken by Karen Scarlett on 13 January 2015 between 09.35 and 15.10. The inspection was facilitated by Mrs Wendy McMaster, registered manager, who was available for verbal feedback at the conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection on 1 October 2013.

A number of documents are required to be returned prior to the inspection and these were submitted within the required timeframe and offered the required assurances.

The patients / residents were well presented and were observed to be comfortable in their surroundings. No concerns were raised in discussion with the patients / residents or their representatives and they were all positive about the care provided and the staff. Refer to section 11.5 for further details about patients/residents and relatives.

The home's compliance with Standard 19 was examined. There was evidence that a continence assessment had been completed for the majority of patients. This assessment formed part of a comprehensive and detailed assessment of patient needs from the date of admission and was found to be updated on a regular basis and as required. The assessment of patient needs was evidenced to inform the care planning process. Comprehensive reviews of both the assessments of need and the care plans were maintained on a regular basis and as required in three records reviewed.

Discussion with the registered manager and staff confirmed that they had been trained and assessed as competent in continence care. A recommendation has been made that training be undertaken in male catheterisation to ensure that sufficient numbers of registered nurses have this skill and competence in order to meet the needs of current patients/ residents.

Policies, procedures and guidelines in the promotion of continence and the management of incontinence were available in the home. However, a number of policies in relation to continence were found to be in need of review and updating. A recommendation has been made in this regard.

From a review of the available evidence, discussion with relevant staff and observation, the inspector can confirm that the level of compliance with the standard inspected was substantially compliant and two recommendations have been made in this regard.

A range of staff were consulted and they all commented on the excellent team work within the home and the approachability of the registered manager. All staff were of the opinion that continence care was of a good standard and no other issues or concerns were raised. Refer to section 11.6 for further information on staff comments.

The home was generally well maintained and presented to a high standard of hygiene throughout. A refurbishment programme had been undertaken and many improvements were noted particularly to the bath and shower rooms. A number of issues were identified in relation to best practice in infection prevention and control and the condition of the premises. Two requirements have been made in this regard. Refer to section 11.7 for further information on the home environment.

An examination of the care records identified that improvements were required in the assessment, documentation and management of patients' pain. A recommendation has been made in this regard. Refer to section 11.8 for further information.

The inspector can confirm that at the time of this inspection, the delivery of care to patients/residents was evidenced to be of a good standard and patients/residents were observed to be treated by staff with dignity and respect.

The inspector reviewed and validated the home's progress regarding the five requirements and three recommendations made at the last inspection on 1 October 2013. All the requirements and recommendations were assessed as compliant and none have been restated.

As a result of this inspection, two requirements and three recommendations were made.

Details can be found under section 11.0 of the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients/residents, registered manager, registered nurses and staff for their assistance and co-operation throughout the inspection process. The inspector would also like to thank the relative who completed a questionnaire.

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	17(2)	The registered person shall supply to the RQIA a report in respect of any review conducted by him for the purpose of paragraph (1) and made a copy of the report available to patients/residents.	A copy of the annual report for 2014 was reviewed. This has been made available to the patients/residents and their representatives within the statement of purpose file on display in the reception area. This requirement has been addressed.	Compliant
2	16(2)(b)	The registered manager must ensure that the registered nursing staff maintains a regular review of all nursing care plans. Care plans must be reviewed and updated to accurately reflect the needs of the patient.	A review of three care records evidenced that care plans were being reviewed and updated monthly and accurately reflected the needs of the patients. This requirement has been addressed.	Compliant

3	19(1)(a) Schedule 3	The registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence care delivered and the date the record was completed. Fluid balance charts should be accurately maintained.	The repositioning charts were reviewed and were found to be consistently completed, reflective of the positioning of the patient and comments had been made regarding the condition of the skin. Individual time frames for repositioning were stated and adhered to. Fluid balance charts were mainly well completed and the totals reconciled in to the progress notes on a daily basis. This requirement has been addressed.	Compliant
4	13(1)(a)	The registered manager must ensure that; • quality assurance of the management of wounds is appropriately established • wound care records are maintained to an acceptable professional standard.	The registered manager is carrying out monthly audits of wound care and relaying the outcome to the staff for action as required. Two records reviewed in relation to wound care demonstrated a full assessment, an up to date care plan and body map. A wound care chart was in place to detail the condition of the wound at each dressing change and the specialist advice of the tissue viability nurse had been sought and the recommendations incorporated in to the care plan. This requirement has been addressed.	Compliant

