The Regulation and Quality Improvement Authority

Inspection Report

01 June 2021

Shaftesbury Mews

Type of Service: Nursing Home (NH)
Address: 646 Shore Road, Newtownabbey, BT37 0PR
Tel No: 028 9085 2866

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Amore (Watton) Limited **Responsible Individual:** Mrs Nicola Cooper	**Registered Manager:** Miss Stephanie Shannon – registration pending
Person in charge at the time of inspection: Miss Stephanie Shannon	**Number of registered places:** 18 A maximum of 12 patients in category NH-LD/LD(E) to be accommodated in bungalows 1 and 3 and a maximum of 6 patients in category NH-PH/PH(E) to be accommodated in bungalow 2.
Categories of care: Nursing Home (NH) LD – Learning disability. LD(E) – Learning disability – over 65 years PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 18
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 18 patients. The home is comprised of three detached bungalows: Eden (Bungalow 1), Sleepy Hollow (Bungalow 2) and Sea Breeze (Bungalow 3).	

2.0 Inspection summary

An unannounced inspection took place on 1 June 2021 between 9.30 am and 6.30 pm. The inspection was carried out by the care Inspector.

The 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.

Areas requiring improvement were identified in relation to staffing levels, care documentation, professional registration of staff, neurological observations, fire safety, record keeping and care documentation post fall.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Comments received from patients and staff, are included in the main body of this report.

RQIA were assured that the delivery of care in Shaftesbury Mews was safe, effective and compassionate and there were appropriate management arrangements within the home.

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

Throughout the inspection patients and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working in this home. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

Questionnaires and 'Tell Us' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

At the end of the inspection the manager was provided with details of the findings.

4.0 What people told us about the service

We spoke with two patients and 13 staff. No questionnaires or staff survey responses were returned within the indicated timeframe. The patients we spoke with expressed no concerns and those patients who were not able to voice their opinions verbally were seen to be relaxed and comfortable in their interactions with staff. Staff said that teamwork was good and that they enjoyed their job and providing care to the patients. Staff also told us that they felt supported in their role and that the manager was approachable.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 16 March 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 15 (2) (a)(b) **Stated:** First time	The registered person shall ensure patient care plans and risk assessments are reviewed regularly and consistently.	**Not met**
	Action taken as confirmed during the inspection: A review of care records evidenced gaps in the consistent regular review of some care plans and risk assessments. This area for improvement has not been met and is stated for a second time.	
Area for improvement 2 **Ref:** Regulation 30 (d) **Stated:** First time	The registered person shall give notice to the Regulation and Improvement Authority without delay of the occurrence of any event in the nursing home which adversely affects the wellbeing or safety of any patient.	**Met**
	Action taken as confirmed during the inspection: A review of documentation evidenced this area for improvement has been adequately met.	

Area for improvement 3 **Ref:** Regulation 10 (1) **Stated:** First time	The registered person shall ensure that having regard to the size of the nursing home, the statement of purpose, and the number and needs of the patients, that they carry on or manage the nursing home (as the case may be) with sufficient care, competence and skill. This is in specific reference to ensuring that a robust system is in place which ensures that staff complete all mandatory training / competencies in a timely manner.	**Met**
	Action taken as confirmed during the inspection: A training and competency matrix is in use which indicates staff attendance at training; this is updated and regularly reviewed by the manager	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure the prescription details on topical administration medication records are verified and signed by two registered nurses. The administration instructions should also be clearly documented.	**Not met**
	Action taken as confirmed during the inspection: A review of topical administration records evidenced incomplete documentation in regard to the nurse's signature, body map and instructions for application. This area for improvement has not been met and is stated for a second time.	

Area for improvement 2 **Ref:** Standard 35 **Stated:** Second time	The registered person shall ensure the overall quality of the action plans produced from governance audits are a robust account of detailed actions to address the deficits identified.	**Not met**
	Action taken as confirmed during the inspection: A review of governance audits evidenced the quality of audits by the manager has improved, however, the review of the accident/ incident, falls and care record audits did not evidence a robust action plan. Deficits were also noted in the governance audits which had been delegated to other members of the nursing team. This is further discussed in section 5.2.8. This area for improvement has not been met and is stated for a third and final time.	

5.2 Inspection findings

5.2.1 How does this service ensure that staffing is safe?

Safe staffing begins at the point of recruitment. There was a robust system in place to ensure staff were recruited correctly to protect patients as far as possible. All staff were provided with a comprehensive induction programme to prepare them for working with the patients.

There were systems in place to ensure staff were trained and supported to do their job. Staff received regular training in a range of topics, for example, first aid, diversity and inclusion, moving and handling and infection control.

