Annadale
RQIA ID: 1047
11 Annadale Avenue
Belfast
BT7 3JH

Inspector: Dermot Walsh
Lay Assessor: Robert Watson
Inspection ID: IN021805

Tel: 028 9064 5900
Email: annadalenursinghome@hotmail.co.uk

Unannounced Care Inspection
of
Annadale

15 January 2016

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 15 January 2016 from 10.25 to 15.15. RQIA were assisted by a lay assessor who, along with the inspector, met with residents to obtain their views on the quality of care provided within the home.

The focus of this inspection was continence management which was underpinned by selected criterion from DHSSPS Care Standards for Nursing Homes, April 2015:

Standard 4: Individualised Care and Support
Standard 6: Privacy, Dignity and Personal Care
Standard 21: Health Care
Standard 39: Staff Training and Development

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Please also refer to sections 5.2 and 6.2 of this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP, there were no further actions required to be taken following the last care inspection on 22 September 2015.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2*

*The total number of recommendations includes one recommendation stated for the second time.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the home's owner, Micheal McGranaghan and the registered nurse in charge, Florina Lenta, as part of the inspection process. Details of the inspection, including the QIP, were also discussed with the registered manager, Winnie Mashumba, via telephone on 18 January 2016. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Annadale Private Nursing Home William Gage	**Registered Manager:** Winnie Mashumba
Person in Charge of the Home at the Time of Inspection: Sr Florina Lenta	**Date Manager Registered:** 1 April 2005
Categories of Care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 38
Number of Patients Accommodated on Day of Inspection: 37	**Weekly Tariff at Time of Inspection:** £668 - £718

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the selected criteria from the following standards have been met:

Standard 4: Individualised Care and Support, criterion 8
Standard 6: Privacy, Dignity and Personal Care, criteria 1, 3, 4, 8and 15
Standard 21: Health Care, criteria 6, 7 and 11
Standard 39: Staff Training and Development, criterion 4

4. Methods/Process

Specific methods/processes used in this inspection include the following:

- discussion with the nurse in charge
- discussion with patients
- discussion with patient representatives
- discussion with staff
- review of a selection of records
- observation during a tour of the premises
- completion of six patient questionnaires
- evaluation and feedback

The inspector met with 17 patients individually, two care staff, two patient representatives, three ancillary staff members and two registered nursing staff.

Prior to inspection the following records were analysed:

- 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 returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report

The following records were examined during the inspection:

- a sample of staff duty rotas
- staff training records
- staff induction templates for registered nurses and care assistants
- competency and capability assessments for the nurse in charge
- three electronic care records
- selection of electronic personal care records
- a selection of policies and procedures
- incident and accident records
- care record audit template

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced pharmacy inspection dated 16 November 2015. The completed QIP was returned and approved by the pharmacy inspector.

5.2 Review of Requirements and Recommendations from the Last Care inspection

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Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 4 Criteria (5) (6) (11) **Stated:** First time	The registered person should ensure evidence that patients and/or their representatives were involved in the assessment; planning and evaluation of the patients care to meet their needs. If this is not possible the reason should be clearly documented within the care record.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that patients and/or their representatives are involved in the assessment, planning and evaluation of patient care. A new template has been uploaded to the electronic records providing the opportunity to record the patient/representative involvement in the assessment, planning for the patients' care. The registered manager confirmed this template is currently being updated for all patients residing in Annadale Nursing Home.	

Recommendation 2 **Ref**: Standard 46 Criteria (1) (2) **Stated:** First time	The registered person should ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager post inspection confirmed that infection prevention and control audits are carried out monthly with a second intense audit carried out quarterly using an identified audit tool. The registered manager also confirmed that they, along with the responsible person, carry out a weekly walk around the home checking on cleanliness and environmental issues.	
Recommendation 3 **Ref**: Standard 4 Criteria (1) (7) **Stated:** First time	The registered person should ensure that patients continence assessments and care plans are fully completed and include: • the specific continence products required by the patient • the patients' normal bowel pattern	**Partially Met**
	Action taken as confirmed during the inspection: A review of three care records evidenced specific continence products required to meet patients' needs were included in the continence assessment and care plan. However, the patients' normal bowel pattern has not been included within the assessment or care planning process. Normal bowel pattern should include frequency and reflect Bristol Stool Score.	

Areas for Improvement

The registered person should ensure the patients' continence bowel assessment is completed in full to include the patients' normal bowel pattern.

Number of Requirements:	**0**	**Number of Recommendations:**	**1**

5.3 Continence Management

Is Care Safe? (Quality of Life)

Policies and procedures were in place to guide staff regarding the management of continence. Policies available included Managing Continence; Bowel Care; Catheterisation and Bladder Lavage.

Guidance documents on continence management were not provided when requested on the day of inspection. Post inspection the registered manager confirmed that up to date continence guidelines were available and located at the nursing station. An assurance was given by the registered manager that all staff are now aware where to locate the continence guidelines.

Discussion with staff and the registered manager and a review of training records sent to RQIA post inspection confirmed that 24 staff had received training in continence management.

