Rathmena
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Ballyclare
BT39 9HU

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Unannounced Care Inspection
of
Rathmena

14 December 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced care inspection took place on 14 December 2015 from 11.00 to 14.45.

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

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015.

For the purposes of this report, the term 'patients' will be used to described those living in Rathmena 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 23 June 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	2

The details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Wendy Mc Master, Registered Manager as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four Seasons Health Care Dr Maureen Claire Royston	**Registered Manager:** Mrs Wendy McMaster
Person in Charge of the Home at the Time of Inspection: Mrs Wendy McMaster	**Date Manager Registered:** 3 April 2013
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: 23	**Weekly Tariff at Time of Inspection:** £470.00 - £593.00

3. Inspection Focus

This inspection was undertaken to follow up on the issues raised as a result of an unannounced care inspection on 23 June 2015.

4. Methods/Process

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

- discussion with the registered manager;
- discussion with the deputy manager;
- discussion with patients and relatives;
- a general tour of the home and review of a random selection of patients' bedrooms, bathrooms and communal areas;
- examination of a selection of patient care records;
- examination of a selection of records pertaining to the inspection focus;
- observation of care delivery; and
- evaluation and feedback.

During the inspection, five patients were spoken with individually and with others in smaller groups; two care staff, the deputy manager and two patients representatives and/ visitors.

Prior to inspection the following records were analysed:

- the registration status of the home;
- written and verbal communication received by RQIA since the previous care inspection;
- the returned quality improvement plan (QIP) from the care inspection of 23 June 2015;
- notifiable events submitted since the previous care inspection.

The following records were examined during the inspection:

- four patient care records
- staff training records
- care record audits
- safe guarding records.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of Rathmena was an unannounced care inspection dated 23 June 2015. The completed QIP was returned and approved by the care inspector.

Review of Requirements and Recommendations from the last care inspection on 23 June 2015

5.2

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 14 (4) **Stated:** First time **To be Completed by: 21 August 2015**	The registered person shall make suitable arrangements, by training of staff or by other measures, to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse. The correct reporting procedures must be followed by the manager and all staff. **Action taken as confirmed during the inspection**: The Registered manager advised that there were no current safeguarding issues. Discussion with the registered manager confirmed that they were knowledgeable in regards to the protocol and procedures for safeguarding. The registered manager advised that staff had completed training in this regard. A review of documentation pertaining to a recent safeguarding matter was reviewed. The documentation evidenced that all processes had been implemented and all agreed actions resulting from the investigation had been implemented. This requirement has been met.	**Met**

Requirement 2 **Ref:** Regulation 27 (2) (d) **Stated:** First time **To be Completed by: 21 August 2015**	The registered person shall ensure that all parts of the nursing home are kept clean. This is particularly in relation to a toilet in an identified bathroom. **Action taken as confirmed during the inspection**: A tour of the home including the identified toilet evidenced that all areas of the home were maintained to a satisfactory level of cleanliness.	**Met**
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 32 **Stated:** First time **To be Completed by:** **8 September 2015**	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. **Action taken as confirmed during the inspection**: A review of training records evidenced that fifteen staff had completed training in the areas identified. Some staff supervisions have been completed and the registered manager advised that all staff will have supervision following the completion of their training to determine the learning achieved.	**Met**
Recommendation 2 **Ref**: Standard 4 **Stated:** First time **To be Completed by:** **8 September 2015**	It is recommended that the care plan should clearly state how the emotional, social and psychological needs of the patient will be met alongside physical and other healthcare needs. The language used should be reflective of person-centred principles. **Action taken as confirmed during the inspection**: A review of four care records evidenced that in most cases care plans were reflective of person centred principles. This recommendation has been partially met and will not be stated again. Others findings were evidenced in regards to care planning and can be referred to in section 5.5.3 and 6.3.	**Partially Met**

5.3 Additional Areas Examined

5.3.1. Consultation with Patients, Relatives and Staff

Five patients were spoken with individually and with others in smaller groups; two care staff, the deputy manager and two patient representatives and/ visitors.

Observations confirmed that patients who could not communicate due to their condition were relaxed and content in their environment. Patients were observed to be in either the lounge or in their bedroom and reflected their choice. There was evidence of good relationships between patients and staff. Staff were observed to attend to patients' needs in a caring and sensitive manner.

