The Regulation and Quality Improvement Authority

Inspection Report

29 June 2023

Daleview House

Type of Service: Nursing Home
Address: Shepherds Way, Dungiven Road, Londonderry, BT47 5GW
Tel no: 028 7134 8015

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation: Apex Housing Association **Responsible Individual:** Ms Sheena McCallion	**Registered Manager:** Mrs Marcella Harriet McCorkell **Date registered:** 31 December 2008
Person in charge at the time of inspection: Irene McCandless – nurse in charge	**Number of registered places:** 30
Categories of care: Nursing Home (NH) I – Old age not falling within any other category.	**Number of patients accommodated in the nursing home on the day of this inspection:** 26
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 30 patients. Patient have access to communal lounges, a dining room and a mature garden. Patients bedrooms are located over two floors.	

2.0 Inspection summary

An unannounced inspection took place on 29 June 2023, from 9.30am to 5.00pm by a care inspector.

The inspection assessed progress with all areas for improvement identified in the home 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.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients and staff are included in the main body of the report.

Areas requiring improvement were identified during the inspection as detailed in this report and within the Quality Improvement Plan (QIP) in section 6.0.

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with the nurse in charge at the conclusion of the inspection.

4.0 What people told us about the service

Patients said that staff were looking after them well and that there were enough staff to look after them. Patients were complimentary about the meals and the food provided.

Staff told us that they had been given a good induction and training was being completed. Staff were complimentary about the support received from the manager.

Returned questionnaires confirmed that patients/visitors were very satisfied that care was safe effective, compassionate and well-led.

A record of compliments received about the home was kept and shared with the staff team, this is good practice.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 17 May 2022		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 23 **Stated:** First time	The registered person shall ensure that where a patient requires repositioning: • recording charts are reflective of the patients recommended frequency of repositioning within the care plan • the position that the patient is changed to is clearly documented within repositioning charts • the patients skin condition is clearly documented within repositioning charts recording charts are signed by two staff where assistance of two staff are required.	**Not met**
	Action taken as confirmed during the inspection: Evidence showed that this area for improvement has not been met. This is discussed further in section 5.2.3. This area for improvement has been stated for a second time.	
Area for improvement 2 **Ref:** Standard 4.8 **Stated:** First time	The registered person shall ensure that where a patient is at risk of dehydration: • the recommended daily fluid target within the care plan is accurately recorded within the dietary/fluid recording chart the action to be taken, and at what stage, if the recommended fluid target is not met is clearly documented within the care plan.	**Not met**

	Action taken as confirmed during the inspection: Evidence showed that this area for improvement has not been met. This is discussed further in section 5.2.3. This area for improvement has been stated for a second time.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a robust system was in place to ensure staff were recruited correctly to protect patients.

There were systems in place to ensure staff were trained and supported to do their job. Mandatory training is in progress including fire training and infection prevention and control.

Staff said there was good team work and that they felt well supported in their role, were satisfied with the staffing levels and the level of communication between staff and management. The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the manager was not on duty.

It was noted that there was enough staff in the home to respond to the needs of the patients in a timely way; and to provide patients with a choice on how they wished to spend their day. For example, call bells were answered in a timely manner and resident said there were plenty of staff around if you needed them.

Staff told us that the patients' needs and wishes were very important to them. It was observed that staff responded to requests for assistance promptly in a compassionate manner.

Records were kept of staff supervision, however, the nurse in charge advised that annual appraisals were not completed. An area for improvement was identified.

5.2.2 Care Delivery and Record Keeping

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, bed rails, alarm mats. It was established that safe systems were in place to manage this aspect of care.

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. In addition, patient care records were maintained which accurately reflected the needs of the

patients. Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly.

Patients who are less able to mobilise require special attention to their skin care. Review of the record of repositioning identified that not all patients had their position changed as directed in their plan of care and not all pressure relieving devices were set correctly. This area for improvement has been stated for a second time.

Where a patient was at risk of falling, measures to reduce this risk were put in place. For example, be rails and alarm mats were in place following a risk assessment.

Examination of records and discussion with staff confirmed that the risk of falling and falls were well managed. There was evidence of appropriate onward referral as a result of the post falls review.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this may include simple encouragement through to full assistance from staff.

The dining experience was an opportunity for patients to socialise. The atmosphere was calm, relaxed and unhurried. It was observed that patients were enjoying their meal and their dining experience. Staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed.

There was evidence that patients' needs in relation to nutrition and the dining experience were being met. Staff told us how they were made aware of patients' nutritional needs and confirmed that patients care records were important to ensure patients received the right diet.

There was a choice of meals offered, the food was attractively presented and smelled appetising, and portions were generous. There was a variety of drinks available.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain. If required, records were kept of what patients had to eat and drink daily.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs; and included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

Care records reviewed identified that low fluid intake levels for patients were not all responded to in a timely manner and reported to the GP were appropriate. This area for improvement has been stated for a second time.

Patients' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each patients' care needs and what or who was important to them.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

5.2.3 Management of the Environment and Infection Prevention and Control

Observation of the home's environment evidenced that the home was clean, tidy and well maintained. For example; patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished and comfortable.

