The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
5 December 2016

Deanfield

Type of Service: Nursing Home
Address: 19 Deanfield, Limavady Road, Londonderry, BT47 6HY
Tel no: 02871344888 / 02871341754
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Deanfield took place on 5 December from 09.15 to 13.30 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.

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	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Joy McLaughlin, 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 finance inspection undertaken on 29 July 2016. Other than those actions detailed in the QIP there were no further actions required to be taken.

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.

2.0 Service details

Registered organisation/registered person: Loughview Homes Ltd Michael Curran and Paul Steele	**Registered manager:** Joy McLaughlin
Person in charge of the home at the time of inspection: Joy McLaughlin	**Date manager registered:** 13/12/2007
Categories of care: NH-I	**Number of registered places:** 28

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

- 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.

A poster was prominently displayed in the home, inviting feedback from patients and their representatives. During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff.

We also met with four patients, four care staff, one registered nurse, one laundry assistant, two domestic staff and two visiting professionals. No patients' representatives were present during the inspection.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training records for 2015/2016
- accident and incident records
- audits in relation to care records and falls
- two staff recruitment and selection records
- complaints received since the previous care inspection
- records pertaining to NMC and NISCC registration checks
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 29 July 2016

The most recent inspection of the home was an unannounced finance inspection. The completed QIP was returned and approved by the finance inspector. This QIP will be validated by the finance inspector at the next finance inspection.

Following discussion with the finance inspector for the home, it was agreed that the safe place within the home would be followed up, to ensure that it had been adequately secured, to mitigate the risk to the safe keeping of patients' money or valuables.

Despite the narrative in the returned finance QIP which stated that 'the home safe has now been bolted to the wall', this had not been actioned. The registered manager stated that this would be completed following the inspection. This matter has been communicated to the finance inspector for follow up.

4.2 Review of requirements and recommendations from the last care inspection dated 05 July 2016

Last care inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 15 (2) (a) **Stated:** Second time	A pain assessment must be maintained in patients' care records, if applicable.	**Met**
	Action taken as confirmed during the inspection: A review of patient care records confirmed that pain assessments were in place and reviewed on a regular basis.	
Requirement 2 **Ref**: Regulation 27 (4) (b) **Stated:** Second time	Precautions must be in place that minimise the risk of fire and protect patients, staff and visitors in the event of a fire. This refers specifically to the observed practice of fire doors being propped open.	**Met**
	Action taken as confirmed during the inspection: Fire exits and corridors were maintained clear from clutter and obstruction. Reactive door guards had been installed on identified bedroom doors, to ensure that the practice of propping doors opened had ceased,	

<table>
<tr><td rowspan="2">Requirement 3

Ref: Regulation 21 (1) (b)

Stated: First time</td><td>The registered persons must ensure that staff members do not commence employment until an enhanced criminal record check with Access NI has been completed and employment references have been received.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There had not been any new staff employed following the last inspection; however, the registered manager was able to demonstrate compliance with the requirement.

This was evidenced by a new system that had been developed, which documents when the relevant checks had been received.</td></tr>
<tr><td rowspan="2">Requirement 4

Ref: Regulation 20 (1) (a)

Stated: First time</td><td>The registered persons must ensure that a robust system is implemented, to ensure that registered nurses’ registration with the Nursing and Midwifery Council (NMC) is checked on a regular basis.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed.

