# Unannounced Care Inspection Report
# 8 July 2020

# Shaftesbury Mews

**Type of Service: Nursing Home**
**Address: 646 Shore Road, Newtownabbey, BT37 0PR**
**Tel No: 028 9085 2866**
**Inspector: Mandy Ellis**

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 nursing home registered to provide nursing care for up to 18 persons.

## 3.0 Service details

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| **Organisation/Registered Provider:**<br>Amore (Watton) Limited<br><br>**Responsible Individual:**<br>Nicola Cooper | **Registered Manager and date registered:**<br>Stephanie Shannon<br>Acting manager – application to be submitted |
| **Person in charge at the time of inspection:**<br>Stephanie Shannon | **Number of registered places:**<br>18<br><br>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:**<br>Nursing Home (NH)<br>LD – Learning disability.<br>LD(E) – Learning disability – over 65 years I –<br>PH – Physical disability other than sensory impairment.<br>PH(E) - Physical disability other than sensory impairment – over 65 years Old age not falling within any other category. | **Number of patients accommodated in the nursing home on the day of this inspection:**<br>18 |

## 4.0 Inspection summary

An unannounced inspection took place on 8 July 2020 from 09.30 to 15.30 hours.
Due to the coronavirus (COVID-19) pandemic the Department of Health (DOH) directed RQIA to continue to respond to ongoing areas of risk identified in homes. The inspection sought to assess 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.

The following areas were examined during the inspection:

- staffing
- the use of personal protective equipment (PPE)
- infection prevention and control (IPC)
- the environment
- care delivery
- the dining experience of patients
- governance and management arrangements.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

## 4.1 Inspection outcome

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 3* | 3* |

*The total number of areas for improvement includes one under regulation and one under the standards which have been stated for a second time. A further area for improvement under the standards has been stated for a third and final time. One area for improvement under regulation was not reviewed and has been carried forward to be reviewed at a future inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) 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.

Enforcement action did not result from the findings of this inspection.

## 5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report.

The following records were examined during the inspection:

- the duty rota from 29 June 2020 to 12 July 2020
- six patients' care records
- four patients' supplementary care records including food and fluid intake charts, observation charts, personal care and elimination records and sleep observation records
- one central nervous system (CNS) patient observation chart
- a sample of governance audits/ records
- a sample of monthly monitoring reports.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

## 6.0 The inspection

## 6.1 Review of areas for improvement from previous inspection(s)

The most recent inspection of the home was an unannounced care inspection undertaken on 12 June 2020.

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection 12 June 2020</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1<br><br>Ref: Regulation 13 (7)<br><br>Stated: First time</td><td>The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk of spread of infection. This relates specifically to the following:<br><br>• The cleanliness of shower chairs / hand sanitisers<br>• Staff compliance with hand washing / wearing of jewellery<br>• Ensuring that bed linen/pillows are clean and fit for purpose</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:<br>The above areas were all reviewed on inspection and were assessed as met.</td></tr>
<tr><td rowspan="2">Area for improvement 2<br><br>Ref: Regulation 13 (7)<br><br>Stated: First time</td><td>The registered person shall ensure that regional Covid -19 guidance for nursing and residential homes is implemented in relation to twice daily recording of staff and patients’ temperatures.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:<br>Staff and patient temperatures were not consistently recorded twice daily as per regional guidance.<br><br>This area for improvement has not been met and is stated for a second time.</td></tr>
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| **Area for improvement 3**<br><br>**Ref:** Regulation 15 (2) (a)(b) and Regulation 16 (2) (b)<br><br>**Stated:** First time | The registered person shall ensure patients' care plans and risk assessments are kept up to date and reviewed to accurately reflect the assessed needs of the patient. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Review of five patient care records and risk assessments confirmed that they were up to date and reflected the patients' assessed needs. | |
| **Area for improvement 4**<br><br>**Ref:** Regulation 13 (1) (a)(b)<br><br>**Stated:** First time | The registered person shall promote and make proper provision for the nursing, health and welfare of patients as follows:<br><br>• Ensuring that care record audits are completed in a robust manner | **Carried forward to the next inspection** |
| | **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.** | |
| **Area for improvement 5**<br><br>**Ref:** Regulation 29 (5) (a)<br><br>**Stated:** First time | The registered person shall ensure that the monthly monitoring reports are available for viewing on inspection. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The monthly monitoring reports were available and were reviewed on inspection. | |
| **Action required to ensure compliance with The Care Standards for Nursing Homes (2015)** | | **Validation of compliance** |
| **Area for improvement 1**<br><br>**Ref**: Standard 22<br><br>**Stated:** Second time | The registered person shall ensure that in the event of a fall, where a head injury is either suspected or confirmed, neurological observations are completed for the full 24 hour period of time following the fall. | **Not met** |
| | **Action taken as confirmed during the inspection**:<br>A review of care records relating to the management of one patient following a fall highlighted that the patient's neurological observations had not been carried out for the duration of time required; this is discussed further in section 6.2.4.<br><br>This area for improvement has not been met and is stated for a third and final time. | |

