Unannounced Care Inspection Report
10 April 2018

Annadale

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

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 38 persons.

3.0 Service details

Organisation/Registered Provider: Annadale Private Nursing Home Ltd **Responsible Individual(s):** William Trevor Gage	**Registered Manager:** Winnie Mashumba
Person in charge at the time of inspection: Winnie Mashumba	**Date Manager Registered:** 21 October 2008
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of registered places:** 38

4.0 Inspection summary

An unannounced inspection took place on 10 April 2018 from 09.30 to 16.30 hours.

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 Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified 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.

There were examples of good practice found throughout the inspection in relation to staffing arrangements, recruitment practice, monitoring registration status of staff, the home's general environment, risk assessment, teamwork, management of complaints, governance risk management, maintaining good working relationships and in relation to the culture and ethos of the home in relation to dignity and privacy.

An area was identified for improvement under regulation in relation to the development of care plans for patients deemed at risk of falls. Areas were identified for improvement under care standards in relation to the maintenance of wound care plans and the updating of care plans to reflect other health professionals' recommendations.

Patients were positive in their feedback of the care provided in the home. Patient comments can be reviewed in section 6.6. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

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	1	2

Details of the Quality Improvement Plan (QIP) 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.

4.2 Action/enforcement taken following the most recent inspection dated 3 January 2018

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 3 January 2018. There were no further actions required to be taken following the most recent 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 which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection the inspector met with six patients and five staff. A poster was displayed at a staffing area in the home inviting staff to respond to an online questionnaire. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. Ten questionnaires for patients and 10 for patients' representatives were left for distribution.

A poster indicating that the inspection was taking place was displayed at the sign in desk in the reception area of the home and invited visitors/relatives to speak with the inspector.

The following records were examined during the inspection:

- 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
- one staff recruitment and induction file
- three patient care records
- three patients' daily care charts including bowel management, food and fluid intake charts and reposition charts
- a selection of governance audits
- records pertaining to safeguarding
- complaints record
- compliments received
- RQIA registration certificate
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

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

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 3 January 2018

The most recent inspection of the home was an unannounced medicines management inspection dated 3 January 2018. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 4 April 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time	The registered person must ensure good practice guidance is adhered to with regard to post falls management.	**Met**
	Action taken as confirmed during the inspection: A review of accident records evidenced that the accident had been managed in accordance with best practice guidance.	

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 **Ref:** Standard 47 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: The identified door had been maintained open in a safe manner. No doors within the home were observed to have been propped or wedged open.	
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Three repositioning records reviewed had been maintained in accordance with the corresponding patients' risk assessments and care plans.	

6.3 Inspection findings

6.4 Is care safe?

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

Discussion with patients and staff evidenced that there were no concerns regarding staffing levels. Staff consulted confirmed that staffing levels met the assessed needs of the patients. 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. A review of one staff's recruitment records evidenced that enhanced Access NI checks were sought, received and reviewed prior to the staff commencing work and records were maintained. Appropriate references had also been obtained prior to the staff member commencing employment.

Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training. Staff consulted confirmed

that the training provided was relevant to their roles and responsibilities. Staff also confirmed that additional face to face training had recently been conducted on the management of topical preparations, fluid thickeners and oral hygiene.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

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. An adult safeguarding champion had been identified. Discussion with the registered manager confirmed that there had been no recent or ongoing safeguarding concerns relating to the home.

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. However, there were also three areas for improvement identified in relation to care planning. See section 6.5 for further information.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. A review of accident records pertaining to falls evidenced that these had been maintained appropriately. An area for improvement identified at the previous care inspection in relation to the management of falls has now been met.

A review of the home's environment was undertaken and included observations of an identified selection of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Fire exits and corridors were observed to be clear of clutter and obstruction. Compliance with infection prevention and control (IPC) had been well maintained. Isolated IPC issues were managed during the inspection.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing arrangements, recruitment practice, monitoring registration status of staff and the home's general environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

Review of three patients' 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. However, it was also observed within two patients' care records that a specific falls care plan had not been developed following an identified risk of falls. This was discussed with the registered manager and identified as an area for improvement under regulation.

The registered nurses were aware of the local arrangements and referral process to access other relevant professionals including general practitioners, tissue viability nurses, speech and language therapists and dieticians. A review of one patient's care records did not evidence that the patient's care plan had been updated to reflect the recommendations of the health professional. This was discussed with the registered manager and identified as an area for improvement.

A review of one patient's wound care records evidenced conflicting information contained within the patient's wound care plan. Two separate dressing regimes were included within the care plan. The wound care plan had not been updated to reflect the current management of the wound. This was discussed with the registered manager and identified as an area for improvement.

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

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. Staff confirmed that sufficient information was handed over in order to meet the needs/changing needs of patients in their care.

Staff also confirmed that there was effective teamwork and 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 spoken with expressed their confidence in raising concerns with the home's staff/management.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to risk assessment, teamwork and communication.