Staff said there was good team work and that they felt well supported in their role, they were satisfied with the staffing levels and the level of communication between staff and management. Staff also said; “I love my work” and “this is the best job I’ve ever had”.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis. The duty rota identified the person in charge when the manager was not on duty. Although the staff did not highlight any concerns with staffing levels a review of the duty rota highlighted staffing deficits within one bungalow when compared with the required staffing levels as assessed by the manager. Details were discussed with the operations manager and an area for improvement was identified.

There was a system in place to monitor the registration status of nursing and care staff with their appropriate regulatory body on a regular basis. The nursing registration records reviewed were up to date. However, records reviewed in regard to care staff registration identified a lack of robust managerial oversight.

A number of staff had not processed an application of registration with the Northern Ireland Social Care Council (NISCC) within the required time frame. This was discussed with both the manager and operations manager for their appropriate action. Information received after the inspection advised only one staff member is still waiting registration with NISCC. An area for improvement was identified in regard to the robust checking of NISCC registration of staff members.

There were systems in place to ensure staff were recruited and trained properly. Two new areas for improvement were identified in regard to staffing levels and the monitoring of the professional registration of staff.

5.2.2 How does this service ensure patients feel safe from harm and are safe in the home?

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was identified as the appointed safeguarding champion for the home.

Review of staff training records confirmed that all staff were required to complete mandatory adult safeguarding training. The manager monitors compliance with attendance at mandatory training sessions.

Review of patients' records and discussion with the manager and staff confirmed that the use of restrictive practices was effectively managed. Staff confirmed that they had attended training in relation to the use of restrictive practices and how to engage in best interest decision making.

Staff were observed to be prompt in recognising patients' needs and early signs of distress, especially in those patients who had difficulty in making their wishes known. Staff were skilled in communicating with patients; they were seen to be respectful, understanding and sensitive to their needs.

There were systems in place to ensure that patients were safely looked after in the home and to ensure that staff were appropriately trained for their role in keeping patients safe.

5.2.3 Is the home's environment well managed to ensure patients are comfortable and safe?

The home's internal environment was noted to be well maintained. Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, clean, tidy and comfortable.
The flooring in two communal lounge areas was observed to be marked and scored and in need of repair or replacement. This was discussed with the manager to address and will be followed up on a future inspection.

Within the kitchen of one bungalow the fridge and freezer was observed in need of a better clean and food was seen inappropriately stored. The washing machine drawers within the laundry of all three bungalows were observed heavily clogged with excess washing powder. These deficits were discussed with the manager who agreed to action and add the cleaning and maintenance of these areas to the cleaning schedules. This will be followed up on a future inspection.

It was evident that patients felt at home and comfortable in their surroundings. Patients could choose where to spend their time and take their meals and staff were observed supporting them to make these choices. The garden area at bungalow three is in the process of being refurbished and will be fully enclosed once completed for the patients' enjoyment and safety.

We reviewed fire safety arrangements within the home; the fire risk assessment available for inspection was dated 4 December 2019. The manager later forwarded the annual in house review of fire safety which was conducted in January 2021. Both these documents were reviewed by the estates inspector who provided the following information.

This fire risk assessment should be reviewed annually, or following any significant changes to the premises, to ensure it remains valid (Northern Ireland Health Technical Memorandum 84). It is therefore important that this fire risk assessment is reviewed to ensure that the overall risk identified has been reduced from 'Moderate' to 'Tolerable' as stated therein.

The in house 'Annual Review of Fire Safety Management Plan' which is completed annually, is a comprehensive audit tool and its use should be commended. However, it cannot be considered to be a fire risk assessment as it does not provide any mechanism for assessing the overall risk within the premises or for the ongoing review of this risk. An area for improvement was identified.

There was evidence the home conducted frequent fire drills however, the documentation evidenced a poor standard of record keeping for example errors had been scribbled out which is not in keeping with record keeping guidelines. An area for improvement was identified.

There were systems in place to ensure that the environment of the home was well maintained in order that patients were comfortable. Two areas for improvement were identified in relation to fire risk assessments and record keeping.

5.2.4 How does this service manage the risk of infection?

Feedback from the manager provided assurance that effective systems were in place regarding the management of risks associated with COVID-19 and other potential infections. The home has also been participating in the regional testing arrangements for patients, staff and Care Partners and any outbreak of infection was reported to the Public Health Authority (PHA).

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures and the use of Personal Protective Equipment had been provided.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

Visiting arrangements were managed in line with Department of Health guidance.

There were effective systems were in place to manage the risk of infection within the home.

5.2.5 What arrangements are in place to ensure patients receive the right care at the right time? This includes how staff communicate patients' care needs, ensure patients' rights to privacy and dignity; manage skin care, falls and nutrition.

