Unannounced Care Inspection Report
25 July 2018

Kilwee Care Home

Type of Service: Nursing Home (NH)
Address: 42f Cloona Park, Dunmurry, Belfast BT17 0HH
Tel No: 028 9061 8703
Inspector: Sharon McKnight

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 48 persons.

3.0 Service details

Organisation/Registered Provider: Merit Retail Ltd Responsible Individual: Therese Elizabeth Conway	Registered Manager: See below
Person in charge at the time of inspection: Tomasz Janik –nurse in charge 06:45 – 08 00 Priscilla Roche – Manager 08:00 – 16 00	**Date manager registered:** Priscilla Roche – Acting- No Application Required
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. MP – Mental disorder excluding learning PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of registered places:** 48 A maximum of 36 patients in category NH-DE and 12 patients in categories NH-I, NH-PH and NH-PH(E).

4.0 Inspection summary

An unannounced inspection took place on 25 July 2018 from 06:45 to 15:30 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 DHSSPS 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.

At the time of the inspection RQIA were aware of concerns by the South Eastern Health and Social Care Trust and the Belfast Health and Social Care Trust. These concerns were being managed by the Trusts' internal quality monitoring and safeguarding procedures.

Evidence of good practice was found in relation to staffing, accident notification and the home's environment. There were examples of good practice found throughout the inspection in relation to record keeping and the management of nutrition and wound care. We observed good practice in regard to the early morning routine, the culture and ethos of the home and responding to patients and relatives views.

Areas requiring improvement were identified with the completion of neurological observations in the event of a suspected head injury and further development of the auditing of accidents.

Patients said they were happy living in the home. Those who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

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**	1

Details of the Quality Improvement Plan (QIP) were discussed with Priscilla Roche, manager and Jane Bell, regional manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

4.2 Action/enforcement taken following the most recent inspection dated 6 March 2018.

The most recent inspection of the home was an unannounced care inspection undertaken on 6 March 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.

During the inspection we met with five patients individually and with others in small groups, eleven staff and two patients' visitors/representatives.

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

The following records were examined during the inspection:

- duty rota for 13 and 20 July 2018
- incident and accident records
- four patient care records
- two patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits
- complaints record

- 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, 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 March 2018.

The most recent inspection of the home was an unannounced care inspection untaken following concerns raised with RQIA via the duty inspector system. Due to the focus of this inspection three areas for improvement made as a result of the care inspection completed on 19 February 2018 were not reviewed but were carried forward for review at the next care inspection. This QIP will be validated by the care inspector during this inspection.

6.2 Review of areas for improvement from the last care inspection dated 6 March 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 13(1)(b) **Stated:** Second time	The registered person shall ensure that contemporaneous nursing records are kept of all nursing provided to evidence that patients receive the care and treatment they require.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was made in regard to the recording of wound care. A review of wound care for two patients evidenced that care was delivered as prescribed. This area for improvement has been met.	

Area for improvement 2 **Ref**: Regulation 20(2) **Stated:** Second time	The registered person shall ensure that nurses awaiting registration with the NMC are appropriately supervised. Records must be maintained to evidence the supervision completed.	**Met**
	Action taken as confirmed during the inspection: At the time of inspection there was one pre-registration nurse employed; the manager confirmed that were working as a care assistant and were not undertaking any nursing duties; supervision was completed in accordance with their role as care assistant. This area for improvement has been met.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 4.8 **Stated:** Second time	The registered person shall ensure that wound care is recorded in accordance with best practice.	**Met**
	Action taken as confirmed during the inspection: A review of wound care records evidenced that this area for improvement has been met.	
Area for improvement 2 **Ref**: Standard 44 **Stated:** First time	The registered person shall ensure that the management of odours in the identified bedroom is reviewed and necessary action taken to eliminate the malodour.	**Met**
	Action taken as confirmed during the inspection: There were no odour management issues in the identified bedroom. This area for improvement has been met.	
Area for improvement 3 **Ref**: Standard 21 **Stated:** First time	The registered person shall ensure that recommendations made by healthcare professionals are actioned in a timely manner	**Met**
	Action taken as confirmed during the inspection: This area for improvement was made in regard to recommendations made by and occupational therapist (OT) for one identified patient. A review of records and discussion with staff evidenced that this area for improvement has been met.	

Area for improvement 4 **Ref**: Standard 41.4 **Stated:** Second time	The registered person shall ensure that a minimum skill mix of at least 35% registered nurses and 65% care assistants is maintained over 24 hours.	**Met**
	Action taken as confirmed during the inspection: A review of the duty rosters for week commencing 13 and 20 July evidenced that the 35% registered nurses and 65% care assistants was maintained. This area for improvement has been met.	
Area for improvement 5 **Ref**: Standard 41.2 **Stated:** First time	The registered person shall that ensure that clear guidance on the number of staff required is available to those staff with the responsibility of the day to day management of the home. The number of staff required must be determined by jointly considering the occupancy of each unit and the dependency of patients.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and staff evidenced that staff were aware of the required staffing levels. The manager confirmed that dependence levels were calculated monthly to ensure the planned staffing continues to meet the needs of the patients. This area for improvement has been met.	
Area for improvement 6 **Ref**: Standard 16 **Stated:** First time	The registered person shall ensure that complaints management is monitored to ensure they are responded to in a timely manner.	**Met**
	Action taken as confirmed during the inspection: A review of the complaints register evidenced that complaints were responded to in a timely manner. This area for improvement has been met.	

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 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 week commencing 13 and 20 July 2018 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. Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. We spoke with relatives of two patients during the inspection, no issues were raised with regard to staffing.

We reviewed accidents/incidents records completed 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.