The registered manager agreed to implement a ‘reminder system’ to ensure that registered nurses, whose registrations expired between checks, were followed up.</td></tr>
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Requirement 5 **Ref**: Regulation 20 (1) (c) **Stated:** First time	The registered person must ensure that staff receive mandatory training and other training appropriate to the work they perform. The registered manager should provide RQIA (at the time of return of QIP) with the schedule of dates at which these training requirements will be delivered.	**Met**
	Action taken as confirmed during the inspection: Following the last inspection the registered manager had developed a training matrix, which provided oversight on the staff's compliance with mandatory training requirements. Given that this had been recently developed, there were numerous gaps in the matrix. RQIA are satisfied by the planned inspection dates provided, that this requirement had been met.	
Requirement 6 **Ref**: Regulation 30 (1) (c) **Stated:** First time	The registered persons must ensure that RQIA is notified of any serious injury to a patient in the home.	**Met**
	Action taken as confirmed during the inspection: A review of the notifiable events submitted since the previous care inspection did not identify that any patient had sustained a head injury as a result of having fallen in the home. Discussion with the registered manager and a review of the accident and incident records confirmed that there was a prompt in place on the accident record, to direct staff when a notification to RQIA was required. These records were reviewed by the registered manager on a daily basis.	
Requirement 7 **Ref**: Regulation 14 (2) (c) **Stated:** First time	The registered persons must ensure that all cleaning chemicals are securely stored in keeping with COSHH legislation, to ensure that patients are protected from hazards to their health.	**Met**
	Action taken as confirmed during the inspection: Cleaning chemicals used in the home were safely stored.	

Requirement 8 **Ref**: Regulation 16 (2) (b) **Stated:** First time	The registered persons must ensure that the patient's care plan must be kept under review in relation to wound care. The wound must be reassessed at each dressing change and this assessment documented in accordance with best practice guidelines. Wound care records should also be supported by the use of photography in keeping the National Institute of Clinical Excellence (NICE) guidelines.	**Met**
	Action taken as confirmed during the inspection: A review of the care records evidenced that wounds were regularly assessed and care plans were reviewed accordingly. There was evidence of wound photography being used. The registered manager was advised that any photographs should be maintained within the patients' care record.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 46.1 **Stated:** Second time	The registered manager should ensure that there is an identified nurse with day-to-day responsibility for monitoring compliance with infection prevention and control procedures and that the role and responsibility of this person is reviewed, to address the issues identified.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of records confirmed that the identified nurse with day to day responsibility for infection prevention and control, conducted regular audits pertaining to infection control practices within the home.	
Recommendation 2 **Ref**: Standard 37.5 **Stated:** First time	The registered persons should ensure that staff fully complete accident and incident reports, in line with good practice.	**Met**
	Action taken as confirmed during the inspection: A review of the accident and incident records confirmed that records were accurately completed.	

<table>
<tr><td rowspan="2">Recommendation 3

Ref: Standard 4.1

To be completed by:
12 September 2016</td><td>The registered manager should ensure that all relevant risk assessments and care plans are completed/updated within five days of admission/readmission to the home.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A system had been developed to ensure that the patients' care records commenced on the day of admission and were completed within the recommended timeframe. A similar system had also been developed for patients who were readmitted to the home, following a period of hospitalisation.</td></tr>
<tr><td rowspan="2">Recommendation 4

Ref: Standard 39.9

Stated: First time</td><td>The registered persons must ensure that registered nursing staff receive training and support in respect of care planning so as their understanding of providing individualised care and support is enhanced and staff understand their responsibility and accountability regarding this area of care.

Evidence is to be available in the home that the training and support, <u>in whatever form</u>, has taken place.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of the training records evidenced that this training had been provided.</td></tr>
<tr><td rowspan="2">Recommendation 5

Ref: Standard 35

Stated: First time</td><td>The monthly monitoring visits should focus on progress made in relation to the requirements and recommendations made in this and subsequent RQIA Quality Improvement Plans.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of the monthly quality monitoring reports evidenced that the requirements and recommendations made in the care inspection reports had been reviewed.</td></tr>
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Recommendation 6 **Ref**: Standard 35.3 **Stated:** First time	The registered persons should further develop the auditing processes, specifically in relation to: • auditing the care records of patients who have been newly admitted/readmitted to the home following a period of hospitalisation • wound care management • cleaning schedules and infection prevention and control audits • mandatory training requirements	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of records confirmed that the above audits and processes had been further developed, in order to address the deficits identified during the last inspection.	

