Unannounced Care Inspection Report
19 June 2017

Rockfield Care Centre

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

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 and residential care for up to 34 persons.

3.0 Service details

Organisation/Registered Provider: Burnview Healthcare Ltd **Responsible Individual:** Briege Kelly	**Registered Manager:** Ciara Power
Person in charge at the time of inspection: Ciara Power	**Date manager registered:** 31 March 2014
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. MP – Mental disorder excluding learning disability or dementia. PH – Physical disability other than sensory impairment. Residential Care (RC) I – Old age not falling within any other category.	**Number of registered places:** 34 comprising: Not more than 2 residential beds. Not more than 2 persons in category NH-MP and a maximum of 8 persons in category NH-PH.

4.0 Inspection summary

An unannounced inspection took place on 19 June 2017 from 09.40 to 17.30 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 Care Standards for Nursing Homes 2015.

The term ‘patients’ is used to describe those living in Rockfield which provides both nursing and residential care.

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 recruitment procedures; notifications of incidents; delivery of compassionate care; adult safeguarding; monitoring staffs’ registration status with the appropriate bodies; the management of mealtimes and engagement with patients/patients’ representatives.

Areas requiring improvement were identified in relation to staff training, auditing, care records and management of accidents.

Patients said that they were satisfied with the care and services provided and 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.

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	3	3

Details of the Quality Improvement Plan (QIP) 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.

4.2 Action/enforcement taken following the most recent inspection dated 5 January 2017

The most recent inspection of the home was an announced premises inspection undertaken on 5 January 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this 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 the inspector met with 10 patients and eight staff. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

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.

The following records were examined during the inspection:

- duty rota for all staff from 12 to 25 June 2017
- 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
- one staff recruitment and induction file
- three patient care records
- three patient care charts including food and fluid intake charts, bowel management and reposition charts
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability insurance
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

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.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance was 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 5 January 2017

The most recent inspection of the home was an announced premises inspection. The completed QIP was returned and approved by the estates inspector and will be validated at the next premises inspection.

6.2 Review of areas for improvement from the last care inspection dated 7 June 2016

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 4 Criteria (9) **Stated:** Second 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.	**Met**
	Action taken as confirmed during the inspection: A review of bowel management records evidenced that these had been completed appropriately.	
Area for improvement 2 **Ref:** Standard 41 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and staff and a review of the duty rota evidenced that where possible, there were sufficient staff on duty to meet the needs of patients.	
Area for improvement 3 **Ref:** Standard 43 Criteria (4) **Stated:** First time	The registered person should ensure equipment, such as toilet aids, are used safely and minimise any risk to patient safety.	**Met**
	Action taken as confirmed during the inspection: All equipment observed in use was used in a safe manner and for the purpose in which it was designed.	

Area for improvement 4 **Ref:** Standard 4 Criteria (9) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Repositioning records reviewed had been completed in full and contained evidence of skin checks.	
Area for improvement 5 **Ref:** Standard 37 **Stated:** First time	The registered person should ensure that staff date and sign any record they create in accordance with best practice and professional guidance.	**Met**
	Action taken as confirmed during the inspection: All records reviewed on inspection had been dated and signed appropriately.	
Area for improvement 6 **Ref:** Standard 16 Criteria (9) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of complaints records evidenced that this area of improvement had been met.	

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 for week commencing 12 June 2017 evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained.

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. An induction booklet was completed and signed by the new employee and the staff member responsible for completion of the induction. There was evidence that the induction process had oversight from the registered manager.

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 majority of staff were compliant with mandatory training requirements. However, discussion with staff confirmed that training had been provided electronically. The provision for providing practical training on moving and handling was not appropriate as the assessed competence of training providers had not been established. There was no practical element in relation to basic life support training in accordance with best practice guidelines. This was discussed with the registered manager and identified as an area for improvement.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. An adult safeguarding champion had been identified. A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

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. However, following a review of bed rail risk assessments it was concerning that registered nurses had not evidenced their decision to use bed rails when a high level of risk had been identified. This will be further discussed in section 6.5.