Patients were complimentary regarding the care they received from staff and stated that they felt safe in the home. One patient spoken with did raise some concerns regarding some aspects of care with which they were dissatisfied with. The registered manager was present during this consultation and agreed with the patient what actions would be taken. The patient indicated their satisfaction with this and the registered manager took immediate actions to address the concerns raised during the inspection process.

Patients representatives and/ visitors spoken with were complimentary of the care delivery and praised the staff for all the care and attention provided to their loved ones. No concerns were raised.

5.3.2 Quality of nursing care

The majority of patients were observed to be well groomed and appropriately dressed. However, one identified patient's personal care needs had not been adequately met. The patient was observed to be unkempt and greater attention was required to ensure the patient's dignity. The patients care plan did indicate that the patient may refuse "offers of assistance" however a recorded entry had been made to indicate the patient had been " assisted with personal care" that morning. The standard of presentation including the condition of the patients clothing would be considered below the standard expected. There were no records available to evidence when the patient had received a shower/bath in accordance with their care plan. This was discussed at feedback with management who gave an assurance that this would be addressed and actions taken accordingly. RQIA will continue to monitor this area of practice during subsequent inspections.

5.3.3 Care records

A review of care records evidenced that care plans were either not in place or sufficiently reviewed in response to the changing needs of patients or contained conflicting information.

For example, in one patient record examined there were two care plans in place for the nutritional needs of the patient in regards to their fluid requirements. Both care plans stated different fluid targets for the patient. In the same care record the manual handling risk assessment indicated the patient required the use of a stand aid hoist however, the care plan did not include this identified intervention. In another patient's care record the patients care plan was not updated to reflect recent changes in regards to the individual's health and wellbeing. Another care plan reviewed indicated that the patient was weighed monthly however, the patient was being weighed weekly due to an increased risk of weight loss. The

care plan had not been updated to reflect same. Given these findings, a requirement has been made.

Care records reviewed evidenced that in some cases registered nurses were not care planning using specific and measurable interventions. Evaluation statements were also generic in nature and in most cases did not reference the identified need and if recorded interventions were adequate. For example, evaluation statements stated, "usually meet his fluid need", "encourage to follow SALT", "washed and changed". Other examples were provided during feedback and the registered manager agreed that these statements were not appropriate. A recommendation has been made that training is provided for registered nurses in care planning.

Care plans were completed for those patients on analgesia in the four records examined. Records were completed when analgesic was administered. However, pain assessments were found to be inconsistently reviewed for patients on analgesic. The home's policy recommends that pain assessments are carried out on admission and evaluated monthly thereafter. A recommendation has been made in this regard.

Areas for Improvement

A requirement has been made that patients care plans are kept under review.

A recommendation has been made that training is provided for registered nurses in developing care planning.

A recommendation has been made that pain assessments are carried out in line with best practice and company policy.

Number of Requirements:	**1**	**Number of Recommendations:**	**2**

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Wendy McMaster as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/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 person/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 16 (1) and 16 (2) (b) **Stated:** First time **To be Completed by:** **25 January 2016**	The registered person must ensure that nursing care records are revised as and when patients need change. **Ref Section: 5.3.3** **Response by Registered Person(s) Detailing the Actions Taken:** Nursing Care records are now revised as and when patients care needs change.
Recommendations	
Recommendation 1 **Ref**: Standard 37 **Stated:** First time **To be Completed by:** **25 January 2016**	It is recommended that registered nurses are provided with training in developing care plans. Care plans should include interventions and evaluation statements that are measurable, specific and relate to the assessed needs of the patient. **Ref Section: 5.3.3** **Response by Registered Person(s) Detailing the Actions Taken:** Nurses are scheduled to attend training on 14th January 2016. This will include the addition of statements that are measureable, specific and relate to the assessed need of the patient.
Recommendation 2 **Ref**: Standard 4 Criteria 7 **Stated:** First time **To be Completed by:** **11 January 2016**	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, documented and kept under regular review to ensure that these needs are met and the effectiveness of any analgesia is documented. **Ref Section: 5.3.3** **Response by Registered Person(s) Detailing the Actions Taken:** Pain assessments are carried out, documented and kept under review. The residents needs re met and the effectiveness of analgesia is documented.

Registered Manager Completing QIP	Wendy McMaster	**Date Completed**	06.01.16
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	06.01.16
RQIA Inspector Assessing Response	Sharon Loane	**Date Approved**	14.01016

Please ensure the QIP is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address