The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
27 January 2020

Owen Mor Care Centre

Type of Service: Nursing Home (NH)
Address: 167 Culmore Road, Londonderry, BT48 8JH
Tel no: 028 7135 3631
Inspectors: Julie Palmer, Mandy Ellis and Paul Nixon

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.

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 81 patients.

3.0 Service details

Organisation/Registered Provider:	Registered Manager and date registered:
Organisation/Registered Provider: East Eden Ltd **Responsible Individual:** Dr Una McDonald	**Registered Manager and date registered:** Joy Hynds Registration pending
Person in charge at the time of inspection: Joy Hynds - Manager	**Number of registered places:** 81 comprising: A maximum of 68 patients in category NH-DE; 24 accommodated in the Foyle/Faughan Unit, 13 accommodated in the Roe Unit, 10 accommodated in the Derg Unit, 10 accommodated in the Mourne Unit and 11 accommodated in the Finn Unit. A maximum of 7 patients in category NH-LD/LD(E) accommodated in the Strule Unit and a maximum of 6 patients in category NH-MP/MP(E) accommodated in the Erne Unit.
Categories of care: Nursing Home (NH) DE – Dementia. MP – Mental disorder excluding learning disability or dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. LD – Learning disability. LD(E) – Learning disability – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 58 A maximum of 68 patients in category NH-DE; 24 accommodated in the Foyle/Faughan Unit, 13 accommodated in the Roe Unit, 10 accommodated in the Derg Unit, 10 accommodated in the Mourne Unit and 11 accommodated in the Finn Unit

4.0 Inspection summary

An unannounced inspection took place on 27 January 2020 from 09.35 hours to 17.25 hours.

This inspection was undertaken by the care and pharmacy inspectors.

Conditions were urgently imposed on the home's registration on 16 August 2019 as a result of ongoing non-compliance with regulations and care standards. At the last care inspection, undertaken on 19 November 2019, we were able to evidence compliance with the conditions imposed and these were removed on 22 November 2019.

This inspection assessed progress with all areas for improvement identified in the home since the last care inspection and sought 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 staffing, risk management, the home's environment, management of medicines, the daily routine, the culture and ethos, communication and listening to patients, relatives and staff. Further evidence of good practice was identified in relation to governance arrangements, quality improvement and maintaining good working relationships.

Areas requiring improvement were identified in relation to recruitment checks, completion of neurological observations, the meal time experience and the duty rota.

Patients were seen to be relaxed and comfortable in their surroundings and in their interactions with staff.

Comments received from patients, people who visit them and staff during and after the inspection, are included in the main body of this report.

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	0	4

Details of the Quality Improvement Plan (QIP) were discussed with Joy Hynds, 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 10 December 2019

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 10 December 2019. No areas for improvement were identified. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous care and medicines management inspection findings, registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home

- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire.

A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff from 20 January to 2 February 2020
- 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
- two staff recruitment and induction files
- six patients' care records including food and fluid intake charts and reposition charts
- a sample of governance audits/records
- complaints and compliments received
- a sample of monthly monitoring reports
- registered nurse competency and capability assessment records
- supervision and appraisal schedule
- RQIA registration certificate
- a sample of medicine records

Areas for improvement identified at the last inspection were reviewed and assessment of compliance recorded as either met, partially met, or not 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 previous care inspection 19 November 2019

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Care Standards for Nursing Homes (2015)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 37 1

Stated: First time</td><td>The registered person shall ensure that patient information is maintained in a confidential manner.

A review of the ‘sleep mode’ timing for the computer screens should be considered.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The manager confirmed that ‘sleep mode’ timing had been reviewed for all computer screens. Staff spoken with demonstrated their knowledge of ensuring that patient information was maintained in a confidential manner.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 4

Stated: First time</td><td>The registered person shall ensure that care plans are developed to manage the care delivered and to reduce and manage identified risks.
This is specific to two identified patients.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
We reviewed the care plans for the identified patients and evidenced that these had been developed as required.</td></tr>
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6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

We discussed the planned daily staffing levels for the home with the manager who confirmed that these were regularly reviewed to ensure the assessed needs of patients were met. A review of the staffing rota from 20 January to 2 February 2020 evidenced that planned daily staffing levels were adhered to.