Areas for improvement

An area was identified for improvement under regulation in relation to the development of care plans for patients deemed at risk of falls.

Areas were identified for improvement under care standards in relation to the maintenance of wound care plans and the updating of care plans to reflect other health professionals' recommendations.

	Regulations	Standards
Total number of areas for improvement	1	2

6.6 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.

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with six patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Staff were observed chatting with patients when assisting them. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. 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.

Patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

The serving of lunch was observed in the dining room. Signage was present on the dining room door signifying the use of the room. Lunch commenced at 12:35 hours. Patients were seated around tables which had been appropriately set for the meal. A menu was displayed at the entrance to the dining room reflecting the food which was served. Food was served directly from the kitchen when patients were ready to eat or be assisted with their meals. Patients were afforded the choice of their preferred dining area. Food was covered when transferred from the dining room. The food served appeared nutritious and appetising. The portion size was appropriate for the patients to which the food was served. Staff were observed to encourage patients with their meals and patients were observed to be assisted in an unhurried manner. Staff wore the appropriate aprons when serving or assisting with meals and patients wore clothing protectors when required. A range of drinks were offered to the patients. Patients appeared to enjoy the mealtime experience. The mealtime was well supervised.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

A compliments file was maintained to record and evidence compliments received.
Some examples of compliments received are as follows:

- "… It meant so much to the family to know he was being looked after in such a caring and compassionate manner."
- "… We were so impressed by the warmth and care shown to … and the other residents."
- "Thank you so very much for all your loving care shown to and attention of … . We really appreciate how you made his life so much better."

Five staff members were consulted to determine their views on the quality of care within Annadale. As discussed earlier a poster was displayed at a staffing area inviting staff to respond to an on-line survey. One response was received at the time of writing this report. The

staff member was either very satisfied or satisfied with the care provided across the four domains.

Some staff comments were as follows:

- "I am very happy working here."
- "Excellent place to work! Great team work! Residents well looked after. Concerns are dealt with efficiently."
- "I love it here."
- "I really enjoy it here."
- "It's grand, I enjoy it."

Six patients were consulted during the inspection.

Some patient comments were as follows:

- "The staff are really nice and friendly. They always help me."
- "The home is very warm and comfortable. Staff are very nice."
- "The home is very good."
- "They (the staff) are very very good to us here."

Ten patient questionnaires were left in the home for completion. None of the questionnaires were returned within the timescale for inclusion in the report.

No patient representatives were consulted during the inspection. Ten patient representative questionnaires were left in the home for completion. Six of the questionnaires were returned within the timescale for inclusion in the report. All respondents indicated that they were either very satisfied or satisfied with the care provided across the four domains.

Some patient representative comments were as follows:

- "Staff are very friendly. Any information you request, you will get."
- "I have visited many homes and none measure up to the quality of care given to the residents of Annadale."
- "Excellent care."

Any comments from patients, patient representatives and staff in returned questionnaires or online responses received after the return date will be shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home in relation to dignity and privacy.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 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.

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.

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 Care Standards for Nursing Homes 2015.

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, regular audits were completed in accordance with best practice guidance in relation to accidents; incidents; staff training and infection prevention and control. A recent audit on infection prevention and control conducted in the home was reviewed. Shortfalls had been identified within the auditing records and there was evidence of a review of the shortfalls found.

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.

A review of records evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. Copies of the reports were available for patients, their representatives, staff and Trust representatives.

The registered manager provided evidence on the completion of risk assessments pertaining to fire and legionnaires. The registered manager also provided evidence of examination for all hoists and slings in use within the home in accordance with Lifting Operations and Lifting Equipment Regulations (LOLER).

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement 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 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	
Area for improvement 1 **Ref**: Regulation 16 **Stated:** First time **To be completed by:** 17 April 2018	The registered person shall ensure that when a patient is assessed as at risk of falls, a detailed falls care plan is developed for the patient. Ref: Section 6.5
	Response by registered person detailing the actions taken: Care plans for all residents assessed as at risk of falls have been reviewed and amended to include a detailed fall care plan. Discussed with all named nurses to keep this under review.
Action required to ensure compliance with The Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 30 April 2018	The registered person shall ensure that recommendations from other health professionals are documented; adhered to and care provided evidenced within the patients' care records. Ref: Section 6.5
	Response by registered person detailing the actions taken: The nurse manager will review and audit recommendations from other health professionals to ensure that they are documented and evidenced within the named residents' care records.
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 17 April 2018	The registered person shall ensure that the identified patient's wound care plan is reviewed to ensure that the prescribed care is consistent throughout the record. Ref: Section 6.5
	Response by registered person detailing the actions taken: The wound care plan for the named resident was reviewed and initial assessment archived. Prescribed care is now consistent from assessment to wound care plan.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews