Unannounced Care Inspection Report
28 January 2019

Longfield Care Home

Type of Service: Nursing Home (NH)
Address: 2 Longfield Road, Eglinton BT47 3PY
Tel No: 02871812552
Inspector: Michael Lavelle

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 35 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons (Bamford) Ltd **Responsible Individual(s):** Dr Maureen Claire Royston	**Registered Manager:** Louise McCloskey
Person in charge at the time of inspection: Louise McCloskey	**Date manager registered:** 1 April 2005
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of registered places:** 35

4.0 Inspection summary

An unannounced inspection took place on 28 January 2019 from 10.40 hours to 15.10 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.

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	0

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Louise McCloskey, 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 August 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 6 August 2018. 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 the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events 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 QIP from the previous care inspection
- the previous care inspection report
- pre-inspection audit.

During the inspection the inspector met with five patients, one patient's relative and four staff. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. Ten patients' questionnaires and ten patients' relatives/representatives questionnaires were left for distribution. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. The inspector provided the registered manager with 'Have we missed you' cards which were then placed in a prominent position to allow patients and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision.

A poster informing visitors to the home that an inspection was being conducted was displayed at the front door of the home.

The following records were examined during the inspection:

- duty rota for all staff from weeks commencing 21 January 2019 and 28 January 2019
- incident and accident records
- a selection of agency staff induction files
- four patient care records
- a selection of patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits
- RQIA registration certificate
- a sample of monthly quality monitoring reports undertaken 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 or partially 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 August 2018

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

6.2 Review of areas for improvement from the last care inspection dated 6 August 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 20 (1) (a) **Stated:** First time	The registered person shall ensure that at all times suitably qualified, competent and experienced persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients. This area of improvement is made with specific reference to staffing arrangements in the home at night.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager confirmed relatives were informed at a meeting that staff would not be available to accompany patients to hospital at night. This was followed up with a letter to relatives.	

Area for improvement 2 **Ref**: Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that nursing staff carry out clinical/neurological observations, as appropriate, for all patients following a fall and that all such observations/actions taken post fall are appropriately recorded in the patient's care record.	**Partially met**
	Action taken as confirmed during the inspection: Review of two care records evidenced this area for improvement has been partially met. This is discussed further in Section 6.3 **This area for improvement is partially met and is stated for a second time**.	
Area for improvement 3 **Ref**: Regulation 27 (4) (c) **Stated:** First time	The registered person shall ensure adequate means of escape. This area of improvement is made with specific reference to ensuring fire exits and corridors are kept clear and not obstructed.	**Met**
	Action taken as confirmed during the inspection: Review of the environment evidenced fire exits and corridors were clear from obstruction.	
Area for improvement 4 **Ref**: Regulation 13 (7) **Stated:** First time	The registered person shall ensure suitable arrangements are in place to minimise the risk/spread of infection between patients and staff. This area for improvement is made in reference to the issues highlighted in Section 6.4.	**Met**
	Action taken as confirmed during the inspection: Review of the environment, observation of practice and discussion with staff evidenced improvements since the last care inspection. The deficits identified at the previous care inspection have been addressed. This area for improvement has been met.	

Area for improvement 5 **Ref**: Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that nursing staff promote and make proper provision for the nursing, health and welfare of patients and where appropriate treatment and supervision of patients. This area for improvement is made in reference to the following: • ensuring a wound evaluation chart is maintained for patient with wounds.	**Met**
	Action taken as confirmed during the inspection: Review of two patient care records evidenced wound evaluation charts were well maintained.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 39.1 **Stated:** First time	The registered person shall ensure all agency staff complete a structured orientation and induction and records are retained.	**Met**
	Action taken as confirmed during the inspection: Review of agency staff induction files and discussion with staff confirmed agency staff complete a structured orientation and induction.	
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered person shall ensure accurate recording in relation to topical medicine administration. Robust arrangements should be in place to audit all aspects of medicine management to identify deficits and take appropriate action.	**Met**
	Action taken as confirmed during the inspection: Review of a selection of topical medicine administration records evidenced they were generally well completed. There was evidence of oversight of the records by registered nurses.	

