The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
26 September 2016

Hillcrest Care Facility

Type of Service: Nursing Home
Address: 23 Old Mountfield Road, Omagh, BT79 7EL
Tel no: 028 8225 1222
Inspector: Sharon Loane

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Hillcrest Care Facility took place on 27 September 2016 from 11.15 to 18.00 hours.

On 15 June 2016, Hillcrest nursing home merged with Hillview Lodge nursing home and the home was registered as Hillcrest Care Facility, with a total of 76 beds. The inspection sought to assess progress with any issues raised during and since the previous inspections of Hillcrest on 24 September 2015 and Hillview Lodge 6 January 2016 and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence of competent and safe delivery of care on the day of inspection. Staff were required to attend training and the observations of care delivery evidenced that the knowledge and skills gained through training, were embedded into practice. Staff confirmed that there were good communication systems and teamwork in the home, including; staff appraisal and supervisions. Staff advised that the registered manager was very supportive and approachable and any concerns raised were dealt with effectively.

The home was found to be warm, fresh smelling and clean throughout. The standard of décor within the Hillcrest unit was maintained to a very high standard. The registered manager indicated that there were plans to upgrade the décor within Hillview unit.

During the inspection, CCTV cameras were observed in use, although there was no policy available. A recommendation has been made.

Is care effective?

There was evidence of positive outcomes for patients living in Hillcrest Care Facility. All staff demonstrated a high level of commitment ensuring patients received care to meet their identified needs. Each staff member understood their role, function and responsibilities.

In the majority, care records were maintained to meet the needs of the patients however; a recommendation has been made in regards to the management of documentation for wound care.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

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. The comments received from patients and their representatives were positive and praiseworthy of staff.

Is the service well led?

Discussion with the registered manager and staff advised that there was a clear organisational structure within the home.

Discussion with the registered manager and staff; and a review of records evidenced that systems were in place to monitor and report on the quality of nursing care and other services provided.

A review of staffing duty rotas and a discussion with the registered manager evidenced that the registered manager, due to registered nursing staff recruitment issues, was working as a registered nurse on the floor for approximately three days per week and also had worked night duty on one occasion.

Although there was no evidence to indicate that this arrangement was having a negative impact on the quality of care and services provided, this is not a sustainable measure given that there is no deputy manager and/or clinical lead employed to support the registered manager. The home also need to review the hours worked by the registered manager in this capacity given the recent changes in the homes registration and the increased responsibilities the registered manager had acquired. Management have agreed to review the current arrangement and consider alternative measures to manage this situation.

The term ‘patients’ is used to describe those living in Hillcrest Care Facility which provides both nursing and residential care.

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	0	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Julie Taylor, 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 12 September 2016. 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.

There were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person:	Registered manager:
Knockmoyle Lodge Ltd operating Hillcrest Care facility Ms Therese McGarvey, responsible person	Ms Julie Ann Elizabeth Taylor
Person in charge of the home at the time of inspection: Julie Ann Elizabeth Taylor	**Date manager registered:** 1 October 2009
Categories of care: NH-I, NH-PH, NH-DE, RC-DE, RC-I 56 Nursing: 20 Residential. Maximum of 44 persons in category NH-I, 12 persons in category NH-DE, 17 persons in category RC-DE and 3 persons in category RC-I. The home is also approved to provide care on a day basis to 4 persons	**Number of registered places:** 76

3.0 Methods/processes

Prior to inspection we analysed 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 quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection reports for Hillcrest and Hillview Lodge
- pre inspection assessment audit.

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with 18 patients individually and the majority of others were observed and/or spoken with in small groups. Two registered nurses, unit manager for the residential unit, two senior care staff and four care staff and the homes administrator were consulted.