There was evidence throughout the home of 'homely' touches such as snacks and drinks available throughout the day.

Observation of two doors noted that they were wedged open which would cause a risk in the event of a fire. This was brought to the attention of staff for immediate action and an area for improvement was identified.

There was evidence that systems and processes were in place to ensure the management of risks associated with infectious diseases. For example, any outbreak of infection was reported to the Public Health Authority (PHA).

Review of records and observation of the environment identified deficits in infection prevention and control practice from a cleanliness perspective. An area for improvement was identified.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

It was also noted that cleaning chemicals and fluid thickening powders were not always locked away when staff were not present. This was brought to the attention of staff for immediate action and an area for improvement was identified.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were generally able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV.

Records showed that patients were encouraged to participate in patient meetings which provided an opportunity for patients to comment on aspects of the running of the home. For example, planning activities and menu choices.

It was observed that staff offered choices to patients throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

Activities were seen to be limited to watching TV and colouring in. It was observed that there was a lack of stimulation for patients throughout the day. An area for improvement was identified.

Staff recognised the importance of maintaining good communication with families. Visiting arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to patients. There was evidence of auditing across various aspects of care and services provided by the home.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

Patients spoken with said that they knew how to report any concerns and said they were confident that the person in charge would address this.

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

It was established that the manager had a system in place to monitor accidents and incident that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

Staff commented positively about the management team and described them as supportive, approachable and always available for guidance.

The home was visited each month to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These are available for review by patients, their representatives, the Trust and RQIA.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with **The Nursing Homes Regulations (Northern Ireland) 2005 and/or the Care Standards for Nursing Homes (April 2015).**

	Regulations	Standards
Total number of Areas for Improvement	2	5*

* the total number of areas for improvement includes two standards that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Irene McCandless, nurse in charge, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (7) **Stated:** First time	The responsible individual shall ensure the infection prevention and control issues identified during the inspection are addressed. Ref: 5.2.3
To be completed by: With immediate effect	**Response by registered person detailing the actions taken:** The specific infection prevention and control issues identified by the Inspector on the day of the inspection have now been addressed by the manager.
Area for improvement 2 **Ref:** Regulation 14 (2)(a) **Stated:** First time	The responsible individual shall ensure all parts of the home to which patients have access to are free from hazards to their safety. Ref: 5.2.3
To be completed by: With immediate effect	**Response by registered person detailing the actions taken**: The manager has spoken to relevelant staff to ensure they understand the importance of proper storage of cleaning chemicals and fluid thickening powders.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 23 **Stated:** Second time **To be completed by:** With immediate effect	The responsible individual shall ensure that where a patient requires repositioning: • recording charts are reflective of the patients recommended frequency of repositioning within the care plan • the position that the patient is changed to is clearly documented within repositioning charts • the patients skin condition is clearly documented within repositioning charts recording charts are signed by two staff where assistance of two staff are required.

	Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: A review has taken place of all patients repositioning charts and it was identified that not all patients required to be on aforementioned charts. For those who require repositioning charts to be in place,going forward the charts will now be signed off by two members of staff.Overall governance will be monitored by the NIC on each shift.
Area for improvement 2 **Ref:** Standard 4.8 **Stated:** Second time **To be completed by:** With immediate effect	The responsible individual shall ensure that where a patient is at risk of dehydration: • the recommended daily fluid target within the care plan is accurately recorded within the dietary/fluid recording chart the action to be taken, and at what stage, if the recommended fluid target is not met is clearly documented within the care plan. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Where a patient is at risk of dehydration the recommended daily fluid target will be documented within the care plan and daily progress notes.If the recommended fluid target is not met the GP will be informed for advice and this will be reflected in the patients care plan.
Area for improvement 3 **Ref:** Standard 40 **Stated:** First time **To be completed by:** With immediate effect	The responsible individual shall ensure staff have their performance appraised annually and a record is maintained. Ref: 5.2.1
	Response by registered person detailing the actions taken: The training department have reviewed the Supervision & one to one Policy to reflect standard 40 (Care standards for Nursing Homes) staff will have their performance appraised annually.
Area for improvement 4 **Ref:** Standard 48	The responsible individual shall ensure that doors are not propped open in order to reduce the risk of spread of fire. Ref: 5.2.3

Stated: First time **To be completed by:** With immediate effect	
	Response by registered person detailing the actions taken: The manager and the Nurse in charge will ensure that doors are not propped open in order to reduce the spread of fire.

Area for improvement 5 **Ref:** Standard 11 **Stated:** First time **To be completed by:** 15 July 2023	The responsible individual shall ensure that activity provision to all patients is understood to be an integral part of the care process and are planned and delivered to suit the patients' preferences and individual needs. Activity care records should evidence a meaningful review of the patient's involvement in the activity. Ref: 5.2.4
	Response by registered person detailing the actions taken: A diverse activity programme is planned for all residents taking into consideration personal preferences, cognitive and physical abilities. A review of the residents involvement is documented by the activity co-ordinator and is available for review on the electronic care planning system(Eppicare)

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