4.3 Inspection findings

4.3.1 Staffing Arrangements

The registered 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 for the week commencing 28 November 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. The registered manager explained there were currently no staff vacancies and that the home did not use agency staff. Anytime a staff member could not attend, due to illness, other staff members would work additional hours. The staff consulted with stated that they would ‘never allow the home to be short staffed’. Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

4.3.2 Care Practices

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 patients 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. Patients were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients’ wishes, preferences and assessed needs as identified within the patients’ care plan.

Observation of the delivery of care evidenced that training had been embedded into practice. Patients were assisted to mobilise, in line with their moving and handling assessment and care plan. Patients consulted with stated that there were always drinks and snacks available throughout the day.

We observed the lunch time meal being served in the dining room. The atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set with and specialist cups were available to help patients who were able to maintain some level of independence as they ate their meal. The menu was displayed on a white board in the dining room, to assist in making choices and to provide an awareness of the meal to be served. The lunch served appeared very appetising.

Observation of one electric pressure relieving mattresses evidenced that staff had to 'set' the pressure according to the patient's weight. One mattress was observed to be too high for the patient requiring it. Too high or too low a pressure setting has the potential to cause pressure damage rather than relieving it. Specific details of the findings were discussed with the registered manager who ensured that the mattress setting was corrected. The registered manager also provided assurances that a system would be developed to ensure that mattress setting would be checked and recorded on a daily basis. RQIA were satisfied that this concern had been managed appropriately.

4.3.3 Care Records

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. Risk assessments informed the care planning process and both were reviewed as required.

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.

A review of patients' personal care records evidenced that records were generally 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. However, a review of the patients' bowel records evidenced gaps in completion, in some cases of up to two weeks. Although RQIA acknowledges that some patients used the toilet independently, there were a number of patients who required assistance to use the toilet. The staff did not record days when the patients did not have their bowels opened; therefore we could not be assured of the accuracy of the records. Discussion with the registered manager and one registered nurse also agreed that the registered nurses generally did not have oversight of the bowel records. The registered manager agreed to review the current system for recording patients' bowels movements and address this with staff. A recommendation has been made in this regard.

A review patient care records identified that risk assessments for falls had not been updated after a patient had fallen. This meant that patients were not being adequately protected against further risks of falls. A recommendation has been made in this regard.

4.3.4 Consultation

During the inspection we met with four patients, four care staff, one registered nurse, one laundry assistant, two domestic staff and two visiting professionals. No patients' representatives were present during the inspection. Some comments received are detailed below:

Staff

"Everything is fine here".
"It is brilliant, all good like a home away from home".
"The care is excellent, it is very person-centred and everyone works as a team".
"It is excellent, we are all very close to the patients, like family members to us".
"I love it here, the patients are well looked after".
"It is great, if you get a job here, you certainly don't leave, that is why we are all here so long".

Patients

"The care is very good. Staff and patients are all the one around here".
"It is alright here, they come quickly if I need them".
"I have nothing bad to say".
"Everything is alright".
"It's great, I can come and go as I like, do what I want".

Visiting Professionals

"'I have no concerns".
"They seem very good. No problems here".

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. No questionnaires were returned within the timescale for inclusion in this report.

4.3.5 Environment

A review of the home's environment 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. The majority of patients' bedrooms were personalised with photographs, pictures and personal items

One armchair in the lounge was worn and in need of replacement. When raised with the registered manager, this chair was removed from use and replaced with a new chair. Another chair was observed to be torn and to have a small area where the foam was exposed. The registered manager explained that this chair belonged to one of the patients and that arrangements would be made to have the chair repaired. Advice was given in relation to a temporary repair, which would allow the chair to be effectively cleaned.

The smoking room was observed to have dirt and debris on the floor and it was evident that it had not been thoroughly cleaned in some time.

