Holywood
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Unannounced Care Inspection
of
Holywood

5 November 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 5 November 2015 from 09.25 to 17.30.

The focus of this inspection was continence management, which was underpinned by selected criteria from the DHSSPSNI Care Standards for Nursing Homes (2015):

Standard 4: Individualised Care and Support; Standard 6: Privacy, Dignity and Personal Care; Standard 21: Heath Care and Standard 39: Staff Training and Development.

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; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

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 on 11 June 2015.

1.2 Actions/Enforcement Resulting from this Inspection

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	2	3

The details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager, Mauro Magbitang, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four Season Health Care Dr Maureen Claire Royston	**Registered Manager:** Mauro J Magbitang Jr
Person in Charge of the Home at the Time of Inspection: Mauro J Magbitang Jr	**Date Manager Registered:** 05 November 2015
Categories of Care: NH-DE, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 71
Number of Patients Accommodated on Day of Inspection: 42	**Weekly Tariff at Time of Inspection:** £593 - £693

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the selected criteria from the following standards have been met:

Standard 4: Individualised Care and Support, criteria 8
Standard 6: Privacy, Dignity and Personal Care, criterion 1, 3, 4, 8 and 15
Standard 21: Heath Care, criterion 6, 7 and 11
Standard 39: Staff Training and Development, criteria 4

4. Methods/Process

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

- discussion with the registered manager
- discussion with patients
- discussion with staff
- review of a selection of records
- observation during a tour of the premises
- evaluation and feedback

The inspector met with 18 patients individually and with the majority of others in groups, two patient representatives, four care staff, one ancillary staff member and three registered nursing staff.

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

The following records were examined during the inspection:
- a sample of staff duty rotas
- staff training records
- staff induction templates for registered nurses and care assistants
- competency and capability assessment template for nurse in charge
- three care records and a selection of personal care records
- a selection of policies and procedures
- incident and accident records
- care record audits
- call bell response time audits
- regulation 29 file
- guidance for staff in relation to continence care
- records of complaints

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced medicines management inspection dated 16 September 2015. The completed QIP was returned and approved by the pharmacy inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref:** Standard 32 **Stated:** First time	It is recommended that the policies relating to death and dying; palliative and end of life care; and communication are made available to staff, when finalised.	**Met**
	Action taken as confirmed during the inspection: Policies relating to death and dying; palliative and end of life care; and communication have been made available to staff with evidence of staff signature and date read.	

Recommendation 2 **Ref:** Standard 41.7 **Stated:** First time	Duty rotas should identify the name of the nurse in charge of the home. The registered manager or designated representative should also sign the duty rota.	**Met**
	Action taken as confirmed during the inspection: A review of duty rotas for three weeks evidenced the name of the nurse in charge and signature from the registered manager.	
Recommendation 3 **Ref:** Standard 35.16 **Stated:** First time	The registered manager should audit the call bell response times on a regular basis. This audit should include response times at or nearing change of shifts. The audit should clearly record outcomes and any follow up action required for improvement.	**Met**
	Action taken as confirmed during the inspection: A review of a quality assurance file evidenced the call bell response time audit had been completed appropriately.	
Recommendation 4 **Ref:** Standard 35.16 **Stated:** First time	The registered manager should review the level of complaints regarding one identified patient and provide RQIA with a report regarding this review, actions taken, whether or not the complainant was satisfied with the outcome and how this level of satisfaction was determined. The registered manager should also ensure that the patient's care manager has been informed and should confirm to RQIA that this has been done. **This information should be submitted to RQIA with the returned QIP.**	**Met**
	Action taken as confirmed during the inspection: Information was submitted to RQIA which evidenced that a review of complaints had been carried out. However, further detail was requested from the registered manager regarding the outcome of the complaint. This information was subsequently provided and the inspector was satisfied with the action taken.	

5.3 Continence Management

Is Care Safe? (Quality of Life)

Policies and procedures were in place to guide staff regarding the management of continence.

