Unannounced Care Inspection Report
20 April 2021

Deanfield

Type of Service: Nursing Home (NH)
Address: 19 Deanfield, Limavady Road, Londonderry, BT47 6HY
Tel No: 028 71 344888
Inspector: Jane Laird

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.

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.

1.0 What we look for

2.0 Profile of service

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

3.0 Service details

Organisation/Registered Provider: Loughview Homes Ltd **Responsible Individual:** Mr Paul Steele Mr Michael Curran	**Registered Manager and date registered:** Mrs Joy McLaughlin – 13 December 2007
Person in charge at the time of inspection: Mrs Joy McLaughlin	**Number of registered places:** 28
Categories of care: Nursing Home (NH) I – Old age not falling within any other category.	**Number of patients accommodated in the nursing home on the day of this inspection:** 24

4.0 Inspection summary

An unannounced inspection took place on 20 April 2021 from 10.30 to 16.00 hours.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DoH) directed RQIA to continue to respond to ongoing areas of risk identified in homes. In response to this, RQIA decided to undertake an inspection to this home.

The following areas were examined during the inspection:

- staffing
- care delivery
- communication
- care records
- infection prevention and control (IPC) measures
- the home's environment
- leadership and management arrangements.

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	3	3

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Joy McLaughlin, 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.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection, registration information, and any other written or verbal information received.

This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report.

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

The following records were examined during the inspection:

- staff duty rota from 11 to the 24 April 2021
- three patients' daily reports and care records
- record of staff mandatory training
- three patient care charts including dietary intake charts and repositioning charts
- complaints ledger
- compliments
- incident and accident records
- a sample of governance audits/records
- one staff recruitment and induction file
- monthly quality monitoring reports from February 2021
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- registered nurses competency and capability assessments for taking charge of the home in the absence of the manager
- fire risk assessment.

An area for improvement identified at the last inspection was reviewed and an assessment of compliance was recorded as 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 previous inspection

The most recent inspection of the home was an announced medicines management inspection undertaken on 17 September 2020. There were no areas for improvement as a result of this inspection.

Areas for improvement from the last care inspection 10 October 2019		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 27 (4) (b) **Stated:** Second time	The registered person shall take adequate precautions against the risk of fire to ensure the safety and wellbeing of patients in the home. Specific reference to ensuring that fire doors are not propped/held open.	**Met**
	Action taken as confirmed during the inspection: Observation of the environment evidenced that this area for improvement has been met.	

6.2 Inspection findings

6.2.1 Staffing

On arrival to the home at 10.30 hours we were greeted by the manager and staff who were helpful and attentive. There was a pleasant, relaxed atmosphere in the home throughout the inspection and staff were observed to have caring, cheerful and friendly interactions with patients.

The manager advised us of the daily staffing levels and how these levels were reviewed regularly to ensure the assessed needs of the patients were met. On review of the staff duty rotas the planned staffing levels had been adhered to however, abbreviations were evident on the duty rota without a code to signify what they represented. This was discussed with the manager and following the inspection written confirmation was provided on the 21 April 2021 that codes are now in place for all abbreviations used within the duty rota.

Discussion with staff confirmed that they were satisfied with current staffing arrangements. Comments from staff included:

- "The manager goes above and beyond to support us".
- "We are more than a team, we are a family".
- "This is a great place to work".
- "Love working here".
- "We all work really well together".

Review of mandatory staff training records evidenced 'gaps' where training dates were not recorded beside staff names to indicate if they had completed relevant training. We further discussed staff training specific to the Mental Capacity Act (MCA) (Northern Ireland) 2016 deprivation of liberty safeguards (DoLS) and were advised by the manager that the majority of staff had completed training relevant to their role. However, there was no record of registered nurses with overseeing responsibilities having completed this training. We were therefore unsure if all staff had relevant training and discussed this with the manager as an area for improvement.

We reviewed four registered nurse competency and capability assessments and found that these were in place for staff in charge of the home in the manager's absence and were signed/dated by the manager; however, they had not been signed/dated by the nurse to confirm that an assessment had been completed. This was discussed with the manager as an area for improvement.

There was a system in place to monitor staff registration with the Northern Ireland Social Care Council (NISCC) and the Nursing and Midwifery Council (NMC). However, the manager's name was not included within these checks. Following the inspection the manager provided written confirmation on the 22 April 2021 that her name had been included to the monitoring list.

Review of one staff recruitment and induction file evidenced that relevant pre-employment checks had been received prior to commencing employment in line with best practice and the record of induction was available within the employees file.

6.2.2 Care delivery

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients' needs in a timely and caring manner. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and of how to provide comfort if required.

Patients told us that they were well looked after by the staff and felt safe and happy living in Deanfield. Comments from patients included:

- "Very happy here".
- "They are all more than good to us here".
- "Great place."
- "Food is excellent".
- "Staff are very friendly".

