Unannounced Care Inspection Report
18 October 2017

Deanfield

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

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 28 persons.

3.0 Service details

Organisation/Registered Provider: Loughview Homes Ltd **Responsible Individual(s):** Paul Steele Michael Curran	**Registered Manager:** Joy McLaughlin
Person in charge at the time of inspection: Joy McLaughlin	**Date manager registered:** 13 December 2007
Categories of care: Nursing Home (NH) I – Old age not falling within any other category	**Number of registered places:** 28

4.0 Inspection summary

An unannounced inspection took place on 18 October 2017 from 10.00 to 16.15 hours.

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 Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified during and 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.

There were examples of good practice found throughout the inspection in relation to staff development, adult safeguarding, infection prevention and control, risk management and the home's environment. Risk assessments and care plans were generally well maintained; patients' food and fluid intake was monitored and the registered nurses had oversight of any weight loss. Communication between residents, staff and other key stakeholders was well maintained. The culture and ethos of the home promoted treating patients with dignity, listening to and valuing patients and their representatives; and taking account of the views of patients. Mealtimes and activities were well managed. There were examples of good practice found throughout the inspection in relation to governance arrangements and quality improvement, There were good working relationships within the home.

An area for improvement made under the regulations related to mandatory training.

Areas for improvement made under the care standards related to record keeping; improvements required in the care planning process; the system of managing alerts for staff that had sanctions imposed on their employment by professional bodies; and in relation to the updating of policies and procedures. Two areas for improvement previously made under the care standards were not fully met and have been stated for the second time.

Patients said that they were very happy living in the home.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	*6

*The total number of areas for improvement made under the care standards includes two which have been stated for the second time.

Details of the Quality Improvement Plan (QIP) 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.

4.2 Action/enforcement taken following the most recent inspection dated 6 June 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 6 June 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- 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 the inspector met with five patients, three care staff, one registered nurse and three patients' representatives. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- staffing arrangements in the home
- supervision and appraisal records
- staff training records for 2016/2017
- accident and incident records
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- emergency evacuation register
- five patient care records
- two patient care charts including food and fluid intake charts and repositioning charts
- patient register
- annual quality report
- compliments records
- RQIA registration certificate
- certificate of public liability
- audits in relation to falls
- a selection of policies and procedures
- minutes of staff', patients' and relatives' meetings held since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 6 June 2017

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector; and will be validated at the next medicines management inspection.

6.2 Review of areas for improvement from the last care inspection dated 5 December 2016

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time	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.	**Partially met**
	Action taken as confirmed during the inspection: Although there was evidence of improvements in the bowel functioning records; some gaps in completion remained; and staff had not recorded when there were no bowel motions. This area for improvement was partially met and has been stated for the second time.	
Area for improvement 2 **Ref**: Standard 22.4 **Stated:** First time	The registered persons should ensure that risk assessments are completed following patients' falls	**Not met**
	Action taken as confirmed during the inspection: A review of patient care records confirmed that this was not consistently completed. This area for improvement was not met and has been stated for the second time.	
Area for improvement 3 **Ref**: Standard 44.1 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A review of the smoking room evidenced that this had been cleaned on a regular basis.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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 8 October 2017 evidenced that the planned staffing levels were generally adhered to. Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. Discussion with staff, patients and their representatives evidenced that there were no concerns regarding staffing levels.

Communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

Discussion with the registered manager confirmed that there were processes in place to ensure that the recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Given that no new staff had been recruited from the last care inspection, recruitment records were not examined.

There were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, undertook competency and capability assessments and completed annual appraisals.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and records were kept up to date. A review of staff training records confirmed that staff completed face to face training modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. However, the records reviewed identified deficits in staff training, particularly in relation to adult safeguarding and participation in fire drills. This has been identified as an area for improvement under the regulations.

The registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff were appropriately managed in accordance with NMC. Similar arrangements were in place to ensure that care staff were registered with NISCC.

Staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The staff understood what abuse was and how they should report any concerns that they had. Discussion with the registered manager confirmed that they were knowledgeable regarding the new regional operational safeguarding policy and procedures. Training had been scheduled for the registered manager to attend in relation to the role of the safeguarding champion; this will assist in embedding the procedures into practice.

Review of patient care records evidenced that validated risk assessments were completed as part of the admission process and were reviewed as required. These risk assessments informed the care planning process.

As discussed in section 6.2, a review of the accident and incident records confirmed that the falls risk assessments and care plans were not consistently completed following each incident. This area for improvement previously made under the care standards was not met and has been stated for the second time.