Best practice guidance on continence care was available in the home for staff to consult from the Royal College of Nursing (RCN); National Institute for Health and Clinical Excellence (NICE) and Four Seasons Health Care (FSHC). These included:

- Improving Continence Care for Patients (RCN)
- Continence Care in Care Homes (RCN)
- Catheter Care (RCN)
- Lower Urinary Tract Symptoms (NICE)
- Urinary Incontinence (NICE)
- Faecal Incontinence (NICE)
- Caring for a Patient With a Urinary Catheter (FSHC)
- Bowel Management Workbook (FSHC).

A Four Seasons Health Care patient information leaflet, 'Advice on Incontinence' was usually available in the home and a supply had been re-ordered to provide advice and guidance to patients and/or their representatives on continence issues.

Discussion with staff and the registered manager confirmed that staff had received training in relation to the management of urinary and bowel incontinence. Twenty care staff and six registered nursing staff had completed training in relation to incontinence products. E-learning on continence management had been completed by 20 care assistants and six registered nursing staff.

Discussion with staff and a review of the training records confirmed there were three registered nurses trained and assessed as competent in urinary catheterisation. Two registered nursing staff had been identified as requiring an update in catheterisation training and plans were in place to address this.

Staff were knowledgeable about the important aspects of continence care including the importance of dignity, privacy and respect as well as skincare, hydration and reporting of any concerns.

Observation during the inspection and discussion with staff evidenced that there were adequate stocks of continence products available in the nursing home.

A continence link nurse has been identified for the home.

Is Care Effective? (Quality of Management)

Review of three patients' care records evidenced that a continence assessment was recorded and reviewed on a monthly basis for each patient. However, two of the three continence assessments required an annual revision. A requirement was made.

Continence care plans were in place in each of the three patient care records with evidence of monthly review. However, there was no evidence of the involvement from the patient or patients' representatives in the development of the continence care plans in two out of three of the care records reviewed. A recommendation was made.

Two out of three of the continence care plans did not specify the actual product requirement to meet the needs of the patient. The product requirement was not included in any of the continence assessments. A recommendation was made in this regard.

Records reviewed evidenced that urinalysis was undertaken as required and patients were referred to their GPs appropriately.

Is Care Compassionate? (Quality of Care)

During the inspection staff were noted to treat the patients with dignity and respect. Good relationships were very evident between patients and staff. Staff were observed to respond to patients' requests promptly. Patients confirmed that they were happy in the home and that staff were kind and attentive.

Areas for Improvement

All patient assessments must be revised at least annually and the revised assessment placed in the patient care record.

Patients and/or their representatives should be involved in the development of care plans and this involvement should be evidenced within the care plan.

The actual continence product requirement to meet the needs of the patient should be included within the continence assessment and the continence care plan.

Number of Requirements:	**1**	**Number of Recommendations**:	**2**

5.4 Additional Areas Examined

5.4.1. Consultation with Patients, Representatives and Staff

During the inspection process, 18 patients, eight staff, and two patient representatives were consulted with to ascertain their personal view of life in Holywood Care Home. Ten patient questionnaires were given out and six were returned. Overall, the feedback from the patients, representatives and staff indicated that safe, effective and compassionate care was being delivered in Holywood Care Home.

Some patients' comments received are detailed below:
"It's very nice here. Plenty to eat."
"The staff are super. I like it here."
"It's brilliant. I absolutely love it here."
"The staff are lovely but sometimes it can be boring and tedious here."
"It's alright around here."
"I feel so safe and staff are so friendly. No need to say more."

Two respondents indicated their pain was not well controlled. This was brought to the registered manager's attention who agreed to have the patients' pain management plans reviewed.

The patient representatives consulted with were very positive about the care provided.

The general view from staff cited in completed questionnaires and during conversations was that they took pride in delivering safe, effective and compassionate care to patients.

Some staff comments received are detailed below:
"We work well as a team here. It's really good."
"I love it here."
"I really like it here. We are a good team."
"I am very pleased here. I like my work."

5.4.2. Infection Prevention and Control and the Environment

A tour of the home confirmed that rooms and communal areas were generally clean and spacious. However, a range of issues were identified within the homes which were not managed in accordance with infection prevention and control guidelines:

- inappropriate storage in identified rooms
- not all signage was laminated
- rusted rollater observed in toilet.

