Inspection Report

06 May 2021

Rathfriland Manor

Type of Service: Nursing Home
Address: Rosconnor Terrace
Rathfriland, Newry,
BT34 5DJ
Tel no: 028 4063 8383

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Manor Healthcare **Responsible Individual:** Mr Eoghan King	**Registered Manager:** Mrs Rachel McCaffrey **Date registered:** 1 February 2016
Person in charge at the time of inspection: Mrs Bridie Matthews - Nurse in Charge until 8 a.m. Mrs Rachel McCaffrey – Registered Manager after 8 a.m.	**Number of registered places:** 54 A maximum of 30 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.
Categories of care: I – Old age not falling within any other category. DE – Dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** 53
Brief description of the accommodation/how the service operates: This is a registered Nursing Home which provides nursing care for up to 54 persons. The home is divided into three units over two floors; the Millar Suite for patients requiring general nursing care and the Foley and Shannon Suites for patients requiring dementia nursing care.	

2.0 Inspection summary

An unannounced inspection took place on 6 May 2021 from 6.25 a.m. until 3.40 p.m. The inspection was carried out by the care inspectors.

RQIA received anonymous whistleblowing information which raised concerns in relation to the conduct of staff and night duty staff not respecting patients' personal choices about the time they would get up each day. In response to this information RQIA decided to undertake an inspection to focus on the concerns raised and to establish if the home provided safe, effective and compassionate care and if the home was well led.

Prior to the inspection, RQIA had alerted the Registered Manager to an aspect of the allegation regarding the conduct of staff on night duty. In response to this information the Registered Manager and Mark King, Home Owner, had carried out two unannounced overnight visits to the

home and had provided RQIA with assurances that staff were conducting themselves properly and professionally during their shift and that patients' care needs were appropriately met.

Patients spoke positively about living in the home. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Comments received from patients, relatives, visitors and staff are included in the main body of this report.

Evidence of good practice was identified in relation to the care provided to patients, teamwork, communication and the culture and ethos in the home.

As a result of this inspection RQIA found that the anonymous allegations made were not substantiated. Areas for improvement which were identified are discussed in the main body of the report.

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the anonymous whistleblowing information received, the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

Throughout the inspection patients, their visitors and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working in this home. The daily life within the home was observed, along with how staff went about their work. A range of documents was examined to determine that effective systems were in place to manage the home.

Questionnaires and 'Tell Us' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The findings of the inspection were provided to the Registered Manager and the home owner at the conclusion of the inspection

4.0 What people told us about the service

During the inspection we spoke with 26 patients, both individually and in small groups, one patient's visitor and 10 staff. Patients told us that they felt well looked after, staff were helpful and friendly and the food was lovely. The visitor said that everything was "absolutely brilliant, can't fault a thing". Staff said that they enjoyed working in the home.

Following the inspection we received two completed questionnaires from relatives. Both relatives indicated that they were very satisfied that the care provided was safe, effective, compassionate and well led. One relative commented that staff "genuinely care and are interested and invested" in the welfare of their loved one.

Comments made by patients, staff and relatives both during and following the inspection were brought to the attention of the manager for information.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 19 November 2020		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 30 **Stated:** First time	The registered person shall ensure that all accidents/incidents are appropriately reported to RQIA in a timely manner. This includes accidents/incidents where medical advice or assistance has been sought or where a head injury is confirmed.	**Met**
	Action taken as confirmed during the inspection: Review of records of accidents/incidents evidenced that RQIA was appropriately notified in a timely manner.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 41 **Stated:** First time	The registered person shall ensure that all nurses employed in the home are included on the NMC checklist in order to ensure that the system in place to monitor registration status is robust.	

	Action taken as confirmed during the inspection: Review of the system in place to monitor the registration status of nurses with the NMC evidenced that all nurses employed in the home were included in the monthly check.	**Met**

5.2 Inspection findings

5.2.1 How does this service ensure that staffing is safe?

There was a robust system in place to ensure that staff were recruited correctly to protect patients as far as possible. All staff were provided with a comprehensive induction programme to prepare them for working with the patients. The manager said that staff were extremely helpful in covering vacant shifts and recruitment was underway for new staff with some due to start work imminently.

The manager told us that the number of staff on duty was reviewed on at least a monthly basis to ensure the needs of the patients were met. The staff duty rota accurately reflected all of the staff working in the home on a daily basis and clearly identified the person in charge when the manager was not on duty.

Staff said there was very good teamwork, that they felt well supported in their role and that the manager was approachable. Staff also said that staffing levels were generally satisfactory on day duty and although, occasionally, staffing levels could be short on night duty, management did make efforts to cover any vacant shifts.