Staff were knowledgeable about the important aspects of continence care including the importance of dignity, privacy and respect as well as skincare, hydration and reporting of any concerns.

Discussion with the registered manager and staff confirmed there were 11 registered nurses trained and assessed as competent in urinary catheterisation. A recent refresher course on catheterisation had taken place at the end of January 2016.

Observation during the inspection and discussion with staff evidenced that there were adequate stocks of continence products available in the nursing home.

Two continence link nurses have been identified for the home.

Is Care Effective? (Quality of Management)

Review of three patients' electronic care records evidenced that a continence assessment was in place for each patient. This assessment clearly identified the patient's continence needs. A care plan was in place to direct the care to adequately meet the needs of the patients. However, as previously stated in section 5.2 the patients' normal bowel pattern was not included within the continence bowel assessment. A recommendation was stated for the second time. Records relating to the management of bowels were reviewed which evidenced that staff made reference to the Bristol Stool Score.

The actual product requirement necessary to meet the continence needs of the patients were identified on the continence assessments and included within the continence care plans.

There was evidence in three electronic care records reviewed that Braden risk assessments had been reviewed consistently on a monthly basis. However, on review of the Malnutrition Universal Screening Tool (MUST) risk assessments, it was observed that the MUST scores for all three patients had not been calculated and/or recorded. Monthly weights had been recorded for all patients reviewed. A recommendation was made.

Three continence care plans had been reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected.

Fluid targets had been identified within the patient care records and any shortfall of these targets was clearly recorded to include actions taken to address the shortfall. There was a clear record of skin checks being carried out when patients were being repositioned. The frequency of repositioning in three care records reviewed met the assessed need of all patients reviewed.

Records reviewed also evidenced that urinalysis was undertaken as required and patients were referred to their GPs appropriately.

Is Care Compassionate? (Quality of Care)

During the inspection staff were noted to treat the patients with dignity and respect. Good relationships were very evident between patients and staff. Staff were observed to respond to patients' requests promptly. Patients confirmed that they were happy in the home and that staff were kind and attentive.

Patients who could not verbally communicate appeared well presented and displayed no signs of distress. The patients appeared comfortable in their surroundings.

Areas for Improvement

MUST scores should be calculated and recorded in patient care records for all patients residing in Annadale Nursing Home.

Number of Requirements:	**0**	**Number of Recommendations:**	**1**

5.4 Additional Areas Examined

5.4.1. Consultation with Patients, Representatives and Staff

During the inspection process, 17 patients, two care staff, two patient representatives, three ancillary staff members and two registered nursing staff were consulted with to ascertain their personal view of life in Annadale Nursing Home. Six patient questionnaires were completed with the assistance of a lay assessor during the inspection. The feedback from the patients, representatives and staff indicated that safe, effective and compassionate care was being delivered in Annadale Nursing Home.

Some patients' comments received are detailed below:
'The staff are wonderful.'
'It's very homely here.'
'The food is good.'
'It's alright here.'
'I am totally satisfied. I am happy here.'

Two patient representatives consulted were positive in their experience of Annadale Nursing Home. Some representative comments received are detailed below:
'The staff here are very friendly and polite.'
'The staff look after me and always keep me informed of what is happening with …….'

The view from staff during conversations was that they took pride in delivering safe, effective and compassionate care to patients.

Some staff comments received are detailed below:
'Everybody gets on well.'
'I love it here.'
'I'm very happy here.'
'It's clear who we report too.'

5.4.2. Care Records

Staff in Annadale Nursing Home have commendably adapted to electronic recording of patient care and maintenance of patient records. According to staff, data is easily transferred onto the computerised system. The system highlights, on a daily basis, patients who are at risk of dehydration. The system also highlights daily the date of the patients' last bowel motion which should allow for quick identification of constipation. Any concerns staff may have had or any change in patient condition can be easily identified by the registered manager as the system allows for any staff to electronically notify the manager of any information they wish to inform them off.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with home's owner, Micheal McGranaghan and the registered nurse in charge, Florina Lenta, part of the inspection process. Details of the QIP were also discussed with the registered manager, Winnie Mashumba, via telephone on 18 January 2016. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

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

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref:** Standard 4 Criteria (1) (7) **Stated:** Second time **To be Completed by:** 14 March 2016	The registered person should ensure that patient continence assessments and care plans are fully completed and include the patients' normal bowel pattern. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Residents' 'normal' bowel patterns have been added into their care plans and continence assessments using information recorded by the care staff on the computer system to determine and estimate each resident's 'normal' bowel motion.
Recommendation 2 **Ref:** Standard 12 Criteria (3) (4) **Stated:** First time **To be Completed by:** 29 February 2016	It is recommended that MUST scores should be calculated for each patient, depending on the patients' assessed need and recorded within the patient's care record. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: The system did not have the facility to record the MUST score. This has now been added onto the computer system in the recent upgrade and we have updated MUST scores for all the residents.

Registered Manager Completing QIP	Winn Mashumba	**Date Completed**	01/03/2016
Registered Person Approving QIP	Trevor Gage	**Date Approved**	01/03/2016
RQIA Inspector Assessing Response	Dermot Walsh	**Date Approved**	04/03/2016

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