Unannounced Care Inspection Report
7 June 2016

Rockfield

Type of Service: Nursing Home
Address: Windmill Road, Newry, Co. Down, BT34 2QW
Tel No: 028 3026 9546
Inspector: Dermot Walsh

1.0 Summary

An unannounced inspection of Rockfield took place on 7 June 2016 from 09.50 to 17.50.

The inspection sought to assess progress with issues which were raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led. The inspection also incorporated a post registration inspection due to a change of ownership from 5 April 2016. Burnview Healthcare Ltd. is now the registered organisation and Mrs Briege Kelly, Registered Person.

Is care safe?

Safe systems were in place for recruitment and for monitoring the registration status of nursing and care staff. Accidents and incidents were appropriately managed and RQIA was suitably informed of notifications. Two recommendations have been made in this domain in relation to the review of staffing levels in accordance with patient dependency levels and the safe use of equipment.

Is care effective?

Evidenced gathered during this inspection confirmed that there were systems and processes in place to ensure that the outcome of care delivery was positive for patients. Staff confirmed that they had the opportunity to attend regular staff meetings. Patients and relatives consulted were confident in raising any concerns that they may have. Staff were aware how to escalate concerns if required. Areas of improvement were identified within the patients' care records. All documented entries within the care records must be signed and dated by the person making the entry. The recording of bowel management and documented evidence of skin checks at the time of repositioning was inconsistent. Two recommendations were stated within the effective domain.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. Patients and their representatives were very praiseworthy of staff and a number of their comments are included in the report. The mealtime experience was observed to be well organised and pleasurable for the patients.

Is the service well led?

Systems were in place to manage urgent communications, safety alerts and notices. The quality of care within the home was monitored through the auditing process. Monthly monitoring visits included an action plan to address any shortfalls identified. An improvement was recommended regarding the recording of complaints. There was one recommendation made in the well led domain.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	6*

*The total number of recommendations made includes one recommendation that has been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ciara Power, 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.

1.2 Actions/enforcement taken following the most recent type e.g. care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 7 March 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered provider: Burnview Healthcare Ltd. Briege Kelly	**Registered manager:** Ciara Power
Person in charge of the home at the time of inspection: Ciara Power	**Date manager registered:** 31 March 2014
Categories of care: NH-I, RC-I, NH-MP, NH-PH	**Number of registered places:** 34

3.0 Methods/processes

Prior to inspection we analysed the following information:

- 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 previous care inspection report and the returned quality improvement plan (QIP)
- pre inspection assessment audit.

During the inspection we met with eight patients individually and others in small groups, three care staff and two registered nursing staff.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff not on duty. Nine patient, nine staff and seven patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- three patient care records
- staff training records
- staff induction template
- complaints records
- incidents / accidents records since the last care inspection
- minutes of staff meetings
- a selection of audit documentation
- policy on communication
- a recruitment file
- competency and capability assessments for nurse in charge
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- fire log book
- duty rota from 30 May - 12 June 2016.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 7 March 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 7 March 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 36 Criteria (1) (2) **Stated:** First time	A policy on communication should be developed which includes reference to current best practice guidelines. A system to implement the policies should confirm that all relevant staff have read the documents with evidence of staff signature and date.	**Met**
	Action taken as confirmed during the inspection: A Burnview Healthcare Ltd. policy on communication was available for staff to review. A policy acknowledgement list was also available with evidence of staff signature and date.	
Recommendation 2 **Ref:** Standard 46 Criteria (1) (2) **Stated:** First time	The registered person should ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection.	**Met**
	Action taken as confirmed during the inspection: Safe systems were now in place to ensure compliance with best practice in infection prevention and control.	
Recommendation 3 **Ref:** Standard 4 Criteria (9) **Stated:** First time	The registered manager should ensure that bowel function, reflective of the Bristol Stool Chart, is recorded on admission as a baseline measurement and thereafter in the patients' daily progress records.	**Not Met**
	Action taken as confirmed during the inspection: A review of three patient care records evidenced inconsistent recording of bowel management reflective of the Bristol Stool Chart. Please see section 4.4 for further clarification.	