A poster indicating that an inspection was taking place was displayed on the front door of the home and invited visitors /relatives to speak with the inspectors. Six patients' relatives were spoken with during the inspection.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staff duty rotas for weeks commencing 12 & 19 September 2016
- a sample of training records
- recruitment files for two staff
- staff supervision and appraisal schedule
- complaints and compliments records
- incident and accident records
- sample of quality audits
- records of meetings; staff, patient and relatives
- three patient care records
- reports of monthly monitoring visits undertaken in accordance with Regulation 29.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection of Hillcrest Care Facility dated 12 September 2016

The most recent inspection of the home was an unannounced medicines management inspection. The report of the medicine management inspection was not issued at the time of this inspection.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection of Hillcrest dated 24 September 2015 and last care inspection of Hillview Lodge dated 6 January 2016

Last care inspection for Hillcrest Care Facility statutory requirements		**Validation of compliance**
Requirement 1 **Ref:** Regulation 13 (4) (b) **Stated:** First time	The registered provider must ensure that thickening agents are prescribed and administered only to the patient for whom they are prescribed. **Ref: Section 5.5.2**	**Met**
	Action taken as confirmed during the inspection: Thickening agents were being managed appropriately. The registered manager confirmed that these medicines have been subject to regular audit.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 11 **Stated:** First time	The programme of activities should be reviewed and displayed in a suitable format and location so patients know what is scheduled. **Ref: Section 5.5.2**	Met
	Action taken as confirmed during the inspection: The programme of activities has been reviewed since the last care inspection. The programme was displayed in various locations and patients spoken with advised that they enjoyed the planned activities. Photographs of events were displayed throughout the home. The registered manager advised that the home is in the process of recruiting additional staff for the provision of activities which will enhance the existing arrangements in place. This recommendation has been met.	

Last care inspection for Hillview Lodge dated 6 January 2016	Validation of compliance

There were no requirements of recommendations made as a result of the last care inspection.

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 from 12 to 25 September 2016 evidenced that the planned staffing levels were adhered to.

Discussion with the registered manager and a review of the records aforementioned evidenced that the registered manager was working on the floor as a registered nurse. The information reviewed indicated that she was working at a minimum three shifts per week spanning a twelve hour period and the week prior to this inspection she had worked three day shifts and also one night duty shift. This matter was discussed with the registered manager who advised that this was attributed to a shortfall in registered nurses and whilst efforts had been made to recruit registered nursing staff a shortfall still remained. Whilst there was no evidence that this arrangement was having a negative impact on the quality of care it was reinforced to the registered manager that this staffing arrangement was neither viable nor sustainable in the long term. Other avenues should be explored to manage this identified shortfall.

This was also concerning given that the home had recently merged with Hillview Lodge and as a result of the merge the registered manager had incurred additional responsibilities namely increased occupancy levels and staff management. At the time of registration, the responsible person advised that a clinical lead would be appointed to support the registered manager. To date no appointment has been made. This is discussed further in section 4.6.

Discussion with patients and representatives evidenced that there were no concerns regarding staffing levels. Staff spoken with advised that when planned staffing levels were adhered to there were sufficient staff to meet the needs of the patients. Staff advised that efforts are made by management to cover staff shortages as a result of sickness however it may not always be possible due to short notice. Staff acknowledged that the registered manager was very supportive and was always willing and available to cover shifts however, recognised that she had her own role and responsibilities to meet.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

A review of two personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Staff were supported and mentored by an experienced member of staff during their induction. Records for two staff members were reviewed and found to be completed in full dated and signed appropriately.

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).

Discussion with staff and a review of records confirmed that arrangements were in place for staff supervision and appraisals.