Seating and dining arrangements had been reviewed by the management of the home due to an area of the dining room not in use due to moisture damage to a wall. Portable tables were

provided within the lounge areas during meal times. The manager advised that this was a temporary measure and that the dining room would return to its normal function when relevant remedial works have been completed. Following the inspection on the 26 April 2021 the manager submitted a notification to the estates inspector detailing the issue with the wall and the actions taken to address it.
The manager provided further written confirmation on the 17 May 2021 that remedial works had been completed on the 14 May 2021 and that relevant information was shared with the estates inspector.

6.2.3 Communication

Discussion with staff and patients confirmed that systems were in place to ensure good communications between the home, the patient and their relatives during the COVID-19 visiting restrictions. Some examples of the efforts made included**;** video calls, telephone calls, visits to the window and indoor visits under COVID-19 guidelines.

Review of the visiting policy evidenced that the duration of the visit was not in accordance with the COVID-19 guidance. This was discussed with the manager and following the inspection written confirmation was received on 21 April 2021 that the policy had been updated to reflect the most recent guidelines.

6.2.4 Care Records

Review of three patient care records evidenced that care plans were in place to direct the care required and generally reflected the assessed needs of the patient. However, where identified care plans had been amended they did not consistently contain a date/staff signature when changes had been made. This was discussed in detail with the manager who agreed to monitor this through regular audits and to discuss the importance of accurate record keeping with relevant staff. This was identified as an area for improvement.

6.2.5 Infection prevention and control (IPC) measures

There was an adequate supply of face masks, gloves and hand sanitising gel within the home. However, there was limited availability of aprons within corridor areas. This was discussed with the manager who provided written confirmation on 22 April 2021 that additional aprons had been provided.

A number of light pull cords were stained and uncovered and could therefore not be effectively cleaned. Corrosion was evident to some sink plug chains and a number of over sink light covers were broken. Nurse call leads were observed wrapped around the grab rails of raised toilet seats in a number of communal toilets and hand paper towel dispensers and gloves were observed beside identified toilets with the potential risk of contamination. There was surface damage to some bedroom furniture, an identified wash hand basin, skirting boards, walls, and a section of hand rail on the stairs. We discussed the above findings in detail with the manager and an area for improvement was identified. Following the inspection on the 22 April 2021 the manager provided written confirmation that broken over sink light covers had been removed and that relevant action had been taken to address the deficits with ongoing review dates scheduled to ensure all actions are completed.

6.2.6 The home's environment

The environment was neat and tidy with the majority of communal areas throughout the home kept clear and free from obstruction. Patients' bedrooms were found to be personalised with items of memorabilia and special interests. We discussed the importance of ensuring that clocks throughout the home are set at the correct time to aid orientation for patients.

The manager confirmed that this would be monitored during daily walk arounds and discussed with staff where necessary.

Potential trip hazards were identified where floor coverings were uneven and/or damaged in identified areas of the home, one of which was at an emergency exit door on the first floor. We observed holes in the ceiling and wall of a communal toilet and a pane of glass cracked within a communal toilet. A malodour was evident within one communal shower room and a communal toilet. The above deficits were discussed in detail with the manager and an area for improvement was identified. Following the inspection the manager provided written confirmation on the 21 April 2021 that most of these issues have been addressed with ongoing review dates to address all other actions.

We reviewed a record of fire evacuation drills and evidenced that the most recent drill completed on 25 September 2020 did not contain a list of the staff names who attended. Personal emergency evacuation plans (PEEP's) had not been updated for identified patients on at least a yearly basis and a number of identified fire doors were not closing properly. We further identified a store without any fire detection which was being used to store oxygen cylinders, hair dressing equipment and a linen trolley with combustible items. These findings were discussed with the manager and an area for improvement was identified. Following the inspection on 21 April 2021 written confirmation was received that all fire doors had been checked and adjusted where necessary. Further written confirmation was received on the 17 May 2021 that a fire risk assessment was completed on the 29 April 2021 and a fire detector is now in place within the identified store.

The hair dressing room on the first floor was being used as a temporary store room. The importance of rooms being used for the purpose that they are registered for was discussed with the manager. Following the inspection, the manager provided written confirmation the room had been reinstated and an alternative storage area arranged.

6.2.7 Leadership and management arrangements

Since the last inspection there has been no change in management arrangements. The duty rota evidenced that the manager's hours, and the capacity in which these were worked, were clearly recorded.

We reviewed a number of audits in relation to IPC, hand hygiene, PPE and care records. Where there were areas for improvement identified, actions plans were in place with associated timeframes for completion. However, the audits regarding care records did not provide the name of the patient whose care file was being audited. This was discussed with the manager who provided written confirmation on the 22 April 2021 that this system had been updated. This will be reviewed at a future inspection.

