Unannounced Care Inspection Report
29 August 2018

Rathfriland Manor

Type of Service: Nursing Home (NH)
Address: Rosconnor Terrace, Rathfriland, Newry, BT34 5DJ
Tel No: 02840638383
Inspector: Heather Sleator

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 53 persons.

3.0 Service details

Organisation/Registered Provider: Manor Healthcare Ltd **Responsible Individual:** Eoghain King	**Registered Manager:** Rachel McCaffrey
Person in charge at the time of inspection: Rachel McCaffrey	**Date manager registered:** 1 February 2016
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia.	**Number of registered places:** 53 A maximum of 29 persons in category NH-I and 24 persons in category NH-DE. The home is also approved to provide care on a day basis to 1 person in the General Nursing Unit and 4 persons in the Nursing Dementia Unit.

4.0 Inspection summary

An unannounced inspection took place on 29 August 2018 from 09.10 to 17.00 hours.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staffing and staff development, adult safeguarding, infection prevention and control, and the home's environment. There were examples of good practice found throughout the inspection in relation to assessment of patient need, the management of nutrition and hydration, the management of falls and dementia care practice. Good practice was observed in relation to the culture and ethos of the home, mealtimes and the provision of activities.

Areas for improvement were identified under the standards in relation to ensuring contemporaneous nursing records are maintained, monitoring staffs' compliance with the practical components of moving and handling training and fire safety/awareness and that duty rosters reflect the hours worked by the registered manager and in what capacity.

Patients described living in the home in positive terms. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

There was evidence that the management team listened to and valued patients and their representatives and taking account of the views of patients.
The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	3

Details of the Quality Improvement Plan (QIP) were discussed with Rachel McCaffrey, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection dated 26 February 2018

The most recent inspection of the home was an announced premises inspection undertaken on 26 February 2018.

There were no further actions required to be taken following the most recent inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection we met with 13 patients individually and others in small groups. A period of observation of care practice was also undertaken, nine staff and one patient's visitors/representatives. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was provided which directed staff to an online survey for staff not on duty during the inspection. We provided the registered manager with 'Have we missed you cards' which were then placed in a prominent position to allow patients, relatives and families, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision.

The following records were examined during the inspection

- duty rota for all staff from 13 August to 29 August 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- four patient care records
- four patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits
- complaints record
- compliments received
- RQIA registration certificate
- a sample of monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 26 February 2018

The most recent inspection of the home was an unannounced premises inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 14 August 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 43 **Stated:** First time	The registered person shall repair/replace the identified corridor flooring in the Foley unit.	**Met**
	Action taken as confirmed during the inspection: The identified area was viewed and the flooring	

	had been replaced.	
Area for improvement 2 **Ref**: Standard 12 **Stated:** First time	The registered person shall ensure that all staff in the kitchen should be aware of the ordering processes and ensure that sufficient stocks are made available in keeping with the planned menu.	**Met**
	Action taken as confirmed during the inspection: Discussion with the cook and a review of the food stores/stock evidenced that there was sufficient food stocks in the home and a robust ordering system was in place.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 13 August to 29 August 2018 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients' needs in a timely and caring manner. Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients.

We spoke with the relatives of one patient during the inspection; the relative was complimentary regarding staff and commented, "I'm very happy, staff are great". Seven completed questionnaires were received from relatives following the inspection. All of the respondents replied that they were satisfied or very satisfied with the provision of care. One questionnaire included the following comment, "I cannot praise the nursing and caring staff enough for the care they provide. They are what make the home as good as it is".

Review of two staff recruitment files evidenced that these were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records also evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work. Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

A review of records confirmed that a process was in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC.

We discussed the provision of mandatory training with staff and reviewed staff training records. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Records evidenced that there was generally good compliance with mandatory training and that there was a system in place to monitor staffs' compliance with their training requirements. Discussion took place with the registered manager in respect of monitoring staffs' compliance with the practical component of moving and handling training and that all staff completed two fire safety/awareness training sessions during the year, one of which should be face to face training. This was identified as an area for improvement under the care standards. The registered manager and staff confirmed that systems were in place to ensure staff received annual appraisal and regular supervision and supervision and annual appraisal was in place and reviewed.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the registered manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice. Systems were in place to collate the information required for the annual adult safeguarding position report.

