

Inspector: Donna Rogan
Inspection ID: IN022084

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**Unannounced Care Inspection
of
Rathfriland Manor

1 March 2016**

1. Summary of Inspection

An unannounced care inspection took place on 1 March 2016 from 10.00 to 15.35.

Overall 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. There were no requirements or recommendations made as a result of this inspection.

For the purposes of this report, the term 'patients' will be used, to describe those living in Rathfriland Manor, which provides both nursing, residential and day 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 14 September 2015.

1.2 Actions/Enforcement Resulting from this Inspection

Urgent actions or 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	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

2. Service Details

Registered Organisation/Registered Person: Eoghain King	Registered Manager: Rachel McCaffrey
Person in Charge of the Home at the Time of Inspection: Rachel McCaffery	Date Manager Registered: 01 February 2016
Categories of Care: RC-DE, NH-DE, NH-I 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	Number of Registered Places: 53
Number of Patients Accommodated on Day of Inspection: 53 Total 1 residential 23 dementia 29 frail elderly	Weekly Tariff at Time of Inspection: £470 to £596

3. Inspection Focus

The inspection sought to determine if the following standards have been met:

- **Standard 23: Prevention of Pressure Damage**

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

4. Methods/Process

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

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with twenty five patients, five care staff, two ancillary staff, three nursing staff and four patient's representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- four patient care records
- complaints records
- review of policies and procedures

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of St Joseph's was an unannounced care inspection dated 14 September 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection dated 14 September 2015

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 Ref: Standard 36 Stated: First time	The registered persons shall ensure policies and procedures are endorsed by the registered persons. The endorsement should include the review dates.	Met
	Action taken as confirmed during the inspection: A review of the policies and procedure manuals evidenced that they were endorsed by the registered persons.	
Recommendation 2 Ref: Standard 36 Stated: First time	The registered persons shall ensure that the policy on palliative and end of life care should be further developed in line with current regional guidance, such as GAIN (2013) Palliative Care Guidelines and should include the out of hours procedure for accessing specialist equipment and medication and the procedure for managing an unexpected death.	Met
	Action taken as confirmed during the inspection: The policy and procedure has recently been reviewed and is reflective of the current regional GAIN guidelines November 2013. The policy has also been updated to include the procedure for accessing specialist equipment and medication. It also includes the procedure for managing an unexpected death.	

Recommendation 3 Ref: Standard 35 Stated: First time	<p>The registered persons shall ensure that a separate Regulation 29 report is made for each visit or if one report is used that the information provided clearly identifies the date on which the information refers to. The identity of patients spoken with should be included using the unique identification number, the report should also include some examples of the conversations held with patients, relatives, staff and visiting professionals.</p> <hr/> <p>Action taken as confirmed during the inspection: The regulation 29 inspection report is now prepared and relates to one visit. The dates recorded clearly identifies the day of the visit and the findings of that day. The identity of patients spoken with by the person conducting the visit is protected in the report in order to ensure confidentiality.</p>	Met
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5.3 Standard 23 Prevention of Pressure Damage

A review of six patient care records confirmed that pressure damage risk assessments had been carried out for all residents. There was evidence of individualised care plans for patients who were identified as having a high risk for pressure damage. A review of two care records of patients who had pressure ulcers confirmed that risk assessments and care plans were completed. Wound assessments were regularly completed and there was evidence of tissue viability nurse involvement, as deemed appropriate. Discussion with the registered nurses on duty and the review of care records confirmed that all Grade 2 pressure sores were reported to the Health and Social Care Trusts, in line with guidance and protocols.

5.4 Additional Areas Examined

Care Records

A review of six care records pertaining to patients identified that the patients' risk assessments and care plans had been updated following admission and were up to date on the day of inspection. They were individualised and relevant and there was no ambiguity in navigating priorities in nursing care. Re-positioning, food, and fluid charts were maintained contemporaneously and were updated in relation to communication with allied health professionals or families.

Staffing

Review of duty rotas for nursing and care staff confirmed that staffing levels were generally in keeping with the planned staffing levels as discussed. Discussion with staff and the registered manager confirmed that short notice absences were being managed in keeping with the home's protocol.

Activities

There is a well-structured organised activity programme operational in the home. Activities are catered to meet individual patients' needs and preferences. A new spring programme has recently been developed in consultation with patients and their representatives. The programme included favourite pastimes such as arts and crafts. This included making 'hedgehogs' from paperback books and making items for the up-coming spring sale. Patients have recently potted plants and seeds and those spoken with stated that they were looking forward to following their developments. The activities programme and efforts made in order to add structure to the patients' day are to be commended.

Meals and mealtimes

The main meal of the day is served in the afternoon. This is a three course meal with choices served throughout. All patients spoken with were highly complementary of the food served. Stating it was tasty and wholesome. The meal served included homemade soup followed by a choice of boiled ham or steak pie alongside cabbage, peas, potatoes, parsley sauce or gravy. For dessert there was a choice of creamed rice pudding with fresh fruit, ice cream or yoghurt. The meal was observed to be well organised and served in a timely way. Staff were offered choices throughout the meal time and tables were nicely presented and condiments were on display and where relevant offered.

Staff, patients and patients' representative comments

All comments made during the inspection were positive. Some comments made are detailed below:

Staff

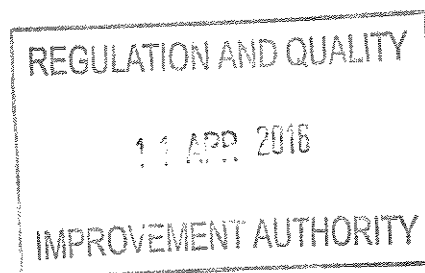
- "We all work together."
- "If we need anything we just ask."
- "There is a good atmosphere in the home."
- "Patients come first."
- "I wouldn't work anywhere else."
- "We think it is great."
- "I would recommend it to my family and friends."

Patients

- "I don't think I could be anywhere better."
- "The food and staff are just great."
- "I couldn't complain about a thing."
- "Plenty to do and see."
- "I can sit and do what I want, it's my home."
- "I have everything I need."
- "Great place."

Patients' representatives

- "I couldn't ask for more for my relative."
- "I think my is very happy and content here."
- "I wouldn't change a thing."
- "It's a lovely place."



Environment

A general tour of the home was undertaken which included review of a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout.

Areas for Improvement

There were no areas for improvement identified during this inspection.

Number of Requirements:	0	Number of Recommendations:	0
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6. No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	R. McCaffrey	Date Completed	5/4/16.
Registered Person	E. J. Ki	Date Approved	6/4/16
RQIA Inspector Assessing Response		Date Approved	

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

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

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.

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RQIA Inspector Assessing Response	Donna Rogan	Date Approved	13/04/16
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