The above issues were discussed with the registered manager on the day of inspection. An assurance was provided by the registered manager that these areas would be addressed with staff to prevent recurrence. A recommendation was made that management systems are put in place to ensure compliance with best practice in infection prevention and control.

5.4.3. Documentation

Records of bowel movements were maintained in a unique 'Bowel Book' for each unit. Bowel movements recorded included the Bristol Stool Score. However, only some of these records were transcribed into the patients' care records. Patients were identified by first name only in some of the records within the bowel book. Large gaps were identified between bowel movements which were not corresponding to the patients' assessments or care plans. One patient assessed to have a bowel movement every two days had a gap of 12 days before there was a recorded bowel movement. Progress reports in the patients' care records reviewed, relating to daily continence management, stated 'continence care rendered' or 'continence care provided'. The records did not refer to either urinary or faecal incontinence care and did not provide any evidence of a bowel movement. The actual care rendered/provided was not specified.

Fluid balance targets had been identified within the patients' continence assessments for all three patient care records reviewed. However, deficits of the fluid targets evidenced from supplementary documentation and actions taken to address the deficits had not been recorded within the patients' records. One patient's fluid target recorded on their continence assessment was different to the fluid target recorded on their fluid balance chart.
Four repositioning charts where reviewed. The recording of skin checks were not consistent. The term 'care delivered' was documented often within the charts and did not specify the actual care delivered.

A requirement was made to ensure that all contemporaneous nursing records are recorded accurately and consistently throughout the home, to reflect the actual care given to patients and evidence action taken to address any concerns or deficits noted were patients' needs are not met as specified within their plan of care.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with registered manager, Mauro Magbitang, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

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

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

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. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref:** Regulation 15 (2) (b) **Stated:** First time **To be Completed by:** 31 December 2015	It is required that the assessment of patients' needs are revised as required but not less than annually. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Patients needs will be reviewed not less than annually.Compliance of this will be monitored through care plan audits..
Requirement 2 **Ref:** Regulation 19 (1) (a), schedule 3, (3) (k) **Stated:** First time **To be Completed by:** 31 December 2015	It is required that the registered person must ensure contemporaneous records of all nursing provided to the patient are recorded accurately to evidence actual care given and accounts for any concerns or deficits identified. Particular attention should focus on the areas identified on inspection. **Ref: Section 5.4.3**
	Response by Registered Person(s) Detailing the Actions Taken: Staff reminded to accurately document resident care through supervision to ensure contemporaneous records of all nursing care provided to the resident is recorded accurately. Staff will ensure that information contained in one document is reflected in care records. This will be monitored for compliance through auditing.
Recommendations	
Recommendation 1 **Ref:** Standard 4 Criteria (5) (6) (11) **Stated:** First time **To be Completed by:** 15 December 2015	It is recommended that care records should evidence patients and/or their representatives' involvement in the assessment; planning and evaluation of the patients care to meet their needs. If this is not possible the reason should be clearly documented within the care record. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Care plans are written to reflect resident and relative involvement, this will be monitored for compliance through audits. If this is not possible the person writing the care plan will record the reason within the plan, this plan will be reviewed during care reviews.

Recommendation 2 **Ref:** Standard 4 Criteria (1) (7) **Stated:** First time **To be Completed by:** 31 December 2015	It is recommended that patients' continence assessments and care plans are fully completed and include the specific continence products required by the patient. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Care Plans were rewritten following continence assessment and include the specific continence product required by the resident.
Recommendation 3 **Ref:** Standard 46 Criteria (1) (2) **Stated:** First time **To be Completed by:** 31 December 2015	It is recommended 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. **Ref: Section 5.4.2**
	Response by Registered Person(s) Detailing the Actions Taken: Infection Control audit done monthly and daily walkaround traca is completed. The rusted rollater has now been removed from bathroom and disposed of.

Registered Manager Completing QIP	Mauro Magbitang	**Date Completed**	29.12.15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	11.01.16
RQIA Inspector Assessing Response	Dermot Walsh	**Date Approved**	18.01.16

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