Recommendation 4 **Ref:** Standard 4 Criteria (9) **Stated:** First time	Meaningful fluid targets should be calculated for patients and were these targets are not met, the actions taken to address the shortfall should be documented within the patient's care record.	**Met**
	Action taken as confirmed during the inspection: A review of three patient care records evidenced that meaningful fluid targets had been calculated and achieved.	
Recommendation 5 **Ref**: Standard 44 Criteria (1) **Stated:** First time	Vanity units in disrepair should be identified and repaired/redecorated in a timely manner to enhance the patient experience of their room and prevent an infection control issue.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of the environment evidenced that vanity units in disrepair had been redecorated. The registered manager also confirmed that bedroom furniture would be included in a refurbishment programme which was under development.	
Recommendation 6 **Ref:** Standard 4 **Stated:** First time	The registered person should ensure that individual patient records reflect the decision making for each patient in a person centred way. Where risks are identified, such as the need to remove the call bell from the patient's room, other options enabling patients to summon staff assistance are explored and put in place.	**Met**
	Action taken as confirmed during the inspection: All rooms reviewed on the day of inspection had a working nurse call provision. The registered manager confirmed that if a decision was made to remove a nurse call provision, a comprehensive care plan would be developed to enable patients to summon assistance.	

4.3 Is care safe?

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 30 May to 12 June 2016 evidenced that the planned staffing levels were adhered to. Consultation with five staff on the day of inspection and questionnaire responses from three staff, two patients and two relatives expressed concerns with staffing levels meeting dependencies. A recommendation was made to review staffing levels in line with current patient dependency levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

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. The induction records are signed on completion by the inductor and the inductee. The registered manager would also verify the successful completion of the induction by signing the record.

Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training. The registered manager would review training records on a monthly basis. Compliance with mandatory training for 2015 was at 84 percent.

Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Observation of the delivery of care evidenced that training had been embedded into practice.

Competency and capability assessments of the nurse in charge of the home in the absence of the manager had been completed appropriately and signed by the nurse and the person conducting the assessment. The completed assessments were reviewed and verified by the registered manager.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC). NMC and NISCC checks were monitored monthly and evidenced within a file. Checks were also monitored at the date of expiry.

A review of the recruitment process evidenced a safe system in practice. Relevant checks and interviews had been conducted prior to the staff member commencing in post.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Discussion with the registered manger and staff confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. There was evidence that risk assessments informed the care planning process.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since 7 March 2016 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The rooms and communal areas reviewed were clean and spacious. Fire exits and corridors were observed to be clear of clutter and obstruction. A number of pull cords throughout the home were observed without any covering. This was discussed with the registered manager and an assurance was given that coverings would be applied to all pull cords within the home.

When reviewing a communal toilet, a toileting aid was observed placed on top of a toilet seat. As a result, the feet of the toilet aid were suspended in the air and not on the floor for stabilisation. This was a potential hazard to any patient who may have sat on the toilet aid. A recommendation was made.

There was evidence on an ongoing refurbishment programme in progress. The main lounge had been redecorated. The visitors' amenities were in the process of being retiled and updated. The registered manager confirmed that further improvements had been planned in relation to landscaping of the garden areas and reviewing and redecorating all corridors, bedrooms and furniture within the home.

Areas for improvement

It is recommended that the current planned staffing levels are reviewed in line with the current patient dependency levels.

It is recommended that equipment used within the home is used in a manner that does not pose a risk to patient safety.

Number of requirements	**0**	**Number of recommendations**:	**2**

4.4 Is care effective?

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. Care plans had been reviewed monthly.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of communication with representatives within the care records.

Staff demonstrated an awareness of patient confidentiality in relation to the storage of records. Records are stored securely in lockable cabinets at the nursing stations.

A review of bowel management records and repositioning charts evidenced these had not been completed in accordance with best practice guidelines. One patient's care record indicated a gap of 10 days between recorded bowel movements. This was not reflected within the patient's daily progress notes. The patient's continence care plan indicated the normal bowel pattern for this patient as 'every other day'. The recording of bowel management reflective of the Bristol Stool Chart in all three patients' progress records was poor and/or inconsistent. A recommendation made in the previous inspection (see section 4.2) regarding the recording of bowel management has been stated for a second time.

Repositioning charts were recorded inconsistently with regards to evidencing skin checks at the time of repositioning on two of the three patient care records reviewed. A recommendation was made.