Area for improvement 3 **Ref**: Standard 4.9 **Stated:** First time	The registered person shall ensure contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each patient, in accordance with NMC guidelines. Registered nurses should have oversight of supplementary care records.	**Met**
	Action taken as confirmed during the inspection: Review of four patient care records and a selection of supplementary care records confirmed contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each patient.	
Area for improvement 4 **Ref**: Standard 4.7 **Stated:** First time	The registered person shall ensure re-assessment is an ongoing process that is carried out daily and at identified, agreed time intervals as recorded in care plans.	**Met**
	Action taken as confirmed during the inspection: Review of four patient care records evidenced assessment of patient need at appropriate intervals.	

6.3 Inspection findings

The inspection sought to assess progress with issues raised during and since the last care inspection on the 6 August 2018.

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from weeks commencing 21 January 2019 and 28 January 2019 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff.

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.

Discussions with the registered manager evidenced systems were in place for the supervision and appraisal of staff.

Observation of the delivery of care evidenced that training had been embedded into practice, for example, the moving and handling of patients. Staff adhered to infection prevention and control best practice guidance, particularly after contact with the patient and the patient environment and appropriate personal protective equipment (PPE) was used.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated and fresh smelling throughout. Many of the patient's bedrooms were found to be highly personalised.

Review of records and discussion with staff evidenced deficits in relation to the post fall management of patients. Review of two care records evidenced that on an occasion when the patients had an unwitnessed fall, neurological and clinical observations were not carried out in accordance with best practice. However, post fall risk assessments were completed within 24 hours of the fall, the next of kin and care manager were informed and the care plans were reviewed. This was discussed with the registered manager and had been identified as an area for improvement at the inspection of 6 August 2018. This area for improvement has been stated for a second time.

Review of four patients' care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process. Care records contained details of the specific care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as General Practitioners (GPs), dentist, optician and podiatrist. Supplementary care charts such as food and fluid intake records, repositioning, topical medicine administration and personal care records evidenced that contemporaneous records were maintained with the exception of minor omissions. These were fed back to the registered manager for action as required.

Patients were positive in their comments regarding the staff's ability to deliver care and respond to their needs and/or requests for assistance. Discussion with staff confirmed that they were aware of the need to deliver care in a holistic and person-centred manner.

Feedback received from several patients during the inspection included the following comments:

- "It's great here."
- "Very good staff. They come at the proper time and there is a good routine."
- "The staff do anything you ask them to do."
- "It couldn't be any better."
- "I couldn't ask for anymore."

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Ten patient questionnaires were left in the home for completion. Seven were returned within the expected timescale with six respondents indicating that they were very satisfied with the care provided across the four domains. One respondent stated they were neither satisfied nor dissatisfied with care in the safe, effective and well led domains and they were very satisfied that staff treated them with compassion. Some of the comments received were as follows:

- "I am more than satisfied with all aspects of my care in Longfield. Actually it couldn't be better. I feel I am so fortunate to be here with a loving and caring staff."
- "Sometimes I would have to wait a while in the bathroom until staff are available and have been busy elsewhere."

Ten relative questionnaires were provided; none were returned within the expected timescale for inclusion in this report. One relative spoken during the inspection spoke positively in relation to the care their relative received. Some comments included:

- "It's absolutely fantastic. They are really caring. My relative has a smile on their face knowing they were coming back to here."

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

We reviewed accidents/incidents records since the last care inspection in comparison with the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were maintained appropriately and notifications were submitted in accordance with regulation.

Discussion with the manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. Review of records evidenced that quality monitoring visits were completed on a monthly basis in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, the home's environment and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Louise McCloskey, 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 2 **Ref:** Regulation 13 (1) (a) (b) **Stated:** Second time	The registered person shall ensure that nursing staff carry out clinical/neurological observations, as appropriate, for all patients following a fall and that all such observations/actions taken post fall are appropriately recorded in the patient's care record. Ref: 6.4
To be completed by: Immediate action required	**Response by registered person detailing the actions taken:** All Nursing staff have had supervision in relation to ensuring neurological observations are carried out on all residents who have had an unwitnessed fall and these are recorded in their care file. This will be reviewed by the Manager as part of the investigation of falls process on Datix.

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

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