Inspection of accident records evidenced that a fall where the patient sustained a head injury had occurred. Records indicated that central nervous system (CNS) observations were not taken immediately following the incident and monitored for 24 hours. This was discussed with the registered manager and identified as an area for improvement to ensure post falls management was conducted in compliance with best practice guidance.

Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

A review of the home's environment was undertaken and included observations of a number of bedrooms, bathrooms, lounges, dining rooms and storage areas. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. Bedrooms and communal areas were clean and spacious. Corridors were observed to be clear of clutter and obstruction. Compliance with infection prevention and control (IPC) was well maintained.

The entrance to the home was observed to have a mechanical keypad, which required a code in order to enter and exit the building. This was discussed with the registered manager and it was requested that this arrangement was reviewed to ensure that patients within the home were not subject to de-facto detention. An area for improvement was identified to review the use of this keypad lock to exit the building.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, monitoring of staff registration, adult safeguarding, the homes environment and compliance with IPC.

Areas for improvement

Areas for improvement under regulations were identified on falls management and review of patients' deprivation of liberty.

An area for improvement under care standards was identified on staff training.

	Regulations	Standards
Total number of areas for improvement	2	1

6.5 Is care effective?

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

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. The majority of care plans had been personalised to meet the individual needs of the patients and had been reviewed monthly. However, following a review of bed rail risk assessments it was concerning that registered nurses had not evidenced their decision to use bed rails when a high level of risk had been identified. This was discussed with the registered manager and identified as an area for improvement.

Supplementary care records in regards to bowel management; repositioning and food and fluid intake were reviewed. Bowel management and repositioning had been recorded well on all three patient care records reviewed. Food and fluid intake also had been recorded well, although, a discussion with the registered manager occurred to ensure that patients, where required, had an appropriate fluid intake target recorded.

One issue arose during the review of patient care records pertaining to wound care management. Evidence was not present that registered nurses were adhering to regional guidelines. Wound observation charts had been completed in regard to an ongoing wound up to 3 June 2017. No further wound observation charts had been completed following this date when there was evidence that the wound had been redressed. This was discussed with the registered manager and identified as an area for improvement.

Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Staff demonstrated an awareness of the importance of patient confidentiality in relation to the storage of records. Patients' records were stored in a lockable nurses' station.

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

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift.

Discussion with staff and the registered manager confirmed that general staff meetings were conducted regularly. Minutes of these meetings had been maintained and were available for review. Discussion with staff and the registered manager also confirmed that patients meetings were conducted regularly.

The registered manager confirmed that they operate an 'open door policy' and are available to discuss any issues with staff, patients and/or relatives. The registered manager also confirmed that they would undertake a daily walk around the home and would avail of the opportunity to engage with patients and relatives at this time.

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. Two staff consulted were off the opinion that their concerns were not taken seriously. These concerns were passed to the registered manager for review. Patients and the representative spoken with expressed their confidence in raising concerns with the home's staff/management.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication through meetings, care planning and the completion of supplementary care records.

Areas for improvement

An area for improvement under regulation was identified on the recording of wound management.

An area for improvement under care standards was identified on care planning.

	Regulations	Standards
Total number of areas for improvement	1	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.

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with 10 patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Staff were observed chatting with patients when assisting them. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Patients stated that they were involved in decision making about their own care. Patients were consulted with regard to meal choices and their choice of attire. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

The provision of activities was reviewed. A programme of activities for week commencing 19 June 2017 was displayed. Activities included a quiz; art; music; newspapers; exercise; one to one activities; hairdressing and nails; baking; outings; games and flower arranging. Discussion with the PAL confirmed that the programme of activities was reviewed monthly. Patients commented on the provision of activities in a positive manner.

Two registered nurses, four carers and two ancillary staff members were consulted to ascertain their views of life in Rockfield. Ten staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. Eight of the questionnaires were returned within the timescale for inclusion in the report.

Some staff comments were as follows:

"It's lovely here. Nice and friendly."
"We're grand here. It's dead on."
"It's ok, the team are very good."
"I love it here."
"I've always loved working here."
"It's home from home here."

