The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
16 January 2017

Templemoyle

Type of Service: Nursing Home
Address: 41a Whitehill Road, Eglinton, BT47 3JT
Tel no: 0287181 1461
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Templemoyle took place on 16 January 2017 from 10.15 to 16.45 hours.

The inspection sought to assess progress with any issues raised, 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.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	5	5

The total number of recommendations above includes one recommendation that has been stated for the second time. Details of the Quality Improvement Plan (QIP) within this report were discussed with Jeya Pratheeksha, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 9 August 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Mrs Elizabeth Kathleen Mary Lisk	**Registered manager:** Mrs Jeya Pratheeksha
Person in charge of the home at the time of inspection: Mrs Jeya Pratheeksha	**Date manager registered:** 09 January 2015
Categories of care: NH-I, NH-PH	**Number of registered places:** 30

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

A poster was prominently displayed in the home, inviting feedback from patients and their representatives. During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. There were no patients' representatives present during the inspection; however, we met with four patients, three care staff, two registered nurses and one visiting professional.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- six patient care records
- accident and incident records
- records relating to adult safeguarding
- complaints received since the previous care inspection
- records pertaining to NMC registration checks
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 9 August 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector; and will be followed up during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 9 August 2016

<table>
<tr><th colspan="2">Last care inspection statutory requirements</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Requirement 1

Ref: Regulation 20 (1) (a)

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

Ref: Regulation 14 (2) (c)

Stated: First time</td><td>The registered persons must ensure that unnecessary risks to the health or safety of patients are identified and so far as possible eliminated.

The treatment room must be kept locked, when not in use.

Cleaning materials must be appropriately stored in keeping with COSHH regulations.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A keypad lock had been installed on the treatment room door, to ensure that it remained locked at all times. Cleaning materials were observed to be stored in locked sluice rooms, to which the patients did not have access.</td></tr>
<tr><td rowspan="2">Requirement 3

Ref: Regulation 13 (7)

Stated: First time</td><td>The registered person must ensure that infection prevention and control issues identified are actioned as required. Systems and protocols must be established to ensure compliance with best practice in infection prevention and control within the home.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of the cleaning schedules for the sluice rooms confirmed that there was traceability in terms of the detailed cleaning which had been carried out. Improvements had also been made to the infection prevention and control auditing system, undertaken by the registered manager. The sluice rooms were clean and tidy on the day of the inspection.</td></tr>
</table>

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 12 **Stated:** First time	The registered persons should review the mealtime experience to ensure that is respectful and the environment is conducive to eating.	**Partially Met**
	Action taken as confirmed during the inspection: Although some improvements were noted, deficits continued in relation to the mealtime experience. This recommendation was not met and has been stated for the second time. Refer to section 4.3.2 for further detail.	

4.3 Inspection findings

4.3.1 Staffing Arrangements

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the week commencing 9 January 2017 evidenced that the planned staffing levels were generally adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. 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 confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

4.3.2 Care Practices

Observation of two electric pressure relieving mattresses evidenced that staff had to 'set' the pressure according to the patients' weight. We identified one patient, whose weight was 73.4 kgs using a mattress that was set for a person of 110 kgs. Another patient, whose weight was 89.1 kgs was using a mattress that was set for a patient of 70 kgs. Too high or too low a pressure setting has the potential to cause pressure damage rather than relieving it. This meant the person was not protected from the risks associated with pressure damage to their skin.

Discussion with staff confirmed that they were unsure how to set the pressure mattress settings and many of the staff stated that it was another person's responsibility to check the mattress settings. There were no records maintained in regards to the monitoring or checking of these settings. Following the inspection, the registered manager confirmed to RQIA that all the electric mattresses in the home had been reviewed and confirmed that all were operating correctly. A requirement has been made in this regard.