5	20(3)	The registered person shall ensure that at all times a nurse is working at the nursing home and that the registered manager carries out a competency and capability assessment with any nurse who is given the responsibility of being in charge of the home for any period of time in the absence of the registered manager.	Two competency and capability records for nurses who can be in charge of the home were reviewed. These were completed and signed by the staff member and the registered manager. This requirement has been addressed.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	28.4	The registered manager must ensure that preceptorship records have been signed off by the preceptor /registered manager when preceptorship has been completed.	A completed preceptorship record for one recently employed staff nurse was reviewed. This was fully completed and signed by the staff member and the registered manager. This recommendation has been addressed.	Compliant
2	30.4	The registered manager must ensure that agency nurse documentation is reviewed to ensure there is clear evidence of an assessment of the competency and capability any nurse who is given the responsibility of being in charge of the home. All nurse in charge competency assessments should be signed and dated by the nurse and have a final statement of competency signed off by the registered manager.	The induction/ competency and capability assessments for two agency nurses were reviewed and had been completed and signed. The acting manager stated that no agency nurses were currently left in charge of the home. This recommendation has been addressed.	Compliant

3.	32.1	The registered person should submit to RQIA a copy of the refurbishment plans for the home together with the timescales.	This plan was submitted to RQIA following the last inspection and many of the planned refurbishments were observed to have been completed. This recommendation has been addressed.	Compliant

9.1 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.

Since the previous inspection on 1 October 2013, RQIA have been notified by the home of an ongoing investigation in relation to an alleged safeguarding of vulnerable adults (SOVA) issue. The issues was appropriately reported and managed in accordance with the regional adult protection policy/procedures.

RQIA have been kept informed at all stages of the investigations by the registered manager and will continue to be updated as required.

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 three patients' care records evidenced that bladder and bowel continence assessments were undertaken for these patients. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. There was evidence in the three patients care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. Review of the three patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. The care plans reviewed addressed the patients' assessed needs in regard to continence management. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
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 inspector can confirm that the following policies and procedures were in place; • continence management • bowel care / management • digital rectal examination However, the policies were in need of review and updating. A recommendation has been made in this regard. The inspector can also confirm that the following guideline documents were in place: • RCN continence care guidelines • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
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:	
The training records were reviewed and there had been no training undertaken regarding continence care in the past year. On discussion with staff many of them recalled having continence training in the past and all were very knowledgeable about the important aspects of continence care including fluid intake, skin care and reporting any concern appropriately. Discussion with the manager revealed that all the registered nurses in the home were deemed competent in female catheterisation. Some registered nurse were trained and competent in male catheterisation, however, a recommendation has been made that training be undertaken to ensure that sufficient numbers of nurses have this skill and competence in order to meet the needs of current patients/ residents. Monthly audits of the care records were undertaken by the registered manager and these included the management of incontinence. A copy of the audit was sent to the appropriate named nurse for action as required.	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 staff were noted to treat the patients with dignity and respect. Good relationships were evident between patients and staff.

Patients were well presented with their clothing suitable for the season. Staff were observed to respond to patients' requests promptly. The demeanour of patients indicated that they were relaxed in their surroundings.

11.2 Complaints

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.

A complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being pro-actively managed.

The inspector discussed the management of complaints with the registered manager and ascertained that no recent complaints had been received.

11.3 Patient Finance Questionnaire

Prior to the inspection a patient financial questionnaire was forwarded by RQIA to the home for completion. The evidence provided in the returned questionnaire indicated that patients' monies were being managed in accordance with legislation and best practice guidance.

