Unannounced Care Inspection Report
4 April 2017

Annadale

Type of Service: Nursing Home
Address: 11 Annadale Avenue, Belfast, BT7 3JH
Tel no: 028 9064 5900
Inspector: Dermot Walsh

1.0 Summary

An unannounced inspection of Annadale took place on 4 April 2017 from 09.30 to 18.15 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

Relevant checks were conducted within the recruitment process prior to a staff member commencing in post. RQIA were suitably informed of notifications under Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. A safe system for monitoring compliance with mandatory training was in place. Compliance with best practice in infection prevention and control was well maintained. A requirement was made in regard to the management of a patient following a fall. A recommendation was made to ensure an identified door was safely maintained in an open position.

Is care effective?

Risk assessments had been conducted and informed subsequent care plans. Staff demonstrated confidence and awareness in raising any potential concerns to the relevant people. Staff meetings were held regularly. There was evidence of engagement with patients' representatives. One recommendation was made in this domain in relation to consistency in care planning.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. Patients and their representatives were very praiseworthy of staff and a number of their comments are included in the report. No requirements or recommendations were made in this domain.

Is the service well led?

Many compliments had been received by the home in relation to the care and compassion provided to patients/relatives and some of these comments are contained within this report. Appropriate certificates of registration and public liability insurance were on display. Complaints received had been managed appropriately and systems were in place to monitor the quality of nursing care. No requirements or recommendations were made in this domain.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Winnie Mashumba, registered 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 25 January 2017. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Annadale Private Nursing Home Ltd. Trevor Gage	**Registered manager:** Winnie Mashumba
Person in charge of the home at the time of inspection: Winnie Mashumba	**Date manager registered:** 21 October 2008
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 38

3.0 Methods/processes

Prior to inspection we analysed the following information:

- 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 previous care inspection report and the returned QIP
- pre inspection assessment audit

During the inspection we met with12 patients individually and others in small groups, two patient representatives, two care staff, three registered nurses and one ancillary staff member.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff not on duty. Nine patient, nine staff and seven patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- three patient care records
- staff training records
- staff induction template
- complaints records
- incidents / accidents records since the last care inspection
- minutes of staff meetings
- a selection of audit documentation
- duty rota for the period 27 March to 9 April 2017

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 25 January 2017

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector and will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 15 July 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 21(1) (b) **Stated:** First time	The registered provider must ensure the recruitment process is reviewed to make sure that all relevant information has been obtained and/or reviewed prior to a staff member commencing in post.	**Met**
	Action taken as confirmed during the inspection: A review of the recruitment records of a recently employed member of staff evidenced that all relevant checks had been completed prior to the staff member commencing in post.	
Requirement 2 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person must ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. A robust system should be developed to ensure compliance with best practice in infection prevention and control.	**Met**

	Action taken as confirmed during the inspection: A robust system had been used to ensure compliance with infection prevention and control and a review of the environment evidenced that best practice in infection prevention and control had been achieved.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 39 **Stated:** First time	The registered provider should ensure that staff induction records are completed in full to include start/finish dates and include a completion signature of the person completing the induction and the mentor.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of induction records evidenced that these had been completed as recommended.	
Recommendation 2 **Ref:** Standard 22 **Stated:** First time	The registered provider should ensure that all equipment used within the home is only used for the purpose for which it is designed. The use of a bed mattress as a crash mat must cease.	**Met**
	Action taken as confirmed during the inspection: All equipment observed on inspection was in use for the purpose in which it was designed.	
Recommendation 3 **Ref:** Standard 44 Criteria (13) **Stated:** First time	The registered provider should ensure that the identified radiator has been covered to prevent a potential burn.	**Met**
	Action taken as confirmed during the inspection: The identified radiator had been covered.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for week commencing 27 March 2017 evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained.

Discussion with staff and review of records confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. An induction booklet was completed and signed by the new employee and the staff member responsible for completion of the induction.

Discussion with the registered manager and review of training records evidenced that a system was in place to monitor staff attendance at mandatory training. Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Observation of the delivery of care evidenced that training had been embedded into practice.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. Information sent to RQIA following the inspection confirmed the identity of the home's adult safeguarding champion.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since 15 July 2016 confirmed that these were appropriately managed. Accidents and incidents were reviewed monthly to identify any potential patterns or trends. Inspection of accident records evidenced that an unwitnessed fall had occurred. Records did not indicate that central nervous system (CNS) observations were taken immediately following the incident and monitored in accordance with best practice guidance. This was discussed with the registered manager and a requirement was made.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. Bedrooms and communal areas were clean and spacious. Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were well maintained.

During the review of the environment, a door leading to a nursing station was observed to be propped open. This was discussed with the registered manager and a recommendation was made to ensure that the door was maintained in an open position in accordance with fire safety legislation.

Areas for improvement

It is required that post falls management is conducted in compliance with best practice guidance.