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. In addition, patient care records were maintained which accurately reflected the needs of the patients. Staff were knowledgeable of individual patients' needs, their daily routine, wishes and preferences.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering and discussing patients' care in a confidential manner. Patients were also noted to be content and settled in their surroundings. Staff were observed providing patients with the appropriate level of supervision and treated them with kindness and respect. Staff were attentive to patients and demonstrated a good understanding of patients' assessed needs.

Examination of care documentation for patients who had experienced a fall evidenced that care plans and risk assessments were not consistently reviewed and updated after the fall. An area for improvement was identified. Patients were commenced on neurological observations for unwitnessed falls; it was observed that on several occasions the neurological observations were not completed for the recommended timeframe and no rationale was documented for stopping the observations. An area for improvement was identified.

Topical medicine administration records were reviewed; shortfalls remain evident in their accurate completion. The records did not consistently evidence two nurses' signatures on the transcription of the medicine, nor did the records have clear application instructions. An area for improvement will be stated for a second time.

There was a system in place to ensure accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The serving of the lunchtime meal was not observed on this inspection. The menu was appropriately displayed in the bungalows which offered the patients a choice of meal. Staff feedback on the quality of the food was positive.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain.

There were systems were in place to ensure that patients' needs, including any changes, were communicated to all staff in a timely manner. Patients' privacy and dignity was maintained. Care delivery to patients will be further improved through compliance with the areas for improvement identified.

5.2.6 What systems are in place to ensure care records reflect the changing care needs of patients?

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

Patients' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each patients' care needs and what or who was important to them. A review of care documentation evidenced gaps in the consistent regular review of care plans and risk assessments, the specific example was discussed with the manager and the records were updated. An area for improvement will be stated for a second time.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

The care records reviewed were person centred however; an area for improvement will be restated in relation to the consistent regular review of care documentation.

5.2.7 How does the service support patients to have meaning and purpose to their day?

Observation of the daily routine confirmed that patients were able to choose how they spent their day. It was seen that patients could, for example, have a lie in and a late breakfast if they wished.

Activity schedules were developed by the home's activity staff member. The schedules were individualised to reflect the activities which the patents found most enjoyable. Patients who were able to go out and about frequently enjoyed bus trips with staff.

There were systems in place to support patients to have meaning and purpose to their day within Shaftesbury Mews.

5.2.8 What management systems are in place to monitor the quality of care and services provided by the home and to drive improvement?

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. While most of these audits are conducted by the manager a number of audits are delegated to nursing staff to complete. A number of deficits were observed in the audits that had been delegated; for example the audits lacked detail, were incomplete and the documentation was not in keeping with the required record keeping standards; there was evidence that errors in documentation had been scribbled out and not signed or dated by the nurse.
A further review of governance audits relating to accident/incidents, falls and care record audits observed these audits still required improvement in regard to the home manager oversight. A number of the audits still did not evidence the home manager's signature, analysis of the audit findings or a robust time bound action plan. An area for improvement will be stated for a third and final time.

There was a system in place to manage complaints. There was evidence that the manager ensured that complaints were managed correctly and that records were maintained. The manager told us that complaints were seen as an opportunity to for the team to learn and improve.

Staff commented positively about the manager and described her as supportive and approachable.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These are available for review by patients, their representatives, the Trust and RQIA.

There were systems were in place to monitor the quality of care delivery and service provision within the home. A previously stated area for improvement will be stated for a third and final time.

6.0 Conclusion

Patients looked well cared for and were seen to be content in their surroundings and in their interactions with staff. Staff were observed engaging compassionately with patients and in a manner which promoted their privacy, dignity and individuality. The environment of the home was suitably decorated and personalised to reflect patients' individual preferences.

Six new areas for improvement were identified. One area for improvement under the regulations has been stated for a second time. Two areas under the standards have been restated, one for a second time and one for a third and final time. Details can be found in the Quality Improvement Plan included.

RQIA were assured that the delivery of care in Shaftesbury Mews was safe, effective and compassionate and there were appropriate management arrangements within the home.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with.