There were systems in place to ensure staff were trained and supported to do their job, for example, staff received regular training in a range of topics including, infection prevention and control (IPC), adult safeguarding, first aid and moving and handling. Staff told us that they felt equipped with the skills and knowledge to carry out their roles effectively. There was a daily handover prior to shifts commencing; the manager used this as an opportunity to update staff on any changes and to remind them of their responsibilities in relation to hand hygiene and the use of PPE. Regular staff meetings were also held.

Staff told us that they made every effort to respect patients' needs and wishes and that the routine was very much led by the patients' needs. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner. Patients said that they felt well looked after and that staff were helpful and friendly.

There were safe systems in place to ensure staff were recruited and trained properly and also to ensure that patients' needs were met by the number and skill mix of the staff on duty.

5.2.2 How does this service ensure patients feel safe from harm and are safe in the home?

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was identified as the appointed safeguarding champion for the home.

Review of staff training records confirmed that all staff were required to complete mandatory training on adult safeguarding. Staff told us they would have no hesitation in reporting concerns about patients' safety or staff misconduct and were confident that such issues would be dealt with appropriately.

Review of the home's record of complaints confirmed that these were well managed and used as a learning opportunity to improve practices and/or the quality of services provided by the home.

At times some patients may be required to use equipment that can be considered to be restrictive, for example, bed rails and alarm mats. Review of patient records and discussion with the manager and staff confirmed that the correct procedures were followed if restrictive equipment was required. Patients who were in their rooms had call bells within reach where appropriate. Alarm mats were seen to be appropriately placed and were fully functional and in good working order.

The manager confirmed that staff had attended specialised training to ensure they were aware of what restrictive practices could be avoided and how to ensure, if they could not be avoided, that best interest decisions were made safely for all patients but particularly those who were unable to make their own decisions.

Staff were observed to be prompt in recognising patients' needs and any early signs of distress, especially in those patients who had difficulty in making their wishes known. Staff were skilled in communicating with patients; they were kind, understanding and sensitive to their needs.

On arrival at the home inspectors could immediately see that all the staff were busy caring for the patients; most patients were in bed, some patients were up and about. Staff explained that patients with dementia frequently experience poor sleep patterns; they said there was no set routine for patients and that every day was different. Staff were seen to tell patients the time, ask them if they wanted to go back to bed and assist them with their needs appropriately. One patient who was up early told us that they had always been an early riser and other patients said they decided for themselves when to get up in the morning.

There were systems in place to ensure that patients were safely looked after in the home and to ensure that staff were adequately trained for their role in keeping patients safe. There was no evidence to substantiate the allegations made in relation to the conduct of staff and staff not respecting patients' personal choice regarding the time to get up in the morning.

5.2.3 Is the home's environment well managed to ensure patients are comfortable and safe?

Examination of the home's environment included reviewing a selection of bedrooms, en-suites, storage rooms, treatment rooms and communal areas such as lounges and bathrooms. There was evidence that the environment was well maintained. The manager said that all the required safety checks and measures were in place and regularly monitored.

It was observed that the treatment room doors were not securely closed. Staff should ensure that medicines are safely and securely stored and that patients are not able to access medicines. This was identified as an area for improvement.

A sluice room door was unlocked. This meant that patients could have access to cleaning agents in the room. Staff should ensure that substances which are hazardous to health are safely and securely stored. This was identified as an area for improvement.

Patients' bedrooms were personalised with items which were important to them such as family photos, ornaments, pictures and cushions. Bedrooms and communal areas were well decorated, suitably furnished, clean and tidy and comfortable. There was evidence throughout all three units of 'homely' touches such as newspapers, magazines, snacks and drinks available and art work undertaken by patients as part of the activity programme provided. TV's or radios were on as patients preferred.

Fire safety measures were in place and were well managed to ensure patients, staff and visitors to the home were safe. Staff were aware of their training in these areas and how to respond to any concerns or risks. The manager had completed fire drill evacuation competencies with staff in March and April 2021. Review of training records identified the need for staff to receive face to face fire safety training from a suitably qualified person. Following the inspection the manager confirmed that face to face fire safety training had been arranged. Corridors and fire exits were clear from clutter and obstruction. Equipment in use was clean and well maintained.

There were systems in place to ensure that the home was kept clean, tidy and well maintained in order that patients were comfortable in their environment. Areas for improvement, which would further enhance the safety of the environment, were identified in relation to ensuring treatment rooms and sluice rooms were kept secured.