There was no evidence of staff signature and date on some documents completed within one patients care records. A recommendation was made.

Registered nurses were aware of the local arrangements and referral process to access other relevant professionals, for example General Practitioner's (GP), SALT, dietician and TVN. Care records reviewed adhered to recommendations prescribed by other healthcare professionals.

Discussion with the registered manager and a review of minutes from meetings confirmed that a general staff meeting had been conducted on 31 March 2016. Minutes of the meeting had been documented appropriately. There was evidence of a 'Falls Awareness' meeting having occurred on 19 May 2016. The registered manager confirmed that these meetings would be conducted on a monthly basis. Discussion with staff and the registered manager confirmed that 'Flash Meetings' occur on a daily basis around midday involving all staff on duty and include any issues pertaining to care; household; catering; maintenance/garden; administrative and/or activities. Staff consulted found this meeting 'very useful as it dealt with any arising issues in a timely manner.'

The registered manager confirmed that relatives' and patients' meetings were now conducted on a monthly basis. Activity preference meetings were conducted on a six monthly basis.

The registered manager confirmed that they would undertake two daily walks around the home and would avail of the opportunity to engage with patients and relatives at this time. A 'night manager's checklist' was completed daily by the nurse in charge verifying that a list of pre-determined safety checks had been completed. A 'daily handover sheet' was also completed by persons in charge to verify for example staff on duty; appointed first aid and fire persons on duty; medication issues; signatures of staff involved in the handover of controlled drug keys; professional visits during the 24 hour period and any care reviews due. The registered manager confirmed that they would review the checklist and handover sheets on a daily basis or when they return to the home following any absence.

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 their line manager and /or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Patients and representatives were confident in raising any concerns they may have with the staff and/or management.

Information leaflets were available to staff, patients and/or representatives at the entrance to the home. These included information on Rockfield, the daily menu, Alzheimer's disease, the Care Standards for Nursing Homes and the Residents' Guide.

Areas for improvement

It was recommended that evidence of patient skin checks are recorded on repositioning charts at the time of repositioning.

It was recommended that all documented entries to patient care records are signed and dated by the person making such entries.

Number of requirements	**0**	**Number of recommendations**:	**2**

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent. Nine staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. Four of the questionnaires were returned within the timescale for inclusion in the report. On inspection two registered nurses and three carers were consulted to ascertain their views of life in Rockfield.

Some staff comments are as follows:
'This is a happy home. We work well here as a team.'
'It's fine here. The care is very good.'
'I love it here.'
'It's like a big family.'
'Staff work exceptionally hard in spite of working with minimum ratio.'
'We need extra staff cover in the morning.'

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives on the running of the home. Annual surveys were sent individually to all patients and patients' next of kin to allow for a provision to feedback on the service provided by the home. The registered manager confirmed the results of these would be included within the 'Annual Quality Report' and discussed during staff, patient and relative meetings. Results would also be displayed on noticeboards within the home.

Patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Consultation with eight patients individually, and with others in smaller groups, confirmed that the care was safe, effective, compassionate and well led. Nine patient questionnaires were left in the home for completion. Eight patient questionnaires were returned within the timeframe.

Some patient comments are as follows:
'I'm well looked after.'
'I have no complaints.'
'I find it satisfactory here.'
'It's very good here.'
'It's perfect.'
'I get communion weekly.'
'There's not always enough staff.'

No patient representatives were available for consultation on the day of inspection. Seven relative questionnaires were left in the home for completion. Five relative questionnaires were returned within the timeframe.

Some representative comments are as follows:
'The compassion in this home from all members of staff is first class.'
'Any issues are always rectified internally. Nurses are very patient. Would be good if staff had more time for even taking resident out round for fresh air.'

The patients' mealtime experience was reviewed during the inspection in the main dining room. The mealtime was well supervised. Menus were available on the tables. Food was served when patients were ready to eat or be assisted with their meals. Staff wore the appropriate aprons when serving or assisting with meals and patients wore dignified clothing protectors. A selection of condiments were available on dining tables and a range of drinks were offered to the patients. The food appeared nutritious and appetising. The mealtime experience was observed to be well organised and pleasurable for the patients.

Areas for improvement

No areas for improvement were identified during the inspection under the compassionate domain.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the registered manager evidenced that the home was operating within its registered categories of care.