Discussion with two domestic staff identified that this room was cleaned when the staff could; however, the cleaning of this room had not been included on the daily cleaning schedule; and there was no recorded evidence of the room having been deep cleaned. Opportunities for when the domestic staff could best enter the room were also discussed. When raised with the registered manager, the smoking room was immediately cleaned. Assurances were provided that the cleaning schedule would be amended, to include the cleaning of the smoking room and that arrangements could be made to have the domestic staff clean the smoking room first in the morning, prior to it being used by the patients. A recommendation has been made in this regard.

Infection prevention and control measures were adhered to and equipment was stored appropriately.

Fire exits and corridors were maintained clear from clutter and obstruction.

4.3.6 Management and Governance Arrangements

The registered manager had been registered with RQIA since 13 December 2007, which meant that the leadership of the home has been consistent. All those consulted with knew who the registered manager was and stated that they were available at any time if the need arose. Staff commented positively in relation to the support they received. Some staff members described the registered manager's leadership style as 'excellent', 'brilliant' and that she was 'very approachable'.

As discussed in section 4.2, action had been taken to improve the effectiveness of the care and all the requirements and recommendations that had been made during the previous care inspection had been met. However, as discussed in section 4.1, a recommendation that had been made as a result of the finance inspection, undertaken on 29 July 2016, had not been met, despite assurances that had been provided in the returned Quality Improvement Plan (QIP), that this had been done. This matter has been communicated to the finance inspector for follow up.

One patient was observed to be calling out for assistance. Another patient consulted with raised concerns with the inspector that this identified patient was continuously calling out asking to be brought to the toilet and that they were not assured that the patient's needs were being met. The patient stated that the staff often replied that they had just brought the patient to the toilet. The identified patient had a confirmed diagnosis of dementia and has been living in the home for more than ten years. As the home is not registered to provide care to patients with dementia, this matter was discussed with the registered manager. RQIA were satisfied on this occasion that the identified patient's care was being appropriately managed with the support of the local health and social care trust and the patient's general practitioner.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussion with the registered manager confirmed that there had only been one complaint received since the previous care inspection. This matter had been communicated appropriately to the patient's care manager.

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, wound management, care records, infection prevention and control, environment, complaints

and 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.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. As discussed in section 4.2, there was evidence that the requirements and recommendations made during the previous care inspection, were followed up during the monthly quality monitoring visits. It was therefore disappointing that this had not been extended to include areas for improvement identified by other specialist inspectors.

Areas for improvement

A recommendation has been made that registered nurses review patients' bowel records on a daily basis and record any actions taken in the patients' daily progress notes. Entries should also be made when there have been no bowel movements, to ensure the accuracy of the records.

A recommendation has been made that risk assessments are completed following patients' falls.

A recommendation has been made that the cleaning schedules are further developed to evidentially ensure that the designated smoking room is cleaned on a daily basis, or more often as required.

Number of requirements	0	Number of recommendations	3

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Joy McLaughlin, 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

Statutory requirements	
No requirements were made during this inspection.	
Recommendations	
Recommendation 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 02 February 2017	The registered persons must ensure that registered nurses review patients' bowel records on a daily basis and record any actions taken in the patients' daily progress notes. Entries should also be made when there have been no bowel movements, to ensure the accuracy of the records. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: Format updated and all staff made aware of new documentation. The R.N to check at each shift
Recommendation 2 **Ref**: Standard 22.4 **Stated:** First time **To be completed by:** 02 February 2017	The registered persons should ensure that risk assessments are completed following patients' falls. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: R. N.s made aware of theis at recent staff meeting
Recommendation 3 **Ref**: Standard 44.1 **Stated:** First time **To be completed by:** 02 February 2017	The registered persons should ensure that the cleaning schedules are further developed to evidentially ensure that the designated smoking room is cleaned on a daily basis, or more often as required. **Ref: Section 4.3.5**
	Response by registered provider detailing the actions taken: Smoke room added to daily schedules and weekly deep clean rota. Cleaning staff updated

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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