Review of four patients' care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process. We reviewed accidents/incidents records for the period May - July 2018 in comparison with the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were maintained appropriately and notifications were submitted in accordance with regulation.

Discussion with the registered manager and review of records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. Following this review an action plan was devised to address any identified deficits. This information was also reviewed as part of the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Observation of practices, discussion with staff and review of records evidenced that infection prevention and control (IPC) measures were adhered to. The registered manager confirmed that IPC audits were completed on a monthly basis and remedial action was taken if shortfalls were identified. We observed that personal protective equipment, for example gloves and aprons, were available throughout the home.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges and dining rooms. The home was found to be warm and clean throughout. The registered manager confirmed that there was an on-going refurbishment programme in place. We observed a carpet that was in need of replacement and a bathroom which due to the placement of the bath did not facilitate the use of a hoist. These areas were brought to the attention of the registered manager who stated that these had already been identified and replacement of the carpet and refurbishment of the bathroom had been agreed with the registered person.

Fire exits and corridors were observed to be clear of clutter and obstruction. The registered manager stated the most recent fire risk assessment had been completed on 6 March 2018 and any actions identified had been addressed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, and the home's environment.

Areas for improvement

An area for improvement was identified under the care standards regarding the monitoring of staffs' compliance with the practical component of moving and handling training and ensuring that all staff completed two fire safety/awareness training sessions during the year, one of which should be face to face training.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of four patient care records evidenced that generally care plans were in place to direct the care required and reflected the assessed needs of the patient. We reviewed the management of nutrition, patients' weight, management of falls and wound care. Care records generally contained details of the care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care.

We discussed the monitoring of patients' weights and were informed that all patients were weighed a minimum of a monthly basis. The registered manager stated that if a patient has a weight loss of between five and 10 percent that they are referred to the dietician. The Southern Health and Social Care Trust have implemented a system similar to a virtual ward round with the dietetics team in the Trust. Dieticians monitor patients who have a weight loss on a weekly basis. We reviewed the management of nutrition for one patient. A nutritional risk assessment was completed monthly; a care plan for nutritional management was in place. Food and fluid intake charts were maintained with fluid intake reconciled on a 24 hour basis.

We reviewed the management of falls for three patients. Falls risk assessments were completed and reviewed regularly. Care plans for falls management were in place and were reviewed for each patient following a fall.

We reviewed the management of wound care for two patients. Care plans were present for one patient and contained a description of the wound, location and the dressing regime. Wound care records evidenced that dressing regimes were adhered to. Wound care management was in accordance with professional and care standards. However, the second care record reviewed did not evidence that wound care management documentation had been written and maintained for a recently identified pressure wound. Care records should be accurate and up to date and this has been identified as an area for improvement under the care standards. Records evidenced that patients were assisted to change their position for pressure relief in accordance with their care plans.

Care records were computerised in the dementia unit and hand written in the general nursing unit. The review of patient care records that were computerised evidenced that care plans were generic and were not personalised to the individual. This was in evidence when reviewing continence management for one patient. This was discussed with the registered manager and has been identified as an area for improvement under the care standards. The review of the management of elimination did not evidence that in the general nursing unit staff were monitoring patients' bowel function using the Bristol Stool Chart as a validated tool. This was discussed with the registered manager who stated she would ensure that the registered nurses and care staff reference this tool in future.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), SALT and dieticians. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), the speech and language therapist (SALT) or the dietician changed.

Discussion with staff evidenced that nursing and care assistants were required to attend a handover meeting at the beginning of each shift. A daily allocation record is completed and shared with care staff. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the manager or the nurse in charge. All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. There was evidence of communication with patients, relatives and staff and the minutes of the meetings were reviewed. There was a relative's noticeboard in the home which provided relatives information in respect of the home's complaints procedure, general information and the activities programme.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to assessment of patient need, the management of nutrition and the management of falls.

Areas for improvement

Areas for improvement were identified in relation to ensuring that patient care records accurately reflect the wellbeing of any patient at all times and that the computerised care records reflect the individual needs of any patient.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We arrived in the home at 09:10 hours. Patients were enjoying their breakfast in the dining rooms or in their bedrooms as was their personal preference; some patients remained in bed, again in keeping with their personal preference. There was a calm atmosphere throughout the home.