Policies and procedures were maintained within files which were located at the nursing station. The registered manager confirmed that new policies and any reviews of policies would be communicated to staff via 'Flash Meetings', staff handovers and staff meetings.

Discussion with the registered manager and review of the home's complaints record evidenced that the last recorded complaint was on 8 September 2014. When reviewing patients' care records, details of concerns raised by a relative on 1 April 2016 was observed within an identified record. This was discussed with the registered manager and a recommendation was made.to ensure complaints / concerns or any dissatisfaction reported in the home were recorded and managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

A record of compliments was maintained. Some examples of compliments received are as follows:

'A short note of thanks for the very high standard of care and appreciation daddy received whilst he was a resident.'
'A thanks notice seems such a very inadequate appreciation of the work of the manageress and her staff in Rockfield.'
'…he never lost his dignity whilst in your care.'

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to wound analysis, care records, falls, accidents and incidents, catering, health and safety and infection prevention and control.

The infection prevention and control audit tool was reviewed on inspection. The tool included an action plan to address shortfalls. The action plan included the issue arising and actions to be taken to address the issue. The person responsible for completing the action was identified in the action plan as was the date for completion. A section was also available to ensure the actions suggested had been completed. The registered manager confirmed that audit results would be discussed at staff meetings.

Urgent communications, safety alerts and notices were reviewed by the registered manager on receipt and, where appropriate, were shared with staff. A system was in place to ensure that all relevant staff had read the communication or had been notified about it.

Discussion with the registered manager and review of records evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. An action plan was generated within the report to address any areas for improvement and a review of the previous action plan was included within the report. Copies of the reports were available for patients, their representatives, staff and trust representatives.

Discussions with staff confirmed that there were good working relationships within the home and that management were responsive to any suggestions or concerns raised.

Areas for improvement

It is recommended that records are maintained of all complaints / concerns and/or dissatisfaction received in the home.

Number of requirements	0	Number of recommendations:	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ciara Power, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 the (Insert Service Type). 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to nursing.team@rqia.org.uk by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref:** Standard 4 Criteria (9) **Stated:** Second time **To be completed by:** 31 July 2016	The registered manager should ensure that bowel function, reflective of the Bristol Stool Chart, is recorded on admission as a baseline measurement and thereafter in the patients' daily progress records. **Ref: Section 4.2, 4.4**
	Response by registered provider detailing the actions taken: A new activities of living form has since been implemented to trigger all nurses to record a baseline on admission and there after on daily progress notes.However after auditing our care plans 29 out of 34 residents individual care plans had Bristol Stool records up to date.
Recommendation 2 **Ref:** Standard 41 **Stated:** First time **To be Completed by:** 30 June 2016	The registered person should review staffing levels to ensure that at all times there are sufficient numbers of staff and skill mix deployed to meet the needs of the patients in the home. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: All our residents dependency levels have been reassessed and our staffing levels are adequate to deliver individualised care from a holistic approach.
Recommendation 3 **Ref:** Standard 43 Criteria (4) **Stated:** First time **To be completed by:** 15 April 2016	The registered person should ensure equipment, such as toilet aids, are used safely and minimise any risk to patient safety. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: One high rise assisted toilet frame had one leg out of line, this was reset immediately after the Inspector pointed it out.

Recommendation 4 **Ref:** Standard 4 Criteria (9) **Stated:** First time **To be Completed by:** 14 July 2016	It is recommended that repositioning charts are completed in full and contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: All staff have been made aware of the importance of documentation of the condition of the skin/pressure areas during repositioning intervention, dated and signed. This will be audited periodically by the Home Manager.
Recommendation 5 **Ref**: Standard 37 **Stated:** First time **To be Completed by:** 30 June 2016	The registered person should ensure that staff date and sign any record they create in accordance with best practice and professional guidance. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: New documentation is in place where there is a space for each staff member to sign and date after completion.
Recommendation 6 **Ref**: Standard 16 Criteria (9) **Stated:** First time **To be completed by:** 30 June 2016	The registered person should ensure that all complaints/concerns/dissatisfaction received in the home are managed and recorded appropriately in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: A new complaints book has been implemented by the new providers and any complaints will be documented and outcomes recorded, signed and dated.

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

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