Staff spoken with expressed their satisfaction with staffing levels and teamwork in the home. They told us:

- "Teamwork is very good."
- "Teamwork is great."
- "The carers are brilliant."
- "This is my favourite job, I enjoy coming into work."

We also sought staff opinion on staffing via the online survey; no responses were received.

Patients' visitors spoken with expressed their satisfaction with staffing levels. They told us:

- "Staff are fantastic."
- "Nurses are very good."
- "The home runs very smoothly."

We also sought the opinion of patients and patients' visitors on staffing levels via questionnaires; no responses were received.

Review of two staff recruitment and induction files evidenced that criminal record checks had been completed to ensure staff were suitable to work with patients in the home prior to commencing employment. However, we noted that a gap in the employment history for one member of staff had not been explored and whilst the other member of staff had provided two written references, neither of these were from their most recent employer. Before making an offer of employment all necessary checks should be completed; an area for improvement was made. There was evidence in the files to confirm that staff had completed a period of induction.

Discussion with staff confirmed they were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Staff spoken with also confirmed they were aware of the home's whistleblowing policy.

Review of staff training records evidenced that none of the staff had received training in deprivation of liberty safeguards (DoLS). Staff spoken with demonstrated an awareness of DoLS and how they would ensure the appropriate safeguards were in place for those patients who required them. We discussed the need for DoLS training with the manager who assured us that the appropriate level of training would be arranged for all staff in the home. Following the inspection the manager confirmed that mandatory DoLS training had been implemented and all staff were aware of the need to complete the appropriate level of training.

A supervision and appraisal schedule was maintained; staff spoken with confirmed they received supervision and a yearly appraisal. Nurses who were left in charge of the home had completed the necessary competency and capability assessments.

There was a system in place to monitor the registration status of registered nurses with the NMC and care staff with NISCC. We observed that two members of staff, who had commenced employment more than six months previously, had not yet registered with NISCC although records indicated that their applications were in progress. We brought this to the attention of the manager who assured us that this matter would be addressed immediately. The following day the manager confirmed that both employees had successfully completed their registration with NISCC.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms, sluices, treatment rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Bedrooms were attractively decorated and personalised with items that were meaningful to the patients. Sluices and storage areas were found to be clean and tidy. Minor environmental issues were brought to the attention of the manager for information and action as required. Fire exits and corridors were observed to be clear of clutter and obstruction. Patients' visitors spoken with told us that the home was always "very clean".

Infection prevention and control (IPC) measures were observed to be adhered to within the home. Staff were observed to use personal protective equipment (PPE). PPE was readily available and stations were well stocked.

Review of care records evidenced that a range of validated risk assessments were completed and informed the care planning process for patients. Where practices were in use that could potentially restrict a patient's choice and control, for example bedrails, validated risk assessments and care plans were in place, consent was obtained where appropriate and care plans were regularly reviewed and evaluated.

Management of Medicines

Audits completed indicated that patients were receiving their medicines as prescribed.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. The manager and nursing staff advised of the procedures to identify and report any potential shortfalls in medicines. Antibiotics and newly prescribed medicines had been received into the home without delay.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home.

Medicine records were well maintained and facilitated the audit process. Personal medication records and handwritten entries on medicine administration records were updated by two registered nurses.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised.

Practices for the management of medicines were audited throughout the month by the nursing staff and management. A review of the audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, induction, supervision and appraisal, adult safeguarding, infection prevention and control, risk management, the home's environment and management of medicines.

Areas for improvement

An area for improvement was identified in relation to ensuring all necessary recruitment checks were carried out prior to making an offer of employment.

	Regulations	Standards
Total number of areas for improvement	0	1

6.4 Is care effective?

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

We observed that patients were well presented and wearing clean clothes; attention had obviously been paid to all aspects of their personal care. Observation of care delivery and the daily routine in the home evidenced that patients' care needs were met at the right time. Call bells were answered promptly; staff were seen to be responsive and helpful to patients.