A review of the home's environment was undertaken which included a number 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. It was evident that a refurbishment programme was ongoing.

Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff development, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

An area for improvement made under the regulations related to mandatory training.

	Regulations	Standards
Total number of areas for improvement	1	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of five 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.

There were a number of examples of good practice found in this domain throughout the inspection. For example, registered nurses were aware of the local arrangements and referral process to access other relevant professionals including general practitioner's (GP), speech and language therapist (SALT), dietician and tissue viability nurse specialists (TVN). Discussion with registered nurses and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Where patients were prescribed antibiotic therapy for the treatment of acute infections, care plans had been developed in relation to this; and patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

Patients who had been identified as being at risk of losing weight had their weight regularly monitored. This ensured that any weight loss was identified and appropriate action taken in a timely manner. The patients' weights were audited by the registered manager on a monthly basis.

Patients who were identified as requiring a modified diet, had the relevant risk assessments completed. Care plans in place were reflective of the recommendations of SALT and care plans were kept under review.

A sampling of food and fluid intake charts confirmed that patients' fluid intake was monitored.

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. RQIA acknowledges that there were no patients in the home with pressure damage to their skin.

Patients who required urinary catheters had care plans in place, to ensure that they were managed in keeping with best practice guidance. The care plan included detail on hygiene care of the catheter; the frequency of tube change; actions to take in case of blockage; and monitoring of fluid intake and output. However, there was no evidence that the care staff recorded when the catheter leg bags were changed. A review of the patients' shower records also evidenced gaps in completion. These matters were discussed with the registered manager and have been identified as an area for improvement under the care standards.

Furthermore, although the majority of care records reviewed evidenced good practice in relation to care planning, a review of one patient's care record evidenced that it required to be further developed. This was discussed with the registered manager and has been identified as an area for improvement under the care standards.

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.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a patient register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective.

Staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The most recent staff meeting was held on 29 August 2017.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities.

All those consulted with confirmed that if they had any concerns, they could raise these with the staff and/or the registered manager. A patients' and relatives' meeting had been held on 7 June 2017 and records were available. The registered manager explained that attendance at the meetings was historically very poor; and that she would ensure to meet the relatives on a regular basis, to ensure that they had an opportunity to raise any concerns with her.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the completion of risk assessments and care plans; food and fluid intake monitoring and oversight of weight loss; and communication between residents, staff and other key stakeholders.

Areas for improvement

Areas for improvement made under the care standards related to record keeping; and improvements required in the care planning process.

	Regulations	Standards
Total number of areas for improvement	0	2

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

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 consulted with regarding meal choices and their feedback had been listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day. The registered manager explained that the patients were encouraged to become involved with a menu committee, which meant twice every year. This meant that the patients had input into the menu planning. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

We observed the lunch time meal in the dining room. The lunch served appeared appetising and patients spoken with stated that they were satisfied with the meals provided. The atmosphere was quiet and tranquil and patients were encouraged to eat their food; assistance was provided by staff, as required. Tables were set with placemats and specialist cups and plate guards were available to help patients who were able to maintain some level of independence as they ate their meal. We also observed that menu was displayed in the dining room; and reflected the meal to be served.

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. One staff member was designated to provide activities in the home. There was evidence of a variety of activities in the home and discussion with patients confirmed that they were given a choice with regards to what they wanted to participate in.

The care plans detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for the patients, as appropriate. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met.

Discussion with the registered 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. An annual quality audit had been undertaken in 2016; and arrangements had been made to commence the quality audit for 2017.

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 registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and their relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included praise for the care and attention given to a patient, when receiving end of life care.

During the inspection, we met with five patients, three care staff, one registered nurse and three patients' representative. Some comments received are detailed below:

Staff

"The care is of a high standard."
"I have no complaints, it is brilliant here."
"We give very individualised care, all the staff are rallying around the new patient to get to know them."
"Everything is grand, no concerns here."

Patients

"Only complaint I have, is that I am treated too well."
"I am treated terribly well, the scones are so moreish, all the food is good."
"I couldn't be treated better."
"You'll find nothing wrong here."
"This place is just great."

Patients' representative

"My relative is happy, therefore I am happy, it is very good."
"I have no concerns, it is absolutely brilliant and the staff are second to none."
"The care is good."

One relative commented in relation to the availability of staff, particularly at the start of the night shift and when staff are taking their lunch breaks. This was relayed to the registered manager to address.

