Maplecourt - Drumclay
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Unannounced Care Inspection
of
Maplecourt - Drumclay

21 January 2016

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 21 January 2016 from 14.00 to 17.00 hours.

The focus of this inspection was continence management which was underpinned by selected criteria from:

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

The care in the home was found to be safe, effective and compassionate. The inspection outcomes found no areas of concern. A Quality Improvement Plan (QIP) is not included in 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 07 May 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	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: Four Seasons Health Care Dr Maureen Claire Royston	**Registered Manager:** Mrs Heather Lyttle
Person in Charge of the Home at the Time of Inspection: Mrs Heather Lyttle	**Date Manager Registered:** 04 September 2015
Categories of Care: NH-LD, NH-LD (E)	**Number of Registered Places:** 22
Number of Patients Accommodated on Day of Inspection: 11 patients	**Weekly Tariff at Time of Inspection:** £637.00

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, criteria 1, 3, 4, 8 and 15
Standard 21: Health Care, criteria 6, 7 and 11
Standard 39: Staff Training and Development, criteria 4

4. Methods/Process

Prior to inspection the following records were examined:

- 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 (QIP) from inspections undertaken in the previous inspection year
- previous care inspection report.

During the inspection, the inspector met with eight patients, one registered nurse and three care staff.

The following records were examined during the inspection:

- validation of evidence linked to the previous QIP
- three patient care records
- records of accident/notifiable events
- staff training records
- staff induction records
- continence care policies and procedures.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 07 May 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection 07 May 2015

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 20.2 **Stated:** First time	A recommendation is made that care records reflect any discussions with patients/relatives and their expressed wishes regarding end of life care.	**Met**
	Action taken as confirmed during the inspection: Review of three patients care records evidenced that this recommendation had been met.	
Recommendation 2 **Ref**: Standard 33.2 **Stated:** First time	It is recommended that a palliative care link nurse is identified for the home.	**Met**
	Action taken as confirmed during the inspection: A palliative care link nurse had been identified for the home.	

5.3 Continence Management

Is Care Safe? (Quality of Life)

Policies and procedures regarding continence management, catheter care and stoma care were available to guide staff.

Best practice guidance on continence care was available in the home for staff to consult. These included:

- Urinary incontinence (NICE)
- Faecal Incontinence (NICE)
- Continence care in Care Homes (RCN)
- Four Seasons Healthcare continence care guidelines.

Discussion with staff and the registered manager confirmed that staff had received training in 2015 relating to the management of urinary and bowel incontinence. Staff had completed training on the use and application of incontinence aids. A review of the induction template for care staff evidenced that the management of toileting needs was included in the induction process.

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.

Discussion with the registered manager and a review of the training records confirmed that two registered nurses were trained in 2014 and assessed as competent in urinary catheterisation.

The identified continence link nurse had recently left her post and plans were in place to identify another continence link nurse 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. The continence assessment clearly identified the patient's incontinence needs.

Continence care plans were in place for each patient with evidence of monthly review.

There was evidence that patients and/ or their representatives had been involved in discussions regarding the development of care plans.

The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Assessments and care plans specified the product required to meets the needs of the patient. Care plans referred to patient's normal bowel patterns and bowel type.

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

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

Is Care Compassionate? (Quality of Care)

Staff were observed to treat the patients with dignity and respect. Good relationships were 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

No areas for improvement were identified.

Number of Requirements:	**0**	**Number of Recommendations**:	**0**

5.4 Additional Areas Examined

5.4.1. Consultation with Patients and Staff

Patients

The inspector met with eight patients and three patients were consulted individually. A number of patients were unable to express their views verbally. All patients appeared well presented and comfortable in their surroundings. Comments from patients regarding the quality of care, food and life in the home were very positive. There were no concerns raised. Comments included:

- "Everything is good."
- "I like it here."
- "Food is good."

Staff

One registered nurse and three care staff took the time to speak with the inspector. The general view from staff during discussions was that they took pride in delivering safe, effective and compassionate care to patients. No concerns were raised by staff. A few staff comments are detailed below:

- "I like working in this unit."
- "We ensure that our patients are cared for to a high standard."
- "We have good support and plenty of training."

5.4.2. Accidents/Incidents

A review of accidents/incidents records evidenced that these were maintained appropriately and in accordance with legislative requirements. Monthly analysis of accidents/incidents was completed and areas for improvements identified and actioned.

Areas for Improvement

No areas for improvement were identified.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

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.

6. No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Heather Lyttle	**Date Completed**	01/03/16
Registered Person	Dr Claire Royston	**Date Approved**	02.03.16
RQIA Inspector Assessing Response	Bridget Dougan	**Date Approved**	07.03.16

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

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