The manager confirmed that 'sleep mode' timing had been reviewed for all computer screens to reduce the risk of unauthorised access to patient information. We observed this to be the case when reviewing computerised care records. Staff spoken with demonstrated their knowledge of ensuring that patient information was maintained in a confidential manner. An area for improvement in this regard identified at the previous inspection had been met.

Review of six patients' care records evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patients. Care records contained details of the specific care requirements in the areas reviewed and a daily record was maintained to evidence the delivery of care. Care records reflected that, where necessary, referrals were made to other healthcare professionals. Care plans reviewed had been updated to reflect recommendations made by other healthcare professionals.

We reviewed care plans for two identified patients to ensure that an area for improvement identified at the previous inspection had been met. Care plans had been appropriately developed; this area for improvement had been met.

In the care records reviewed for one patient who had a wound we noted the wound had not been redressed in accordance with the frequency indicated on the care plan. We discussed this with the nurse who confirmed that the wound had been redressed when required but the care plan had not been updated to reflect a recent change in the frequency of dressing; the nurse updated the care plan to reflect the change.

Review of records confirmed that, on at least a monthly basis, falls occurring in the home were analysed to identify if any patterns or trends were emerging and an action plan was devised if necessary. It was positive to note that the relevant risk assessments and care plans had been updated in the event of a fall and staff spoken with demonstrated their knowledge of how to care for a patient who had a fall. However, in the records reviewed for two patients who had recently had a fall and potential head injury, we observed that there were 'gaps' in recording of neurological observations with no rationale for non-completion recorded. An area for improvement was made.

We observed the serving of lunch in one unit within the home. The menu was on display and the food on offer smelled appetising and was well presented. A nurse was not in attendance at the beginning of the mealtime. Care staff were in attendance and they were observed to provide practical assistance to some patients and to encourage other patients to eat independently. However, we noted that some patients who received encouragement actually required more practical assistance. The manager and the nurse arrived in the unit during the meal and we made them aware of our observations. Action was immediately taken to ensure that all patients who required assistance received this. We also noted that there was no hot trolley available in the unit to ensure that meals could be kept warm until patients were ready to eat. During mealtimes patients should be offered the appropriate level of assistance they require in a discreet and sensitive manner and meals should be kept warm until patients are ready to eat; an area for improvement was made.

Following the meal we discussed our observations with the manager who assured us that an additional hot trolley would be purchased and deployment of staff during mealtimes and the overall mealtime experience would be reviewed to ensure meal times were a positive experience for all patients. We did note that patients' weights were monitored on at least a monthly basis and there was evidence in the care records reviewed of referral to, and recommendations from, the dietician and the speech and language therapist (SALT) where required. Review of supplemental care records evidenced that patients' daily food and fluid intake was recorded and these records were up to date.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the daily routine, record keeping and consultation with other healthcare professionals.

Areas for improvement

Areas for improvement were identified in relation to completion of neurological observations in the event of a fall and the mealtime experience.

	Regulations	Standards
Total number of areas for improvement	0	2

6.5 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.

During the inspection we observed that patients appeared to be comfortable and content in their surroundings and in their interactions with staff. There was a calm and friendly atmosphere throughout the home. Staff obviously knew the patients very well; they spoke knowledgably and with fondness about the patients in their care and told us about individual patient's likes and dislikes.

We spoke to 15 patients during the inspection all of whom appeared to be settled, relaxed and at ease.

Patients' visitors were complimentary about staff and the care provided to their relatives; comments included:

- "When we arrive unannounced we see that staff are always talking to the patients."
- "We are delighted."
- "Staff are very kind and attentive."
- "… is happy, that's the most important thing."
- "We have no complaints."

A record of cards and compliments received was maintained; one relative had recently commented that they "couldn't be happier with the care".

Staff interactions with patients were observed to be kind and caring; they treated patients with dignity and respect. Staff were observed to knock on bedroom and bathroom doors before entering rooms and to keep doors closed when assisting patients in order to ensure their privacy was maintained.

We observed that staff communicated effectively with patients and with each other. Patients' visitors told us that they were very satisfied with communication and consultation regarding their relative. The culture and ethos within the home appeared to be positive and geared towards ensuring patients' needs were met as effectively as possible.