11.4 NMC Declaration

Prior to the inspection the registered manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC.

11.5 Patients/Residents and Relatives Comments

Patient spoken with confirmed that they were treated with dignity and respect, that staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home. All patients/ residents were well presented in clothing suitable for the season. No concerns were raised regarding the care provided in the home.

A number of patients were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients' comments were as follows:

"Everything is good here."
"Food is very good."
"They look after me very well."

The three relatives spoken with were very complementary and positive about the care provided and the staff team. One relative who returned a questionnaire commented:

"The staff are very friendly and helpful. I feel like part of the family and know that everyone is concerned about my relative."

11.6 Staff Comments

The inspector spoke with six staff including registered nurses, care assistants and ancillary staff. The inspector was able to speak to a number of these staff individually and in private. Ten questionnaires were issued to staff but none were returned. Staff responses in discussion indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes. No issues or concerns were raised by staff.

Examples of staff comments were as follows;

"We have a very good team here."
"The care assistants in this home are very good."
"The home is clean and very well organised."

11.7 Environment

The inspector viewed the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and the majority of areas were maintained to a high standard of hygiene. A number of issues were identified in relation to best practice in infection prevention and control and the condition of the premises.

Waste bags, wet wipes and patients' personal items were left in the bathroom. This is not in accordance with best practice in infection prevention and control and this issue had been identified on a number of occasions in the home's monthly quality reports. In addition, a set of cot bumpers in one patient's bedroom were found to be badly worn and were in need of replacement. A requirement has been made in relation to infection control

An inspection of the premises also identified minor wall and paint damage to a number of patients' bedrooms which cannot be effectively cleaned and require repair. One identified sluice room was found to have a heavily stained floor and was malodorous. A requirement has been made in this regard.

11.8 Care Records

An examination of three care records found these to be maintained to a generally high standard. Risk assessments and care plans were being reviewed on a monthly basis or as required. A number of improvements had taken place in repositioning, recording of wound care and the fluid charts in response to the last inspection findings and quality improvement plan. However, a deficit was identified in the assessing and recording of pain. In one record examined the patient was on several types of analgesia and there was no pain assessment completed. In another record a pain assessment had been completed as a "one-off" event on admission and a comment made monthly thereafter. A care plan was also in place to direct staff not to assess the patient's pain as they were on sufficient analgesia. This was discussed with the registered manager who assured the inspector that she would discuss this with the nurse concerned and ensure this care plan was discontinued. Furthermore, the registered manager had arranged training for staff in person-centred care planning which she believed would address some of these concerns.

Patients' experiencing pain should be assessed frequently to determine the need for analgesia and its effectiveness. Staff responses in discussion indicated that they undertook this assessment informally but this was not being documented appropriately. Discussion with the registered manager indicated that this was an issue that she had already identified. A recommendation has been made in this regard.

In one record examined a patient's name was found to be spelled incorrectly on the "Do not attempt cardio-pulmonary resuscitation" form and on the "bed rail consent/ discussion" form. The registered manager assured the inspector that this would be corrected immediately.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Wendy McMaster, registered 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:

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Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
In Rathmena, either the Home Manager or her Deputy carries out a pre-admission assessment. Information is sourced from a variety of sources including resident/representative (if available), care records and the care management team. When all information is gathered a decision is made as to the homes ability to safely and effectively meet the residents needs. In the event of a request for an emergency admission and pre-admission is not possible, a pre-admission can be carried out over the telephone. Written comprehensive multi-disciplinary information must be made available and only if the manager can satisfy herself that the residents needs can be met safely, will the admission proceed. When the resident arrives for admission the nurse-in-charge completes a patient centered assessment. It is discussed with the resident or their representative and information from the pre-admission assessment and care management team. The two documents completed initially within the first twelve hours of the admission are the Admission Assessment and the needs assessment. There are 16 areas assessed which allows the staff enough information to complete a person centered care plan. There are multiple risk assessments completed on admission as well including a skin assessment using Braden tool, a body map, a moving and handling assessment, falls risk assessment, bed rail assessment, pain assessment and nutritional assessments using the MUST tool and Four Seasons nutritional & oral assessments. Initial wound assessments are completed if required. Contenience and bowel assessments are completed within a 7 day time frame. Using the information gathered, her clinical judgement and any information from the resident/representative, the nurse then formulates a person centered care plan which addresses any identified risk, wishes or expectations. The Home Manager and the Regional Manager complete audits on a regular basis.	Compliant