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| **Area for improvement 2**<br><br>**Ref**: Standard 4<br><br>**Stated:** First time | The registered person shall ensure that staff maintain consistent care records for patients by using the correct documentation for daily record keeping. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The documentation reviewed was consistent and new Priory documentation was in progress of being introduced. | |
| **Area for improvement 3**<br><br>**Ref**: Standard 12<br><br>**Stated:** First time | The registered person shall ensure that menus are displayed in each bungalow for patients' information, in a suitable format and updated on a daily basis to reflect the food served. | **Not met** |
| | **Action taken as confirmed during the inspection**:<br>While the menu boards were up to date in two bungalows, this was not the case in a third bungalow.<br><br>This area for improvement has not been made and is stated for a second time. | |

## 6.2 Inspection findings

### 6.2.1 Staffing

We reviewed the duty rotas for the period 29 June 2020 to 12 July 2020 and discussed staffing levels with the manager. We observed that staffing levels were subject to regular review to ensure that the assessed needs of the patients were met. The duty rotas reviewed reflected that the planned daily staffing levels were adhered to. It was identified that on a number of occasions, correction fluid had been used to make amendments to the staff rota information and the full name of staff was not always recorded. This was discussed with the manager and an area for improvement identified.

### 6.2.2 Personal Protective Equipment

We observed that there was a supply of PPE and hand sanitisers at the entrance to each bungalow. The manager advised that there are plans to erect a static PPE station at each bungalow entrance to house PPE supplies. There was a sufficient supply of PPE in the home. All staff are currently completing their donning and doffing of PPE competency training and PPE was observed to be used effectively.

### 6.2.3 Infection Prevention and Control / Environment

We reviewed the home's environment undertaking observations of a sample of bedrooms, bathrooms, toilets, lounges, dining rooms. Patients' bedrooms were tastefully decorated and personalised. We found corridors and fire exits were clear and unobstructed.

Deficits noted in regard to the cleanliness of the environment from the previous inspection had been actioned. The domestic staff cleaning schedule had been reviewed and time was now spent by a member of the domestic team in each of the bungalows.

Patients' bedlinen was clean and fresh and a number of new pillows had been purchased. However, we observed that continence aids, patients' personal toiletries and razors were left unattended in identified bathrooms. This was brought to the manager's attention and these items were removed; an area for improvement was made.

Staff were observed to comply with the home's uniform policy. Documentation was reviewed and evidenced that supervision sessions and monitoring of staff handwashing practice had been employed since the last inspection.

Review of records relating to the management of COVID-19 highlighted an inconsistency in relation to the frequency with which patient and staff temperature recordings were obtained. This was discussed with the manager and an area for improvement was stated for a second time.

### 6.2.4 Care delivery / Patients' dining experience

Patients were dressed in clean clothes and appeared well groomed. 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.

The review of four supplementary care records evidenced that they were accurately completed, providing up to date evidence of food and fluid intake, patients' behaviour and the personal care which had been provided.

Six care records were reviewed and evidence of the transfer of patient information onto new documentation was in progress. Care plans were individualised to the patient and were reviewed when re-written and transferred to the new documentation format. Risk assessments had also been updated upon transfer to the new documentation. Progress made in regard to the ongoing implementation of new documentation will be monitored on future inspections.

A CNS observation chart for a patient who had recently had a fall was reviewed; the chart was not consistently recorded for the recommended time duration. CNS observations should be recorded for at least 24 hours after a fall to observe the patient for any ill effects. A post inspection review of a further CNS observation chart was undertaken and was found to be appropriately recorded. However, this area for improvement is not met and will be stated for a third and final time.

In relation to the dining experience of patients, we spoke to the chef who was preparing an appetising lunch for the patients. The chef discussed the menu and choices available for the patients. The chef commented on how patients enjoy the provision of home baked foods We observed that the menu boards within two of the bungalows were up to date; however, the menu board in bungalow 3 was not updated. This was discussed with the manager who advised that a new menu board will be purchased for this bungalow. This area for improvement was not met and is stated for a second time.

### 6.2.5 Governance and management arrangements

A review of auditing records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. Some new filing and auditing systems had been introduced by the manager and it was evident that improvement had been made in relation to the oversight and governance arrangements in the home since the last inspection.

Audits were reviewed in relation to donning and doffing of PPE, hand hygiene, daily quality monitoring around the home, and tissue viability. The audits generated action plans that highlighted areas for improvement and there was evidence that the deficits identified were addressed, as required. Documentation audits were not reviewed on this inspection and will be reviewed at a future inspection.

Monthly quality monitoring reports were available and upon review evidenced that appropriate action plans were completed in respect to any deficits identified.