The manager told us that five carers had recently completed a dementia training course with the University of Stirling and had received accreditation certificates for this. Additional face to face training in caring for patients with dementia has also been arranged for staff to ensure that they are adequately trained and supported to carry out their roles and responsibilities in this area.

A range of suitable activities were provided for patients and the weekly activity planner was on display. Additional services, such as hairdressing, were available in the home and patients were enabled to avail of these as they wished.

A relatives' meeting was held in January 2020; the manager told us that this had been well attended and she welcomed input and feedback from relatives in order to ensure any areas of concern were addressed to help drive improvement in the home. Meetings are planned on a quarterly basis with all relatives invited.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 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.

The certificate of registration issued by RQIA was displayed in the entrance hall of the home. There had been no change in management arrangements since the last inspection. Discussions with staff and observations within the home confirmed that it was operating within the categories of care registered.

Following the recent enforcement action, the manager confirmed that new admissions to the home were phased, with no more than two per week at the present time, in order to ensure that care was planned and delivered as safely and effectively as possible.

A review of the duty rota evidenced that the manager's hours and the capacity in which these were worked was not recorded, nor was the nurse in charge on each shift indicated; an area for improvement was made.

Staff told us that the manager was accessible and approachable and that they were made aware of any changes that occurred in the home; comments included:

- "It has been challenging but we have made improvements."
- "Joy (the manager) is just lovely."
- "I feel a lot more supported."

We observed that there was a system in place for managing complaints. Patients' relatives told us they were aware of the procedure for making a complaint.

Discussion with the manager and review of auditing records evidenced that a number of monthly audits were completed to assure the quality of care and services. Audits were completed, for example, regarding accidents/incidents, care records, use of restrictive practices, wounds and infection prevention and control practices. An action plan was developed where shortfalls were identified.

Review of records evidenced that systems were in place to ensure notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

We reviewed a sample of monthly quality monitoring reports. These were detailed and contained an action plan which indicated the person responsible and timescale for completion.

Staff meetings were held on at least a quarterly basis and a record was maintained of items discussed. Staff told us that they felt well supported in their roles.

The manager told us that either herself or the nurse in charge completed a daily walk around to ensure that deployment of staff was according to the duty rota and to identify any issues which required remedial action; a record of this was maintained.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

An area for improvement was identified in relation to ensuring the manager's hours and the nurse in charge were indicated on the duty rota.

	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 Joy Hynds, Manager, 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.

Quality Improvement Plan	
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 38 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that, prior to making an offer of employment, all necessary recruitment checks have been carried out. Ref: 6.3
	Response by registered person detailing the actions taken: WAll staff prior to being offered employment going forward, will have the necessary checks in place. Home Manager will audit all new staff employment files and address as necessary via an action plan
Area for improvement 2 **Ref**: Standard 4 (9) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that in the event of a fall neurological observations are completed for 24 hours following the fall; a rationale should be recorded if there is any variance from the care plan. Ref: 6.4
	Response by registered person detailing the actions taken: All nursing staff are receiving further guidance in the form of a group supervision and with intergration of research based practice have been advised regarding the recording of Neurological Observations and the importance of same This is ongoing. Standard operating procedure has also been revised and updated.
Area for improvement 3 **Ref**: Standard 12 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that during mealtimes patients are offered the appropriate level of assistance they require in a discreet and sensitive manner and that meals are kept warm until patients are ready to eat. Ref: 6.4
	Response by registered person detailing the actions taken: TNutritional audits have been carried out by the home manager as planned review of the dining experience . Deficits identified in one unit in particular with regard to the meals being kept warm until residents ready to eat have been addressed by the purchase of a hot food box

Area for improvement 4 **Ref**: Standard 41 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the manager's hours and the capacity in which these are worked and the nurse in charge on each shift is indicated on the duty rota. Ref: 6.6
	Response by registered person detailing the actions taken: With immediate effect the managers' scheduled hours were placed on the rota. The nurse in charge is now highlighted in the duty rota as well as being detailed on notice board in front reception

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

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