The review of completed accident reports and patients' care records evidenced that neurological observations were not always recorded when a possible/actual head injury was sustained. To ensure that there is proper provision for the health and welfare of patients the nurse must ensure that in the event of a suspected head injury neurological observation are recorded in line with best practice. If patients refuse to have the observations taken this should be recorded on each occasion.

Discussion with the manager and review of records confirmed that on a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. Care records evidenced the use of assisted technology, for example alarm mats and tab monitoring, in the management of patient safety. There was evidence of who was involved in the decision making process and best interest decision where equipment with the potential for restrictive practice was in use.

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, fresh smelling and clean throughout. 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 staffing, accident notification and the home's environment.

Areas for improvement

An area for improvement was identified in relation to the completion of neurological observations in the event of a suspected head injury.

	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 four patient care records evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patient. We reviewed the management of nutrition, wound care and falls. 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.

We reviewed the management of patients who were assessed by speech and language therapist (SALT) as requiring a modified diet and/or thickened fluids. A file with a copy of each patient's SALT recommendations was available in each dining room and provided staff with easy access to this information. Copies of the guidance issued by Health and Social Care Northern Ireland, which detailed each type of modified diet and fluids, were laminated and displayed in each dining room. Staff spoken with were knowledgeable of individual patient's consistency of diet and thickening of fluids. We observed the serving of meals for four patients at breakfast and two at lunch; each patient was provided with a modified diet and/or thickened fluids in accordance with their SALT recommendations.

We reviewed the care records of four patients who were assessed as requiring a modified diet and/or thickened fluids. Each patient has a nutritional risk assessment and choking risk assessment completed; care plans were in place to manage any identified risks. Food and fluid intake charts were maintained daily. A review of one patient's charts included a description of the meal offered and the quantity eaten. The chart also included foods which were offered but refused. Fluid intake was reconciled every 24 hours.

We reviewed the management of wound care for two patients. Care plans contained a description of the wound, location and the prescribed dressing regime. A review of care records evidenced that dressings were renewed in accordance with the prescribed care. Repositioning charts for one patient was reviewed; the charts evidenced that the patient consistently was assisted to change their position for pressure relief in accordance with their care plans.

We reviewed the management of falls for three patients. Falls risk assessments were completed and reviewed regularly. Care plans for falls management were in place and were generally reviewed for each patient following a fall. As discussed in section 6.4 an area for improvement was made with regard to the completion of neurological observations.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), SALT and dieticians. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), SALT or the dietician.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping and the management of nutrition and wound care.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	**0**	**0**

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.

We arrived in the home at 06:45 hours and were greeted by the registered nurse in charge of the home. The registered nurse provided us with a full account of the home, staff on duty and patients who were awake and up sitting in the lounges. The lights on the ground floor were dimmed, the atmosphere was quiet and all of the patients were in bed. On the first and second floor a small number of patients were up and dressed and sitting in the lounges or reception areas of the home. The registered nurses on each floor provided us with a full account of the care of these patients. Patients were provided with a cup of tea at approximately 07:15 hours. Staff demonstrated a detailed knowledge of patients' early morning wishes, preferences and assessed needs. The atmosphere throughout the home was quiet and calm and, for those patients who remained in bed, unobtrusive.

We observed the serving of breakfast in the two dementia units and lunch in the general nursing unit. Patients were assisted to the dining room or had trays delivered to them as required. Staff were observed assisting patients with their meal appropriately and a registered nurse was present in the dining rooms throughout breakfast. Patients able to communicate indicated that they enjoyed their meal. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, and as previously discussed, how to modify fluids to the prescribed consistency. We discussed the

We spoke with the relatives of two patients. Both of the relatives commented positively regarding the care their loved ones were receiving. One relative raised issues regarding laundry and clothing; these issues were shared with the manager who agreed to meet with the relative and discuss the issues further. In discussion with the other relative a suggestion was made regarding their loved ones independence with personal care; this suggestion was also shared with the manager who agreed to discuss the suggestion further with the family.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the early morning routine, the culture and ethos of the home and responding to patients and relatives views.

Areas for improvement

No areas for improvement were identified 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.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been a change in the management arrangements. RQIA were notified appropriately. The newly appointed manager was being supported by the regional manager and the company's quality support nurse.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Discussion with the manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents and mealtime experiences. The auditing of accidents/incidents should be further developed to include confirmation the neurological observations are completed. This was identified as an area for improvement under the standards.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the regional manager on behalf of the responsible individual 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 management support, governance arrangements and maintaining good working relationships.

Areas for improvement

An area for improvement was identified to further develop the auditing of accidents/incidents to include confirmation the neurological observations are completed.

	Regulations	Standards
Total number of areas for improvement	**0**	**1**

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Priscilla Roche, manager and Jane Bell, regional 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	
Ref: Regulation 13(1)(a) **Stated:** First time **To be completed by:** Immediate from the day of inspection	The registered persons must ensure that there is proper provision for the health and welfare of patients. In the event of a suspected head injury neurological observations must be recorded. If patients refuse to have the observations taken this should be recorded on each occasion they refuse. Ref: Section 6.4
	Response by registered person detailing the actions taken: Supervision has been completed with RNs to highlight the importance of neurological observations. The HM is monitoring each accident to ensure this is being carried out. The groups policy has been updated to reflect this advice.
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 35.3 **Stated:** First time **To be completed by:** 23 August 2018	The registered person shall ensure that the auditing of accidents/incidents is further developed to include confirmation that neurological observations are completed. Ref: Section 6.7
	Response by registered person detailing the actions taken: The HM is closely monitoring accidents and incidents to determine compliance with this advice.

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

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