Unannounced Care Inspection Report
13 April 2016

Ardlough

Address: 2 Ardlough Road, Drumahoe, Londonderry
Tel No: 02871342899
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Ardlough took place on 13 April 2016 from 08.50 to 16.15 hours.

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

Is care safe?

There were no areas for improvement identified.

Is care effective?

A recommendation has been made with regard to the storing of patients' personal care records, to ensure that confidentiality is maintained.

Is care compassionate?

There were no areas for improvement identified.

Is the service well led?

There were no areas for improvement identified.

This inspection was underpinned by the Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Care Standards for Nursing Homes, April 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

Details of the QIP within this report were discussed with the registered manager and the regional 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

Other than those actions detailed in the previous QIP there were no further actions required.

2.0 Service details

Registered organisation/registered person: Four Seasons Dr Maureen Claire Royston	**Registered manager:** Anne Martina Mullan
Person in charge of the home at the time of inspection: Anne Martina Mullan	**Date manager registered:** 13 February 2014
Categories of care: NH-DE, NH-MP, NH-MP(E) 28 in categories MP,MP(E) and 16 in category DE.	**Number of registered places:** 44

3.0 Methods/processes

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

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
- 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 four patients, three care staff, two nursing staff and two patient's representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training records
- accident and incident records
- notifiable incidents
- audits
- records relating to prevention and protection of adults at risk of harm
- complaints records
- recruitment and selection records
- NMC and NISCC registration records
- staff induction, supervision and appraisal records

- staff, patients' and relatives' meetings
- regulation 29 monthly monitoring reports
- policies and procedures.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection

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

4.2 Review of requirements and recommendations from the last care inspection dated 23 July 2015.

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 27 (4) (a) **Stated:** First time	The fire risk assessment must be updated to include the measures to be implemented for two identified patients, who do not comply with the home's No Smoking policy. **An Urgent action record was communicated in correspondence to Ardlough following the inspection.** **A copy of the fire risk assessment must be returned with the returned QIP.**	**Met**
	Action taken as confirmed during the inspection: A copy of the fire risk assessment was forwarded to RQIA with the returned QIP. A duty shift report form was also amended to evidence any incidence of patients smoking in their bedrooms. This was reviewed by the registered manager on a daily basis.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 32.1 **Stated:** First time	A system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the organisation, in respect of communicating effectively; and palliative and end of life care.	**Met**
	Action taken as confirmed during the inspection: There was a record maintained of staff's signatures to evidence that they had read the end of life care policies and procedures.	
Recommendation 2 **Ref**: Standard 39.1 **Stated:** First time	It is recommended that the induction of newly appointed registered nurses is further developed, to include reference to patients' assessments and care plans, needing to be completed within five days of admission to the home. Specific reference should be given to the prioritisation of the assessments and care plans that need to be completed within this timeframe.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager confirmed that the timescales for completing relevant risk assessments were included in the registered nurse preceptorship programme. In addition, a draft policy was available on planned, emergency and re-admissions from hospital. The policy included timescales for completion of assessments from the day of admission up to day five, post-admission. The registered manager provided assurances that the standard operating procedure would be shared with registered nurses, once the document has been ratified by the senior management.	
Recommendation 3 **Ref**: Standard 18.1 **Stated:** First time	It is recommended that regular audits of restraint and/or restrictive practices are conducted, to ensure that consent forms are monitored regularly.	**Met**
	Action taken as confirmed during the inspection: A review of the bedrail audits confirmed that risk assessments, consents and care plans for the use of bedrails were completed on a monthly basis.	

4.3 Is care safe?

There were safe systems in place for the recruitment and selection of staff. A review of two personnel files evidenced that these were reviewed by the registered manager and checked for possible issues. Where nurses and carers were employed, their pin numbers were checked with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), to ensure that they were suitable for employment. Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. The review of recruitment records evidence that enhanced criminal records checks were done with Access NI and a register was maintained which included the reference number and date received. However, in one staff's recruitment file, there was no evidence of the date the criminal check had been received. This was discussed with the manager and regional manager during feedback who explained that the identified staff member's criminal check had been received by the company's head office and that this recruitment process was unusual. The regional manager agreed to further develop the staff check form in the personnel file, to include provision to enter the date that the criminal check record was received.