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
In Rathmena the Registered Nurse completes a comprehensive holistic assessment of the residents needs within a 7 day frame. This takes into account the wishes and expectations of the resident/representative and any recommendation made by other members of the multi disciplinary team.Registered Nurses are aware of the process to refer to both Tissue viability Nurse and podiatry. Contact numbers and referral forms are available in a file at the nurses station, when a written referral is sent in this is supported by telephone contact in order to get initial advice. Referrals are also made via the GP to the vascular surgeon if necessary. For residents assessed as being at risk of developing a pressure ulcer, a pressure ulcer management and treatment plan is presented. This care plan reflects skin care, frequency of repositioning, mattress type and reflects any advice from other members of the multi-disciplinary team. The risks are discussed with core management and the resident/representative. Regional Manager is notified on a monthly report and during her reg 29 visit. Dietetic referrals are made by the nurse. Her decision is informed by the MUST assessment and her own clinical judgement. The referral forms are available at the nurses station and when they have been sent through this is followed up by a phonecall for initial advice. All advice, treatment and recommendations are added to the care plan and this is reviewed and evaulated on a monthly basis.	Compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
In Rathmena the residents needs are assessed on an ongoing daily basis and recorded on the evaluation document. Any changes in planned care are also added to the care plan. If the residents needs change or on a monthly basis the needs assessment, risk assessments & care plans are reviewed. The frequency of review and re-assessment is recorded on the care plan. Any changes are reported to the Manager on a 24 hour shift report. Audits are completed by the Manager and the Regional Manager.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Rathmena refers to up to date guidelines from professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for reference. In order to effectively screen patients who have skin damage the validated pressure assessment grading tool we use is E PUAP. If a pressure ulcer is present on admission or if a pressure ulcer develops during admission we complete an initial wound assessment which informs the plan of care, this includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of re-positioning, mattress type and frequency of dressing change. Any changes to any of these areas are recorded on an on-going wound assessment and a care plan evaluation. The up to date nutritional guidelines in use are 'Promoting good nutrition'. RCN nutrition now, PHA-nutritional guidelines and a menu check list for residential and care home and NICE guidelines, nutrition and support in adults. Four Seasons Health Care policies and procedures in relation to nutritional care, diabetic care, care of subcutaneous fluids and care of percutaneous endoscopic gastrostory are also available for reference.	Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
In Rathmena we keep nursing records of all interventions, activities and procedures carried out for each resdient. All records are contemporaneous and follow NMC guidelines. All care delivered includes an evalation and an outcome plan. Nurses have access to policies and procedures in relation to records and record keeping. Records of meals are provided for each resident at each meal time and care recorded on a daily menu choice form. The catering manager keeps records of food served including any specialist dietary needs. Some residents are assessed as being at risk of malnutrition, dehydration or eating excessively. They have their food and fluid recorded on a daily basis using the Four Seasons Health Care food record booklet or fluid record booklet. Records are maintained over 24hrs and fluid intake is totalled at the end of the 24hour period. This information is then used by the nurse to inform their daily evaluation. Any deficits are actioned appropriately and if necessary referred to the multidisciplinary team. Changes in planned care are reviewed and discussed with the resident/representative. The Home Manager regularly audits these records.	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
In Rathmena the registered nurses record the outcome of care delivered on a day to day basis on the progress notes. The care delivered is reviewed as indicated on the care plan, or more frequently as the residents condition indicates. Recommendations by the multi-disciplinary team are included.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
In Rathmena Care Management reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, any concerns in regard to care or at the request of the resident or representative. The Trust organise these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the resident's file. Any recommendations made are actioned by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
In Rathmena we follow FSHC policy and procedures in relation to nutrition which follows best practice guidelines as identified in section D. Registered nurses assess each resident's dietary needs on admission and review on an ongoing basis. The care plan reflects the type of diet, any special dietary needs, the residents choice and ability in regard to their meal times. The care plan also includes any recommendations made by the Dietician or the Speech and Language Therapist and is evaluated on a monthly basis or more often if necessary. Rathmena has a 3 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives - residents meetings, one to one meetings and food questionnaires. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied. Copies of instructions and recommendations from the dietician and speech and language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's specific dietary needs. Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything from the daily menu an alternative meal of their choice is provided. The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on the daily menu sheet. Daily menus are on display in each dining room in photographic format.	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
In Rathmena Registered nurses received training on dysphagia and enteral feeding techiques (PEG). The Speech and Language therapist and dietician also give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document - 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by the speech and language therapist are incorporated into the care plan to include type of diet, consistency of fluids, and assistance required. The kitchen receive a copy of the SALT's recommendations and this is kept on file for reference by the kitchen. Meals are served at the following times:- Breakfast - 8.30am-10.30am Morning tea - 11am Lunch - 12.45pm-1pm Afternoon tea - 3pm Evening tea - 5pm Early evening supper - 7.00pm Late Supper 10pm In Rathmena residents can choose to have their meals at different times in consultation with the kitchen. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request. There are foods available outside of these times for those resident's who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedrooms, these are replenished on a regular basis. Registered nurses record individual requirements for residents nutrition on their care plan. A diet notification form is completed for each resident with a copy given to the kitchen and one held in the care file. Meals are not served unless a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Appropriate aids such as plate guards and specialised cutlery are available as necessary and as indicated in the plan of care. Each nurse has completed an education e-learning module on pressure area care. The home has a link nurse who has received enhanced training, to provide support and education to other nurses within the home on an ad hoc basis. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the home have a competency assessment completed. Competency assessments have a quality assurance element built into the process.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	COMPLIANCE LEVEL
	Provider to complete