We also issued ten questionnaires to staff and relatives respectively and eight questionnaires to patients. Four staff, two patients and five relatives had returned their questionnaires, within the timeframe for inclusion in this report. Comments and outcomes were as follows.

Patient respondents indicated that they were either 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. No written comments were received.

Relative respondents indicated that they were 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. No written comments were received.

Staff respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. No written comments were received.

Any comments from patient representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients. Mealtimes and activities were well managed.

Areas for improvement

No areas for improvement were identified in this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Observation of patients and discussion with the registered manager 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.

Staff spoken with confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. All those consulted with described the registered manager in positive terms; comments included 'she is brilliant' and 'she'd do anything for us'. Staff described how they felt confident that the registered manager would respond positively to any concerns/suggestions raised.

There was a clear organisational structure within the home. Staff 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.

There had been no complaints recorded from the last care inspection. Discussion with the registered manager confirmed that there was a process in place to ensure that complaints were appropriately managed. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients 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.

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. An action plan was generated to address any areas for improvement; discussion with the registered manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

Systems were in place to monitor and report on the quality of nursing and other services provided. 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 the patient falls audit evidenced that this 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 Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection, confirmed that these were appropriately managed.

Despite this, areas for improvement were identified. For example, although there were systems and processes in place to ensure that urgent communications and notices were managed in a timely manner, the system for manging alerts for staff that had sanctions imposed on their employment by professional bodies was not up to date. This has been identified as an area for improvement under the care standards.

Furthermore, a sampling of policies and procedures evidenced that many of the policies had not been updated on a regular basis. For example, the policy on adult safeguarding had not been updated from October 2008; and it was not reflective of current regional protocols. This was discussed with the registered manager and has been identified as an area for improvement under the care standards.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, quality improvement and maintaining good working relationships within the home.

Areas for improvement

Areas for improvement made under the care standards related to the management of alerts for staff that had sanctions imposed on their employment by professional bodies; and in relation to the updating of policies and procedures.

	Regulations	Standards
Total number of areas for improvement	0	2

7.0 Quality improvement plan

Areas for improvement 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 if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 20 (1)(c)(i) **Stated:** First time **To be completed by:** 15 December 2017	The registered person shall ensure that a system is put in place to ensure compliance with mandatory training requirements. This relates particularly to, but is not limited to, the completion of training on adult safeguarding and participation in fire drills. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: Dates organised for adults safeguarding and all staff have now completed fire drills
Action required to ensure compliance with The Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref**: Standard 4 **Stated:** Second time **To be completed by:** 15 December 2017	The registered persons shall 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 6.2**
	Response by registered person detailing the actions taken: New chart formats put in place and all staff made aware. Documentation in place to clarify
Area for improvement 2 **Ref**: Standard 22.4 **Stated:** Second time **To be completed by:** 15 December 2017	The registered persons should ensure that risk assessments are completed following patients' falls **Ref: Section 6.2**
	Response by registered person detailing the actions taken: Meeting with the R/N 's to clarify the immediate procedure when a resident has a fall.
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 15 December 2017	The registered persons shall ensure that the system for recording patients' showers; and the changing of urinary catheter bags, is further developed, to ensure that the records accurately reflect the care given. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: New shower format completed, all carers aware of same Changing of catheter bags now incoroperated into individual care plans, all staff aware of same

Area for improvement 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 15 December 2017	The registered person shall ensure that comprehensive care plans are developed to ensure that the care record is reflective of the patients' care needs. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: R/N's spoken to about this and advised re same
Area for improvement 5 **Ref**: Standard 35.18 **Stated:** First time **To be completed by:** 15 December 2017	The registered persons shall ensure that the system for managing alerts for staff that had sanctions imposed on their employment by professional bodies is appropriately maintained. **Ref: Section 6.7**
	Response by registered person detailing the actions taken: Nurse Manager has set up a system to check and manage the alerts
Area for improvement 6 **Ref**: Standard 36.4 **Stated:** First time **To be completed by:** 15 December 2017	The registered persons shall ensure that ensure that a system is put in place to ensure that the policies and procedures are reviewed on a three-yearly basis. **The policy of adult safeguarding must be updated as a priority and submitted to RQIA with the returned QIP.** **Ref: Section 6.7**
	Response by registered person detailing the actions taken: Policy up dated and enclosed Policies now on a rota plan to update

Please ensure this document is completed in full and returned via Web Portal

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