There was evidence that new staff completed an induction programme to ensure they developed their required knowledge to meet the patients' needs. Staff consulted confirmed that they received induction; and included shadowing experienced staff until they felt confident to care for the patients unsupervised. Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. Observation of the delivery of care evidenced that training had been embedded into practice.

A review of staff training records confirmed that staff completed e-learning modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection control, moving and handling and adult prevention and protection from harm. Overall compliance with training was monitored by the registered manager and this information informed the responsible individual's monthly monitoring visit in accordance with regulation 29.

Discussion with the manager and staff confirmed that there were systems in place to monitor staff performance or to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, competency and capability assessments and annual appraisals.

The manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota commencing 4 April 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. Two staff members commented that the recent reduction of care staff hours on the ground floor was not suitable as the majority of patients required the assistance of two staff members, to meet their needs. The inspector did not observe any impact on patient care on the day of inspection. Staff were observed assisting patients in a timely and unhurried way. This matter was brought to the attention of the manager who agreed to address these concerns with the staff.

Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

The staff consulted with were knowledgeable about their specific roles and responsibilities in relation to prevention and protection of harm. A review of documentation confirmed that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

Validated risk assessments were completed as part of the admission process and were reviewed as required. The assessments included where patients may require the use of a hoist or assistance with their mobility and their risk of falling; the use of bedrails and restraint, if appropriate; regular repositioning due to a risk of developing pressure damage and wound assessment, if appropriate; assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties. These risk assessments informed the care planning process.

Discussion with the registered manager confirmed that a range of audits were conducted on a regular basis (refer to section 4.6 for further detail). A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. An action plan was 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 Regulation (2005). Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous inspection, confirmed that these were appropriately managed.

Individual supervisions were also conducted with staff in response to learning that was identified from medication errors. For example, a medication error that related to the management of a hospital discharge letter, resulted in a check-list being developed to prevent recurrence of the incident. This is good practice and is commended.

A general tour of the home was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. Infection prevention and control measures were adhered to and equipment was stored appropriately. One area in the ground floor sluice required cleaning. This was brought to the attention of the manager to address. Fire exits and corridors were observed to be clear of clutter and obstruction. Personal evacuation plans were in place and were reviewed on a regular basis.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.4 Is care effective?

A review of three patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. The review evidenced that risk assessments were completed as part of the admission process and were reviewed as required. There was also evidence that risk assessments informed the care planning process. For example, where a patient had a wound, there was evidence of regular wound assessments and review of the care plan regarding the progress of the wound. A review of the daily progress notes, evidenced that the dressing had been changed according to the care

plan. Another patient who had been prescribed antipsychotic and antidepressant medications had care plans included to address their use; and a care plan had also been developed with regard to challenging behaviour. Patients who were identified as requiring a modified diet, had the relevant choke risk and malnutrition risk assessments completed and patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

The care records accurately reflected the assessed needs of 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. Registered nurses consulted with were aware of the local arrangements and referral process to access other multidisciplinary professionals. There was evidence that the care planning process included input from patients and/or their representatives, if appropriate, and there was evidence of regular communication with patient representatives within the care records.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to discussing patients' details in front of other relatives. However, patient charts regarding personal hygiene, repositioning, and food and fluid intake were observed in a file, on the handrails outside bedrooms on both floors. It was concerning that any one passing through the corridor could have access to the content of these charts and that the staff were not maintaining confidentiality with regards to the patients' personal care records. This was discussed with management during feedback. A recommendation has been made to ensure that consideration is given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and it provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective. Discussion with the manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. 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. Information on advocacy services was not available to staff. However, registered nursing staff confirmed that advocacy services could be accessed via the patients' care management process, if required.