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Care Inspection

Rathmena

13 January 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 the registered manager during 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
1.	13 (7)	The registered person shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff. This is particularly in relation to: • The presence of waste bags, wipes and patients' personal items in bathrooms • The presence of damaged bed rail bumpers in one patient's bedroom which must be replaced. **Ref: section 11.7**	One	The waste bags, wipes and personal items have been removed from the bathroom and is monitored at home level. The bedrail bumper have been replaced and are monitored through audit process	One month from date of inspection
2.	27 (2) (b & d)	The registered person shall ensure that the premises are kept in a good state of repair externally and internally and all parts are clean and reasonably decorated. This is particularly in relation to: • Wall and paint damage in patients' bedrooms • Stained flooring in an identified sluice **Ref: section 11.7**	One	Wall and paint damage in the patient bedrooms have been repaired . New flooring laid to the identified sluice	Three months from date of 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.	26.6	The following policy must be reviewed and updated as required and ratified by the responsible person: • continence care • bowel care / management • digital rectal examination **Ref: Section 10.0 of report**	One	This has been refered to the clinical quality manager and is currently under review.	One month from date of inspection
2.	19.4	The registered manager should ensure that sufficient registered nurses have up to date knowledge and expertise in male catheterisation. **Ref: Section 10.0 of report**	One	Training for the Registered nurses is being arranged on a rolling programme.	Ongoing from date of inspection

3.	5.4	Re-assessment of patients' needs should be an ongoing process and be carried out daily and at agreed time intervals. This is in relation to: • Pain assessments must be carried out and documented and kept under regular review to ensure that these needs are met and the effectiveness of any analgesia is documented. **Ref: section 11.8**	One	Pain assessments are now being carried out , documented and regularly reviewed, and their effectiveness is monitored in the progress notes.	Three months from date of inspection

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	Wendy McMaster
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall DIRECTOR OF OPERATIONS 26/2/15

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes		6/3/15
Further information requested from provider			