Ten patients were consulted. Eight patient questionnaires were left in the home for completion. All eight of the patient questionnaires were returned. All patients indicated that they were very satisfied with the care provided.

Some patient comments were as follows:

"The home is very good. The foods good and the care is good."
"It's very nice living here."
"This is a lovely home. The staff are brilliant."
"It's alright here. We have plenty to do."
"It's very nice and the foods good."
"I am very comfortable here. The care is first class."
"It's great here."

No patient representatives were available for consultation during the inspection. Ten relative questionnaires were left in the home for completion. Two of the relative questionnaires were returned. The respondents indicated that they were very satisfied with the care provided.

Any comments from patients, patient representatives and staff in returned questionnaires 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 privacy, dignity and respect afforded to patients; staff interaction with patients and the mealtime experience.

Areas for improvement

There were no areas for improvement identified during the inspection in the compassionate domain.

	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.

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.

Discussion with the registered manager and review of the home's complaints records evidenced 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. The complaints procedure was displayed at the entrance to the home.

A compliments file was maintained to record and evidence compliments received. Some examples of compliments received are as follows:

"We appreciate all your loving care and support to us over these years."
"We really appreciate all your kindness, help and support during our mothers stay at Rockfield."
"We, the family, always felt very much at home going to visit and hope that Rockfield never changes."

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, regular audits were completed in accordance with best practice guidance in relation to medicines; falls; complaints; care plans; environment and IPC. Auditing records in regard to care plans were reviewed. A system to demonstrate shortfalls, action planning and review of planned actions was not evident. This was discussed with the registered manager and identified as an area for improvement.

Two staff consulted confirmed that when they raised a concern, they did not feel that the home's management would take their concerns seriously. These concerns were passed to the registered manager for review and action as appropriate.

Discussion with the registered manager and review of records evidenced that Regulation 29 monthly monitoring reports were completed and available for patients, their representatives, staff and Trust representatives to review.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements and the management of complaints and incidents.

Areas for improvement

An area for improvement under care standards was identified on auditing records.

	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 Ciara Power, Registered Manger, 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.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for Improvement 1 **Ref:** Regulation 12 (1) (a) and (b) **Stated:** First time **To be completed by:** 30 June 2017	The registered provider must ensure that registered nurses monitor patient observations in the event of a head injury, in accordance with best practice guidance and professional standards, for example; post falls management guidance. **Ref: sections 6.4**
	Response by registered person detailing the actions taken: . All nurses are in the process of receiving supervision with regard to fall managament use of appropriate charts e.g. Glasgow coma scale for Head Injury or unwitnessed fall.
Area for improvement 2 **Ref:** Regulation 13 (1) **Stated:** First time **To be completed by:** 7 July 2017.	The registered person shall review the use of the front door exit keypad in conjunction with guidance from the Department of Health on human rights and the deprivation of liberty (DoLs); and the home's registration categories. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: New care plans have been implemented for deprevitation of liberty regarding front door key pad.
Area for improvement 3 **Ref:** Regulation 12 (1) (a)(b) **Stated:** First time **To be completed by:** 30 June 2017	The registered person shall ensure that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: Ongoing Clinical supervision for all nurses in regards of wound management and proper documentation .

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref:** Standard 39 **Stated:** First time **To be completed by:** 31 August 2017	The registered person shall ensure that practical elements in training on basic life support and manual handling are conducted and in an effective and timely manner in line with best practice guidance. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: Senior Manager will arrange training of all staff.
Area for improvement 2 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 19 July 2017	The registered person shall ensure that when a patient is assessed as high risk from the use of bedrails, that this is kept under review and the reason for the continued use of bedrails is clearly documented within the patient's care plan. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: Clinical supervision is in place and all records are clearly recorded and reviewed monthly or more oftern if there is a change in condition.
Area for improvement 3 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 31 July 2017	The registered person shall ensure that a system to clearly identify shortfalls within patient care record audits is developed and that there is evidence of an action plan and a review of action planning were appropriate. **Ref: Section 6.7**
	Response by registered person detailing the actions taken: Registered nurses are to action any requirements identfied through the care plan audit tool which is at the nurses station and to ensure that they sign all records when completed.

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

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