### Areas of good practice

Areas of good practice were identified in regard to staff knowledge of patients' individual needs and in their compassionate and patient interactions with them.

### Areas for improvement

Two new areas for improvement were identified with regard to storage of items within communal bathrooms and the duty rota.

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 1 | 1 |

## 6.3 Conclusion

On the day of the inspection we observed that patients appeared comfortable, and that staff treated them with kindness and compassion. It was evident that improvements had been made following the last inspection with regard to the oversight and governance arrangements within the home, care documentation and the IPC issues previously identified.

Two new areas for improvement were made in regard to the storage of items within communal bathrooms and, the staff rota.

## 7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP 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.

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 Nursing Homes Regulations (Northern Ireland) 2005**

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| **Area for improvement 1**<br><br>**Ref:** Regulation 13 (1) (a)(b)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With immediate effect | The registered person shall promote and make proper provision for the nursing, health and welfare of patients as follows:<br><br>• Ensuring that care record audits are completed in a robust manner<br><br>Ref: 6.2.5 |
| | **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.** |
| **Area for improvement 2**<br><br>**Ref:** Regulation 13 (7)<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>12 June 2020 | The registered person shall ensure that regional Covid-19 guidance for nursing and residential homes is implemented in relation to twice daily recording of staff and patients' temperatures.<br><br>Ref: 6.1 & 6.2.3 |
| | **Response by registered person detailing the actions taken:**<br>Meeting held with House Managers, NEWS observations are now in place in each of the services. Daily sampling of documentation is being carried out and the House Managers have daily oversight in each of the services. This is also discussed as part of the flash meetings in each of the services. When colleagues sign in and out of shifts each day their temperatures are taken and recorded, this is also being sampled daily by the Manager and the House Managers. |
| **Area for improvement 3**<br><br>**Ref:** Regulation 14 (2) c<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With immediate effect | The registered person shall ensure the home is free from unnecessary risks to the health and safety of patients. This relates specifically to:<br><br>• The safe storage of razors<br>• The storage of patients' toiletries in communal bathrooms<br>• The storage of continence products<br><br>Ref: 6.2.3 |
| | **Response by registered person detailing the actions taken:**<br>This has been discussed with colleagues and House Managers and evidenced at the service. Colleagues are aware of expectations around safe storage and this is being evidenced via the daily quality walk rounds completed in the service. Toiletries and continence products are now stored in service user's personal spaces safely, razors are locked away and accessible when |

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| | needed. |
| **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**<br><br>**Ref**: Standard 22<br><br>**Stated:** Third and final time | The registered person shall ensure that in the event of a fall, where a head injury is either suspected or confirmed, neurological observations are completed for the full 24 hour period of time following the fall.<br><br>Ref: 6.1 & 6.2.4 |
| **To be completed by:**<br>6 February 2020 | **Response by registered person detailing the actions taken:**<br>Meeting held with House Managers in each of the services to reiterate expectations of recording and monitoring post a fall. Standard Operating Procedures in place to ensure expectations are clear. Falls Logs are in place and colleagues are aware of the organisations Falls Strategy. Documentation, in the form of support plans and risk assessments, is in place for people supported that are at known risk of falls, these are all up to date and reflective of service user's current needs. Documentation quality walk round includes the sampling of falls documentation. If a person supported has a witnessed fall, 24 hr monitoring is implemented and evidenced at site, this process is also being followed for unwitnessed falls. Any issues pertaining to falls are discussed during daily flash meetings and incident logs are being reviewed monthly for learning outcomes and root cause analysis. |
| **Area for improvement 2**<br><br>**Ref**: Standard 12<br><br>**Stated:** Second time | The registered person shall ensure that menus are displayed in each bungalow for patients' information, in a suitable format and updated on a daily basis to reflect the food served.<br><br>Ref: 6.1 & 6.2.4 |
| **To be completed by:**<br>12 June 2020 | **Response by registered person detailing the actions taken:**<br>A cook has been newly appointed, there is a four week menu plan in place and pictorial menus are in the process of being completed to ensure food choices represent the actual meals that are prepared at the services. Dining experience quality walk rounds are being completed in the service where this aspect of improvement will be continually monitored. |
| **Area for improvement 3**<br><br>**Ref**: Standard 41<br><br>**Stated:** First time | The registered person shall ensure that the duty rota clearly evidences the full name of all staff working in the home and any amendments made do not involve the use of correction fluid.<br><br>Ref: 6.2.1 |
| **To be completed by:**<br>With immediate effect | **Response by registered person detailing the actions taken:**<br>All colleagues have been made aware that correction fluid cannot be used on any documentation in the service. The use of correction fluid will be added to the relevant quality walk round and competency tools to ensure colleagues are aware of expectations |

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| | and to ensure this can be monitored consistently at the services. |

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

The Regulation and Quality Improvement Authority

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