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that patients were satisfied with the care afforded by staff. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care.

Patients said that they were generally happy living in the home. Those who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings. We observed the approach of staff and interaction and engagement with patient during the serving of the midday meal. This was a positive experience for patients. Staff were attentive providing assistance and prompts to patients during the meal service, quietly and sensitively. We spoke with the relative of one patient who stated they were very happy with the care provided by staff.

The home is registered to provide care and support for persons living with dementia. The environment of the dementia unit was inviting and enabling. There were orientation cues for patient and attractive artwork and murals on the walls. There was a dedicated team of staff who were allocated to and enjoyed caring for persons living with dementia.

Discussion with patients and staff and review of the activity programme evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. Patients spoke highly of the activities on-going in the home. A selection of games/equipment was available in the lounges and there was evidence of the many activities that take place in the home. We observed that whilst staff were involved in a number of duties they made time to spend and engage with patients.

Cards and letters of compliment and thanks were displayed in the home. Some of the comments recorded included:

"Thank you to all the staff for their kindness and attention to my (relative) during their time at the Manor and the care and attention shown to us as a family."
"Appreciate the compassion and excellence of all the staff."
"Appreciate the wonderful care and attention given to my (relative) during their short residency with you."

We spoke with patients and comments included:

"They're (staff) great here."
"Couldn't be better looked after."
"I'm treated with kindness."
"I'm very content here."

We spoke with the relative of one patient who commented positively regarding the care their loved one was receiving and stated:

“Lovely home.”
“You just have to ask and someone sorts everything out.”

Staff commented positively about the home and stated:

“Good communication in this home.”
“I love it here, we’re well supported.”

Relative questionnaires were also provided. Seven were completed and returned following the inspection. All the respondents confirmed that they were either satisfied or very satisfied with the provision of care. Additional comment included:

“I cannot praise the nursing and caring staff enough for the care they provide. They are what make this home as good as it is.”

All of the comments received where shared with the manager who agreed to review those comments which indicated improvements may be required.

Staff were asked to complete an online survey; we received no responses within the timescale specified.

Any comments from relatives and staff in returned questionnaires or online responses received after the return date were shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, mealtimes and the provision of activities.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.
Since the last inspection there has been no change in the management arrangements. A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were not clearly recorded. This has been identified as an area for improvement under the care standards. Staff commented positively on the support and leadership provided to date by the registered manager. Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The registered manager explained that diversity and equality of opportunity for patients was supported by staff; any training required by staff to support patients, would be provided as required.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Discussion with the registered manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, IPC practices, care records and hygiene arrangements. In addition robust measures were also in place to provide the registered manager with an overview of the management of infections and wounds occurring in the home.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed on a monthly basis in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. An action plan was generated to address any areas for improvement.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to management arrangements, management of complaints and incidents and maintaining good working relationships.

Areas for improvement

An area for improvement under the standards was identified with regard to ensuring that the registered manager's hours, and the capacity in which these were worked, are clearly recorded on the duty rosters.

	Regulations	Standards
Total number of areas for improvement	**0**	**1**

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Rachel McCaffrey, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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 the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

Area for improvement 1 **Ref**: Standard 39.9 **Stated:** First time **To be completed by:** 30 November 2018	The registered person shall ensure the monitoring of staffs' compliance with the practical component of moving and handling training and ensuring that all staff completed two fire safety/awareness training sessions during the year, one of which should be face to face training. Ref: 6.4
	Response by registered person detailing the actions taken: all staff will receive moving and handling training and 2 fire training sessions per year, one of which will be face to face
Area for improvement 2 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 31 October 2018	The registered person shall ensure that contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each patient. This includes: • wound care management is in accordance with NICE guidelines • a validated tool is used for the monitoring of bowel function • computerised care records are person centred Ref: 6.5
	Response by registered person detailing the actions taken: All staff have been advised that they must ensure contemporaneous nursing records are kept. Auditing system in place to ensure compliance
Area for improvement 3 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 1 October 2018	The registered person shall ensure that the staff duty roster includes the hours worked by the registered manager and identifies either management duties or nursing duties. Ref: 6.7
	Response by registered person detailing the actions taken: Nurse manager is currently recorded on off duty

Please ensure this document is completed in full and returned via Web Portal

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care