5.2.4 How does this service manage the risk of infection?

The manager told us that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for patients, staff and care partners and any outbreak of infection was reported to the Public Health Authority (PHA).

On arrival to the home all visitors had a temperature check and completed a health declaration. They were also required to wear personal protective equipment (PPE) such as aprons, masks and/or gloves.

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures and the use of PPE had been provided.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. PPE stations were well stocked throughout the home. Staff use of PPE and hand hygiene was regularly monitored by the manager; audits relating to this were available to view.

The manager said that visiting and care partner arrangements were managed in line with Department of Health (DoH) and IPC guidance. Policies regarding visiting and the care partner initiative had been developed. Relatives were provided with guidance regarding visiting and the care partner role and provided with training on the use of PPE and effective hand hygiene.

There were suitable systems were in place to manage the risk of infection in the home.

5.2.5 What arrangements are in place to ensure patients receive the right care at the right time? This includes how staff communicate patients' care needs, ensure patients' rights to privacy and dignity; manage skin care, falls and nutrition.

As previously mentioned, staff met at the beginning of each shift for a handover to discuss any changes in the needs of the patients. Care records were maintained which reflected the needs of the patients. Staff were knowledgeable about individual patients' needs, their daily routine, wishes and preferences. It was observed that staff respected patients' privacy and dignity; they knocked on doors before entering rooms and offered personal care to patients discreetly.

Patients who were less able to mobilise require special attention to their skin care. Staff told us that they assisted these patients to change their position regularly and care plans were in place to direct the frequency of repositioning. However, contemporaneous records of repositioning had not been maintained in the records reviewed; an area for improvement was identified.

Patients who had wounds had this recorded in their care records. There was evidence that nursing staff had consulted with the Tissue Viability Specialist Nurse (TVN) and were following any recommendations they had made. Review of wound care records evidenced that where changes had been recommended in the wound care regime, these were not always accurately reflected in the wound care evaluations. An area for improvement was identified. Nursing staff demonstrated their knowledge of wound care and wound dressings had been freshly changed.

Where a patient was at risk of falling, measures to reduce this risk were put in place, for example, call bells were accessible, aids such as floor alarm mats were in use if recommended and staff carried out regular checks on patients in line with the recommendations in individual care records. Examination of records and discussion with staff confirmed that the risk of falling and falls was well managed. In the event of a fall staff took appropriate action, for example, neurological observations were completed and/or medical attention was sought if required.

There was evidence that patients' needs in relation to nutrition and the dining experience were being met. Breakfast was seen to be served to patients in a relaxed manner and at a time which suited the individual patients, there was no rush. Staff recognised that good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Staff were seen to offer patients support, encouragement and assistance with their meals as required. Patients' weights and nutritional status were monitored and referrals were made to appropriate healthcare professionals in the event of weight loss or swallowing difficulties. Staff told us how they were made aware of patients' nutritional needs and confirmed that patients care records were kept up to date to ensure that they received the correct diet. The manager said that new menus had recently been introduced and patients were complimentary about the food on offer.

There were systems in place to ensure that patients' needs, including any changes, were communicated to all staff in a timely manner. Patient privacy and dignity was maintained and needs regarding management of falls, skin care, wounds and nutrition were met. Two areas for improvement were identified. These were in relation to the accurate recording of repositioning and wound care.

5.2.6 What systems are in place to ensure care records reflect the changing care needs of patients?

Patients' care records were held confidentially. Patients' needs were assessed at the time of their admission to the home. Review of the care records for a recently admitted patient showed that these were completed in a timely manner. Following initial assessment care plans were developed to direct staff on how to meet patients' needs and the plans included any advice or recommendations made by other healthcare professionals. It was noted, however, that care plans for identified patients lacked sufficient detail about bowel management, sleep and behaviours that challenge; this was identified as an area for improvement.

Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate. Patients' individual likes and preferences were reflected throughout the records. There was evidence that care records were regularly reviewed. Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

There were systems were in place to ensure that care records were regularly evaluated, updated to reflect any changes in patients' needs and to ensure that staff were aware of any changes. An area for improvement was identified in relation to ensuring there was sufficient detail in identified care plans.

5.2.7 How does the service support patients to have meaning and purpose to their day?

Patients said that they were able to choose where and how to spend their day, they could have a lie in and a late breakfast or get up early as they wished. It was observed that staff offered choices to patients throughout the day, for example, preferences about what clothes and jewellery they wanted to wear, where they ate their meals and the option to join in with planned activities. Staff were seen to help patients prepare for visits from their families. Staff helped ladies apply their make-up and made sure that all the patients in the home were well dressed and looked their best.

The activity person consulted with patients about their particular interests and hobbies to ensure that activities offered were as inclusive as possible. A range of individual and group activities was provided, such as movement to music, armchair exercises, bingo, reminiscence, arts and crafts, gardening, flower arranging and one to one time. During the morning the activity person read poetry to a group of patients and engaged them in a lively discussion.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Additional staff had been employed to facilitate visiting and care partner arrangements. These staff also assisted with virtual visiting via the facetime portal, telephone calls and window visits as required.

The manager said that patients' and relatives' views and opinions were sought via surveys and that good communication had been maintained throughout the COVID-19 pandemic to ensure that relatives were kept well informed and reassured. Patients said that they felt listened to.

There were suitable systems in place to support patients to have meaning and purpose to their day and to allow them the opportunity to make their views and opinions known.

5.2.8 What management systems are in place to monitor the quality of care and services provided by the home and to drive improvement?

There has been no change in the management of the home since the last inspection. Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment. Staff said they had confidence that any concerns raised would be dealt with.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to patients. Regular audits were completed to review, for example, IPC measures, restrictive practices, falls and care records. The audits contained clear action plans where required. Wound care audits were completed but these had not identified the issues discussed in Section 5.2.5; this was discussed with the manager. Following the inspection the manager told us that the wound care audit had been revised to ensure that deficits in wound care recording were identified.

A record of compliments and thank you cards, which included comments about the kindness shown by staff and the good care provided in the home, was kept and shared with the staff team.

A review of the records of accidents and incidents which had occurred in the home found that these were managed correctly and reported appropriately.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These are available for review by patients, their representatives, the Trust and RQIA.

There were systems were in place to monitor the quality of care and services provided and to drive improvement in the home.

6.0 Conclusion

Patients looked well cared for and were seen to be content and settled in the home. Staff treated patients with respect and kindness and provided them with choice and options as to how they spent their day. The home was clean, tidy and well maintained.

This inspection concluded that the anonymous whistleblowing allegations were not substantiated; staff provided patients with the right care at the right time and conducted themselves appropriately.

Thank you to the patients, relatives and staff for their assistance and input during the inspection and also to those who returned completed questionnaires following the inspection.

Based on the inspection findings and discussions held RQIA is satisfied that, although areas for improvement were identified, this service is providing safe and effective care in a caring and compassionate manner and that the service is well led by the manager and the management team.

7.0 Quality Improvement Plan/Areas for Improvement

Five areas for improvement were identified. These were in relation to safe storage of medicines and of cleaning agents, maintaining contemporaneous records of repositioning and wounds and including sufficient detail in care plans of bowel management, sleep and behaviours that challenge.

	Regulations	Standards
Total number of Areas for Improvement	0	5

Areas for improvement and details of the Quality Improvement Plan were discussed with Rachel McCaffrey, Registered Manger, and Mark King, Home Owner, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 30 **Stated:** First time **To be completed by:** With immediate effect	The responsible person shall ensure that medicines are safely and securely stored at all times and that treatment rooms are not accessible to patients. Ref: 5.2.3
	Response by registered person detailing the actions taken: ———Medications are safely stored and treatment rooms remain inaccessible to patients at all times
Area for improvement 2 **Ref:** Standard 47 **Stated:** First time **To be completed by:** With immediate effect	The responsible person shall ensure that cleaning agents or chemicals which are hazardous to health are safely and securely stored at all times and are not accessible to patients. Ref: 5.2.3
	Response by registered person detailing the actions taken: ———All chemicals are safely stored and not accessible to patients
Area for improvement 3 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** With immediate effect	The responsible person shall ensure that records relating to the frequency of repositioning are accurately maintained. Ref: 5.2.5
	Response by registered person detailing the actions taken: ———Monitoring of repositioning records is in place and these are being accurately maintained
Area for improvement 4 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** With immediate effect	The responsible person shall ensure that records relating to wound care are accurately maintained. Ref: 5.2.5
	Response by registered person detailing the actions taken: ———Records pertaining to wound care are being accurately maintained

Area for improvement 5 **Ref:** Standard 4 **Stated:** First time	The responsible person shall ensure that care records relating to bowel management, sleep and behaviours that challenge are suitably detailed and informative. Ref: 5.2.6
To be completed by: 6 June 2021	**Response by registered person detailing the actions taken:** Home manager has met individually with all nurses and discussed the requirement for more detailed , informative care records, senior staff are auditing care plans to ensure compliance

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

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