An inspection of accidents and incident reports confirmed that these were effectively documented and reported to other relevant organisations in accordance with the legislation and procedures.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the responsible individual. Copies of the report were available for patients, their representatives, staff and trust representatives and provided detailed and robust information in relation to the conduct of the home. Where areas for improvement were identified, there was an action plan in place with defined timeframes.

Areas of good practice

Evidence of good practice was found in relation to the friendly, supportive and caring interactions by staff towards patients and we were assured that there was compassionate care delivered in the home.

Areas for improvement

Six new areas were identified for improvement. These were in relation to mandatory training, competency and capability assessments, record keeping, IPC, environment and fire safety.

	Regulations	Standards
Total number of areas for improvement	3	3

6.3 Conclusion

There was evidence of appropriate leadership and management structures within the home and patients appeared to be content and settled in their surroundings. Staff were knowledgeable regarding the needs of patients and how to access relevant services to ensure that the needs of patients are met. We were satisfied that the appropriate action had been taken to address any immediate issues identified during the inspection.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Joy McLaughlin, 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 13 (7) **Stated:** First time **To be completed by:** 20 May 2021	The registered person shall ensure that the infection prevention and control issues identified during this inspection are urgently addressed and a system is initiated to monitor ongoing compliance. With specific reference to: • surface damage to identified bedroom furniture, wash hand basin, skirting boards, walls and hand rail on the stairs • light pull cords are covered • the location of nurse call leads around the grab rail of raised toilet seats are reviewed • the location of hand paper towels and gloves beside toilets are reviewed • sink plug chains are reviewed and replaced where necessary. Ref: 6.2.5
	Response by registered person detailing the actions taken: Immediately after the inspection an action plan was put in place to cover all itemised above. . new furniture was purchased, the wash hand basin was replaced along with identified sink plug chains. . all areas needing painting or repaired was added to our refurbishment plan and has now been completed . staff have been spoken to with regards the nurse call leads being placed around the grab rail . Our Infection Control Consultant reviewed the location of the hand towel and gloves in the bathroom. He felt that to move these to other areas would also create concerns therefore gave advise when needing to use these facilities in the bathroom

Area for improvement 2 **Ref:** Regulation 27 (2) (b) (c) (d) (t) **Stated:** First time **To be completed by:** 20 May 2021	The registered person shall ensure that the environmental issues identified during this inspection are addressed. With specific reference to: • potential trip hazard from floor coverings within identified areas are repaired/replaced • malodour in identified communal shower room/toilet is investigated and resolved • pane of glass is replaced to identified window • damage to the wall and ceiling within identified communal toilet are repaired. Ref: 6.2.6
	Response by registered person detailing the actions taken: Action taken with regards to the above . floor area identified has been attended to and will be replaced within 1 month . Shower room/toilet terminally cleaned on the 21/04/21, no further issues. Wall and roof repaired as of 27/04/21 . Glass in the identified room replaced .
Area for improvement 3 **Ref:** Regulation 27 (4) (a) (b) (d) (i) (ii) (f) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall take adequate precaution against the risk of fire. With specific reference to: • fire doors are maintained to close properly • relevant fire detecting equipment is installed in the identified store room • oxygen is stored in accordance to the manufactures guidance and a sign is displayed on the identified store door • PEEPs are reviewed no less than yearly and/or when a change of circumstances is evident • all staff participates in a fire evacuation drill at least once a year with a record of staff names who were present. Ref: 6.2.6
	Response by registered person detailing the actions taken: . On the 21/04/21 all fire doors assessed and identified doors corrected. .Sign on oxygen store was removed for painting/decorating. Same now replaced . PEEP's have now been added to the monthly care plan checks ans all R/N's made aware of this . all fire evacuation documentation has now been up dated with the names of staff participating/present

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 39 **Stated:** First time **To be completed by:** 20 May 2021	The registered person shall ensure that the training needs of individual staff for their roles and responsibilities are identified and arrangements in place to meet them. With specific reference to ensuring: • staff training records are maintained to include the date the training was attended and a system for review is implemented for when training is next due • MCA/DoLS training is completed by all staff and evidence of such training is maintained within the home. Ref: 6.2.1
	Response by registered person detailing the actions taken: A new format has been put in place to identify gaps in the training records. MCA/DoLS training was completed on the following dates by the R/Ns- 22/09/20, 29/09/20 All documentation in place
Area for improvement 2 **Ref**: Standard 39 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that where a competency and capability assessment is completed for the nurse in charge that it is signed and dated by both the person carrying out the assessment and the nurse being assessed. Ref: 6.2.1
	Response by registered person detailing the actions taken: All form and assessments have been now signed by each R/N and away that this must be completed at all times.
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that any amendments to care records are signed/dated by the staff member making the amendment. Ref: 6.2.4
	Response by registered person detailing the actions taken: The care record identified on the day of the inspection was immediately amended. All other care files checked and no further amendments identified. Staff have been made aware to completed this when changes have been made.

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

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