The Nursing Homes Regulations (Northern Ireland) 2005 and Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

	Regulations	Standards
Total number of Areas for Improvement	3*	6*

* The total number of areas for improvement includes one regulation which has not been met and is stated for a second time and two areas under the standards, one area will be stated for a second time and one area for a third and final time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Stephanie Shannon, Manager, and Tracey Henry, Operations Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 15 (2) (a)(b) **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure patient care plans and risk assessments are reviewed regularly and consistently. Ref: 5.1 & 5.2.6
	Response by registered person detailing the actions taken: The care plan and risk assessments identified on the day of inspection have been fully reviewed and updated. Documentation quality audits of the care plans will be carried out monthly by the Home Manager and peer review by the house managers in each bungalow. Care plans will be updated if a change of need presents and the allocated Primary Nurses have been updated. Care plans and the importance of timely reviewing has been discussed during House Manager and Staff Nurse meeting. A overarching documentation tracker is in place.
Area for improvement 2 **Ref:** Regulation 21 (5)(d) (i) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that a robust system is in place which ensures that all relevant staff are registered with NISCC within expected timescales. Ref: 5.2.1
	Response by registered person detailing the actions taken: A NISSC tracker is in place and reviewed monthly as a minimum - this is checked and verified by the Home Manager and forms part of the Regulation 29 review. A follow up 1:1 with staff who are newly appointed has been carried out to apply for NISCC registration. A live register is available at site. Staff have been informed of the importance of maintaining annual renewal. Review will be included in the mid probation review of staff.

Area for improvement 3 **Ref:** Regulation 13 (1)(b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all unwitnessed falls are managed in line with best practice guidance: This specifically relates to: • The consistent recording of neurological observations • If observations are stopped before the recommended timeframe a clear rationale must be recorded. Ref: 5.2.5
	Response by registered person detailing the actions taken: Falls Preventation Standard Operating Procedure has been displayed in each bungalow. A Falls Pack has been implemented which includes all revelvant documents to be completed. Details of incidents discussed during flash meetings. The qualified staff have been advised that any decline of observations, the reason why must be recorded in the plan of care to evidence same to ensure gaps are explained fully. Incidents and accidents are reviewed monthly and shared learning and or trends identified and cascaded to staff through - regular team briefs and Governance Meetings.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 29 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure the prescription details on topical administration medication records are verified and signed by two registered nurses. The administration instructions should also be clearly documented. Ref: 5.1 & 5.2.5
	Response by registered person detailing the actions taken: The topical medication records have been reviewed and two nurses signatures are recorded on the adminstration records for verification.This will contnue to be reviewed by the Home Manager through daily quality walk rounds. This has been discussed with the bungalow House Managers and Qualified staff through staff meetings. A monthly Quality Medication Audit also reviews the topical administration records on an ad-hoc basis.

Area for improvement 2 **Ref:** Standard 35 **Stated:** Third and final time **To be completed by:** 30 June 2021	The registered person shall ensure the overall quality of the action plans produced from governance audits are a robust account of detailed actions to address the deficits identified. Ref: 5.1 & 5.2.8
	Response by registered person detailing the actions taken: The actions from the quality walk round audits have been reviewed and 1:1 supervision has been undertaken with those staff who complete quality walk arounds to ensure detail of same completed in full and evidence of completion . A Quality walk around log has been implemented for deficits to be identified and actioned. These are also included in the monthly governance meeting.
Area for improvement 3 **Ref:** Standard 41 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the number and ratio of the staff on duty at all times meet the assessed care needs of the patients. Ref: 5.2.1
	Response by registered person detailing the actions taken: The duty rota is reviewed daily to ensure that safe staffing levels are maintained by the Home Manager. The skill mix is also reviewed alongside same. Staffing ladders are reviewed on a daily basis to ensure they meet the current needs of the home, priortising patient care and safety.
Area for improvement 4 **Ref:** Standard 48.1 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the fire risk assessment is reviewed annually in accordance with current legislation and guidance, and ensure that the level of risk is maintained at a suitable level. Ref: 5.2.3
	Response by registered person detailing the actions taken: The internal Fire risk assessment has been completed and I can confirm that the external Fire risk assessment is to be completed on the 30th September 2021 by Ashby Fire serices.

Area for improvement 5 **Ref**: Standard 37 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that records and documentation is completed in accordance with legislative requirements, minimum standards and best practice. This specifically relates to fire drill records. Ref: 5.2.3
	Response by registered person detailing the actions taken: The completion of records and documentation has been discussed during supervisions, flash meeting and governance meetings to ensure that they are completed in accordance with legislation and best practice. The fire drill records have been addressed with maintenance to ensure legible recording of same.
Area for improvement 6 **Ref**: Standard 22 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that in the event of a fall patients' falls risk assessments and relevant care plans are reviewed and updated. Ref: 5.2.5
	Response by registered person detailing the actions taken: A Falls check list has been implementated which includes all records and documention which needs to be completed in the event of a fall. The Falls prevention Standard Operating procedure has been displayed in each bungalow for reference and this has been highlighted through qualified staff meetings. A monthly review of incidetns and accidents is carried out by the Home Manager to identify any lessons learned and or route cause analysis. The falls documentation is also reviewed as part of the documentation quality walk round by the Home Manager.

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

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