Review of the training matrix/schedule for 2016/17 indicated that training was planned to ensure that mandatory training requirements were met. Staff training was delivered by combining an e-learning programme and face to face training in the home. Training outcomes for 2016, to date, indicated that the registered manager was monitoring staff compliance with mandatory training requirements. A discussion with the registered manager and staff confirmed that compliance is monitored closely and that staff are alerted by email and verbally that they have not met their training requirement. The registered manager advised that staff are given two opportunities to complete the required training and thereafter disciplinary actions are invoked. Staff consulted with and observation of care delivery and interactions with patients clearly, demonstrated that knowledge and skills gained through training and experience were embedded into practice.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. A review of documentation confirmed that any potential safeguarding concerns were managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

Review of 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 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. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. Review of accidents/incidents records confirmed that notifications were forwarded to RQIA appropriately. Although there was evidenced that two recorded accidents that should have been reported to RQIA were not. This shortfall had also been identified during a monthly monitoring visit and a discussion with the registered manager provided assurances that they were knowledgeable of what required reporting under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 and that this had been a genuine oversight.

A review of the homes 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. At the inspection, it was noted that the standard of décor within the Hillcrest unit was to a higher standard than Hillview unit. This observation was discussed with the registered manager who agreed and indicated that plans were in place to upgrade the Hillview environment. Whilst the environment in Hillview unit was comfortable and no concerns were raised by patients and their representatives, an upgrade of the environment would ensure that patients living in this part of the home could enjoy the same standards of accommodation available to them.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

CCTV cameras were observed in use and had surveillance of areas both outside and inside the home. It was evidenced by the inspector that the cameras in use captured the whereabouts of patients and staff in some corridor areas within the Hillcrest unit. The registered manager advised that the CCTV footage was also recorded. The use of CCTV was discussed at length with the registered manager, who indicated that the cameras were used for security and patient safety. There was no policy in place regarding its use and the Guidance on the use of Overt Close Circuit Televisions (CCTV) for the Purpose of Surveillance in Regulated Establishments and Agencies (RQIA) had not been implemented. Following a discussion with senior management at RQIA, the registered manager was contacted post inspection to advise that the use of CCTV cameras should cease immediately until appropriate actions, policies and procedures had been developed and implemented in accordance with guidance documents and the Data Protection Act 1998 and the regulations associated with that Act. A recommendation has been made.

Areas for improvement

A recommendation has been made in regards to the use of CCTV.

Number of requirements	0	**Number of recommendations**	1

4.4 Is care effective?

A 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 registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. Risk assessments informed the care planning process.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

It was evidenced that care records accurately reflected the assessed needs of the patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

Evidence was available that assessments and care plans had been updated following any period of hospitalisation.

A care record reviewed in relation to wound management identified that registered nurses were not always completing the appropriate documentation to evidence the delivery of care in this regard. For example; a review of documentation indicated that a dressing regime had not been adhered to, as the registered nurse had not updated the required documentation. The registered nurse had recorded that the dressing had been changed in the diary on both occasions and a discussion with the patient and observations made confirmed that the dressing had been changed in accordance with the care plan. This matter was discussed with the registered manager and a recommendation has been made.

During the review of care records it became evident that the home was not maintaining an inventory of patients' personal belongings. This matter was discussed with the registered manager who agreed to address same immediately.

Supplementary care charts for example; repositioning 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. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained. Staff advised that they could access the minutes of the meetings if they were unable to attend. The review of the minutes of staff meetings evidenced that the registered manager had held general staff meetings and subsequent meetings with the individual groups of staff. Staff confirmed that they found the level of communication from the registered manager to be very good. Staff also stated that the registered manager was very receptive and encouraged their ideas.

Staff stated that there was effective teamwork; each staff member 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.

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. Some patients and representatives spoken with were aware of who their named nurse was and knew the registered manager. This information was displayed in the majority of patients' bedrooms.

Areas for improvement

Records pertaining to wound management should be kept in accordance with best practice guidelines, legislative requirements and NMC guidelines on record keeping. A recommendation has been made.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs.

Patients were observed to be sitting in the lounges, or in their bedroom, as was there personal preference. We observed numerous occasions when staff offered patients choice and took time to find out what the patients wanted when it was not always apparent and patients were unable to express their wishes clearly. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding the patients' likes and dislikes and individual preferences.