It is recommended that the door leading to the identified nursing station is safely maintained in an open position in accordance with fire safety legislation.

Number of requirements	1	Number of recommendations	1

4.4 Is care effective?

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. Care plans had been personalised to meet the individual needs of the patients and had been reviewed monthly.

However, there was also evidence within one patient's care records that care plans had been reviewed and the information within them conflicted. A review of the patient's care records indicated three different repositioning regimes. This was discussed with the registered manager and a recommendation was made to review the patient's care records for consistency.

Supplementary care charts such as repositioning, bowel management and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift.

Discussion with the registered manager and staff confirmed that staff meetings were conducted regularly. Minutes of the meetings were available and included details of attendees; dates; topics discussed and decisions made.

The registered manager confirmed that they operate an 'open door policy' and are available to discuss any issues with staff, patients and/or relatives. The registered manager also confirmed that a relatives' survey had been sent to patients' next of kin to complete and that feedback from this survey would be provided on a digital display at reception and emailed on request to patients' next of kin.

Staff consulted knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and/or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Patients and representatives were confident in raising any concerns they may have with the staff and/or management.

Areas for improvement

It is recommended that the identified patient's care records are reviewed to ensure that the repositioning regime contained within is consistent throughout the records.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

Three registered nurses, two carers and one ancillary staff member was consulted to ascertain their views of life in Annadale Nursing Home. Staff consulted confirmed that when they raised a concern, they were happy that the home's management would take their concerns seriously. Nine staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. One of the questionnaires was returned within the timescale for inclusion in the report.

Some staff comments were as follows:
"This is a very good nursing home. Just like a family home."
"I'm happy here."
"I love working here."
"It's a very good nursing home."
"It's hard work but rewarding."

Twelve patients were consulted and the patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Nine patient questionnaires were left in the home for completion. Two patient questionnaires were returned within the timeframe.

Some patient comments were as follows:
"This place is fine. They (the staff) are lovely."
"It is very nice here and the people are very friendly."
"They (the staff) are very attentive here and very good."
"I'm very comfortable here."
"I like it here."

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Two patient representatives were consulted with on the day of inspection. Seven relative questionnaires were left in the home for completion. Three relative questionnaires were returned. All respondents indicated that they were very satisfied with the care provided in the home.

Some relatives' comments were as follows:
"The care in the home is very good."
"The staff are always polite and always make me feel welcome."
"Very good communication among staff; everyone is friendly and inviting."

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff were observed in conversation with patients when assisting them and to knock on bedroom doors before entering them. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

The serving of lunch was observed in the main dining room downstairs. Patients were seated around tables which had been appropriately laid out for the meal. Food was served from the kitchen when patients were ready to eat or be assisted with their meals. Food appeared nutritious and appetising. A menu was on display at the entrance to the dining room reflecting the food served. The mealtime was well supervised. Staff were observed to encourage patients with their meals. Staff wore the appropriate aprons when serving or assisting with meals and patients wore clothing protectors where required. Patients were observed to be assisted in an unhurried manner. Condiments were not available on tables and were not observed to be offered to patients. This was discussed with the registered manager who agreed to review this. A range of drinks were offered to the patients. Patients appeared to enjoy the mealtime experience.

Areas for improvement

No areas for improvement were identified during the inspection in this domain.

Number of requirements	0	**Number of recommendations**	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the registered manager evidenced that the home was operating within its registered categories of care.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. The complaints procedure was displayed at reception. The registered manager confirmed that any learning gained from complaints was discussed during staff meetings and/or discussed during one to one supervision sessions.

A compliments file was maintained to record and evidence compliments received.

Some examples of compliments received are as follows:
"I should now like to extend to you and the staff of Annadale the appreciation of … family on the care and attention which you gave to her."
"Your staff are a credit to you. I do not believe we could have chosen better."
"You are an example of what nursing care should be."

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

Areas for improvement have been identified in the safe and effective domains with regard to post falls management, care planning and safe practice. Compliance with this requirement and recommendations will further drive improvements in these domains.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

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

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time **To be completed by:** 5 April 2017	The registered person must ensure good practice guidance is adhered to with regard to post falls management. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Nursing staff reminded to do central nervous system observations immediately following all unwitnessed falls and suspected head injuries and to continue to monitor these for at least 24 hours. All residents who sustain head injuries during falls will continue to be transferred to the Emergency department for further assessments and management.
Recommendations	
Recommendation 1 **Ref:** Standard 47 **Stated:** First time **To be completed by:** 30 April 2017	The registered person should ensure that the door leading to the identified nursing station is safely maintained in an open position in accordance with fire safety legislation. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The door wedge has been removed.
Recommendation 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 5 April 2017	The registered person should ensure that the identified patient's care records are reviewed to ensure that the repositioning regime contained within is consistent throughout the records. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: The assessments and repositioning charts for the resident stated have been reviewed and amended to read the same.

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

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