Discussion with the registered manager and review of records evidenced that patient and/or relatives meetings were held on a regular basis and records were maintained. The registered manager also obtains feedback from three patients' representatives on a weekly basis, to ascertain their views on the home environment and the care of their relative. Relatives are also asked to comment regarding the safety of their relative in the home. Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. One patients' representative discussed specific areas of concern that continued to occur, despite having been raised with the manager. This matter was

communicated to the manager and the regional manager on the day of the inspection to address.

Areas for improvement

Consideration should be given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times.

Number of requirements	0	Number of recommendations:	1

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that they were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care and that they were offered choices at mealtimes and throughout the day. Medicines were administered to patients in a discreet way to maintain their dignity and privacy.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Two patients were identified as being unable to verbalise their feelings. Consultation with the staff confirmed that they felt they have the necessary skills to communicate effectively with the patients and that if additional support was required, they would get this from the manager. One staff member used inappropriate terminology when describing a number of patients. This was brought to the attention of the manager to address.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. Discussion with staff also confirmed that the opportunities for patients to attend external activities were not provided as frequently as in the past. This was discussed with the manager who stated that the home had increased the provision of activities hours in response to the recent cessation of a day care programme that a number of patients used to attend. There was evidence of a variety of activities in the home and discussion with patients confirmed that they were given a choice with regard to what they wanted to participate in. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

A review of patient care records confirmed information about patient's background. However, in three patient care records the 'connecting with community' section had not been completed; therefore, the patients' life histories had not been undertaken. This was discussed with the manager who advised that the completion of the life histories was ongoing and that this would be completed on admission in the future.

Discussion with the manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Views and comments recorded were analysed and areas for improvement were acted upon.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives.

All comments on the returned questionnaires were positive. Some comments received are detailed below:

Staff

'It's very good here. There are good interactions between staff and patients'.
'There is good team spirit. I enjoy it here'.
'The care is excellent, amazing. There is good team-work and we are well supported'.
'The care is excellent. The care staff are streets ahead of ones I worked with elsewhere and they go above and beyond for the patients'.
'We all help each other and work as a team'.

Two staff members commented on the impact of the amount of paperwork they were required to complete, stating that they felt that they had little time to spend talking with the patients. This matter was brought to the attention of the manager who agreed to address these concerns with the staff.

Patients

'They are very kind and respectful. Real stars'.
'They are not bad here. They are good to me'.
'They treat me fairly well. I like going along with the routines of the place'.

Patients' representatives

'The care has definitely improved here. Overall I am happy'.
'They are fantastic. I couldn't ask for better'.

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?

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

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

The manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis. Staff confirmed that they had access to the home's policies and procedures.

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. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the registered manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Discussion with the manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, the registered manager outlined how the following audits were completed in accordance with best practice guidance:

- falls
- wound management
- medicines management
- care records
- infection prevention and control
- environment audits
- complaints
- health and safety
- bedrails
- restraint
- dining experience audits
- human resource audits

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.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately.

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. These included medication and equipment alerts and alerts regarding staff that were had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager and review of records evidenced that Regulation 29, of the Nursing Homes Regulations (2005), monthly monitoring visits were completed in accordance with the regulations and/or care standards and copies of the reports were available for patients, their representatives, staff and trust representatives. An action plan was generated to address any areas for improvement. Discussion with the manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

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

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Martina Mullan, Registered Manager and Louisa Rea, Regional Manager as part of the inspection process. 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the 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 by the registered manager. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed 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 person/manager 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 person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 37.1 **Stated:** First time **To be completed by:** 11 June 2016	Consideration should be given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times. **Ref: Section 4.5** **Response by registered person detailing the actions taken:** The confidential patient information records were removed from outside resident's bedrooms on the day of the inspection and placed in a more secure area to uphold the privacy and dignity of the residents.

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

The Regulation and Quality Improvement Authority

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