Patients spoken with commented positively in regard to the care they received. Those patients who were unable to verbally express their views were observed to be suitably dressed and were relaxed and comfortable in their surroundings. Patients appeared well dressed and there was evidence of staff's attention to detail regarding patients personal care, for example, ladies clothing were accessorized with co-ordinating neck scarfs and jewellery. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner.

A number of patients were observed nursed in bed and discussion with staff and a review of care records evidenced that the decisions made for this intervention were in the patient's best interest. Discussion with some of the patient's representatives confirmed that they were satisfied with the care arrangements in place.

Observations of the mid-day meal arrangements were reviewed. Dining tables were presented well, a range of condiments were available and patients, including those who required a therapeutic diet, were offered a choice of meals at mealtimes. Meals were delivered on trays to patients who choose not to come to the dining room and were managed appropriately. All of the patients spoken with enjoyed their lunch.

Relatives spoken with confirmed that they were made to feel welcome into the home by all staff. They all spoke very positively about the care and services afforded to their loved ones.

They were confident that if they raised a concern or query with the registered manager or staff, their concern would be addressed appropriately and that the actions taken by management were effective, as they never had to raise the concern again. The following comments were provided:

"No concerns, I come into the home smiling and I leave smiling."
"Fantastic, nothing is any bother… kept clean, fed well and staff are very kind."
"The staff are very welcoming, the manager is very visible and we can ask management for anything and provision is made."

In addition questionnaires were provided by RQIA to the registered manager for distribution. These included 10 questionnaires for staff and relatives/patient representatives and five for patients. At time of issuing this report, three patients, four staff and five relatives returned their questionnaires within the identified timeframe. All responses received indicated that they were "very satisfied" across all four domains.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

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

Staff spoken with were knowledgeable regarding line management and who they would escalate any issues or concerns to; this included that reporting arrangements when the registered manager was off duty.

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. Representatives spoken with and who responded by questionnaire confirmed that they were aware of the homes complaints procedure. As previously discussed staff and representatives confirmed that they were confident that staff and management would manage any concern raised by them 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, 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.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

Discussion with the registered manager and review of records evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, and staff and Trust representatives.

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised as discussed in the previous sections

As discussed in the preceding sections, the registered manager was working as a registered nurse on the floor for at least three shifts per week. At this inspection, there was no evidence to indicate that this arrangement was having a negative impact on the quality of care and services provided. Whilst this is acknowledged, the current arrangement is not an effective solution to manage the deficit in staffing for registered nurses and cannot be sustained as part of the long term management arrangements for the home, considering the recent merge of the two services. The registered manager acknowledged that whilst working on the floor had its benefits; it was difficult to carry out and maintain her role and responsibilities as registered manager considering the number of hours that had to be fulfilled as a registered nurse and also that the home does not have a deputy or clinical lead employed to assist with the home's governance arrangements. This operational matter needs to be reviewed and alternative measures implemented to ensure that the home is operating within its statement of purpose and the registered manager is enabled to fulfil their role and responsibilities. This matter was discussed again with the registered manager post inspection, who agreed to discuss same with the responsible person and seek alternative measures to manage the current situation.

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 Julie Taylor, 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

No Statutory requirements	
Recommendations	
Recommendation 1 **Ref**: Standard 44 Criteria 6 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that the practice of using camera monitors is reviewed to ensure compliance with RQIA's guidance on the use of Overt Close Circuit Televisions (CCTV) and the Data Protection Act 1988. If CCTV is to continue to be used internally, the home should ensure full consultation with the appropriate commissioning trust for each patient is included in the individual risk assessment process. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: All relevant guidance used to develop policies and procedures on use of CCTV. Consultation process completed.
Recommendation 2 **Ref**: Standard 4 Criteria 9 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that records pertaining to wound management should be kept in accordance with best practice guidelines, legislative requirements and NMC guidelines on record keeping. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Staff nurses reminded re: documentation on wound care & importance of good record keeping.

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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