We also found that the staff were not recording accurately the care provided to patients with urinary catheters with regard to recording when the leg bags attached to catheters were changed. The review of care records identified that there was no record of when the catheter leg-bags had been changed and although the staff consulted with stated that leg bags were changed on a weekly basis, we were unable to verify this. This meant that for this patient, they were exposed to a greater risk of acquiring an infection. Good practice suggests that reusable drainage bags are changed every five to seven days in accordance with manufacturers'

recommendations and Department of Health guidelines. There were no clear records maintained regarding the on-going management of the urinary catheter. This exposed the patient to the risk of harm as mis-management of catheter care can cause unnecessary risk of infection or blockage due to lack of hygiene and routine changes. A requirement has been made in this regard.

As previously discussed in section 4.2, although some improvements had been made in relation to the meal time experience, deficits continued in relation to the serving of the meals and the way in which staff provided assistance to the patients. The lunch time meal was observed being served in two dining rooms. The atmosphere was quiet and tranquil and patients were encouraged to eat their food. The lunch served appeared very appetising and the patients spoken with stated that it was very nice. All patients consulted with were aware of being given a choice from the daily menu; however, the displayed menu was incorrect. The staff were also confused regarding which week of the rotating weekly menu should have been displayed. The majority of patients ate their meals off portable tables, where they had been sitting in armchairs. Only two patients opted to sit at the dining table. The patients who chose to eat in their bedrooms, had their meals delivered promptly. The desert on the menu was ‘fruit cocktail and custard’; however, the custard was not kept hot. This meant that this would be getting cold, whilst the patients were eating their main meals. Patients who required a modified diet, due to poor swallowing or risk of choking, were only offered the custard for desert. Two staff were observed to be standing whilst providing assistance to patients. This meant there were missed opportunities for meaningful engagement with patients. A recommendation that had previously been made has been stated for the second time in this regard.

The mid-morning refreshment trolley also did not have any snacks that were suitable for patients who required a modified diet. The registered manager explained that a decision had been made to stop offering patients biscuits at the mid-morning tea round as it had been impinging on their appetites and that the patients had not been finishing their main meals as a result. This was discussed with the registered manager and a recommendation has been made in this regard.

4.3.3 Care Records

A review of patient care records evidenced that a range of validated risk assessments were generally completed as part of the admission process and reviewed as required. However, risk assessments did not consistently inform the care planning process.

For example, records in relation to the management of wounds/pressure ulcers indicated that where a patient required a wound dressing to be changed, there was no care plan was in place to direct staff on the management of this risk. Although the registered manager informed the inspector that the patient had been referred to the tissue viability nurse specialist (TVN), there was no record of this in the patient care record. The review of the care records confirmed that the patient’s risk of developing skin pressure damage had been reviewed on a regular basis; however, this had not been updated in response to a change in the patient’s condition. Repositioning records were also not available. A requirement has been made in this regard.

There was little/no evidence in the care records reviewed that pain assessments had been completed/reviewed on a regular basis. For example, one patient who had been prescribed transdermal opioid pain relief had a pain assessment and care plan in place; however, these had not been updated from 30 October 2016. The patient also had medicine prescribed for break through pain. Discussion with the registered nurse and a review of the medication administration record evidenced that the staff were meeting the patient’s need in relation to pain

management; however, the review of another patient's care record, evidenced that a pain assessment had not been completed, following admission to the home. A requirement has been made in this regard.

Risk assessments and care plans for patients who required bedrails were also not consistently completed. This was discussed with the registered manager, who agreed to address the matter. A requirement has been made in this regard.

One patient was observed to have very long nails on his right hand. The patient explained to the inspector that he was only able to cut the nails on his left hand. When raised with the staff, they explained that the patient often refused assistance with personal care and grooming needs; however, a review of the supplementary care records did not evidence any record of nail care, either been offered or refused. The review of the patient's care plan evidenced that compliance with personal care had been problematic; however, the care plan did not include any direction for staff in relation how they could encourage compliance in this area. The care plan updates also did not accurately reflect the level of intervention given or detail the frequency with which the patient had been refusing assistance with personal care. This was discussed with the registered manager. A recommendation has been made in this regard.

There was however, some evidence of good practice within the care records. For example, a review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident, care management and patients' representatives were notified appropriately. Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day. Referrals were made to relevant health care professionals, such as GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of the patient's poor nutritional intake. Care plans had also been developed in response to acute infections patients had and these were updated when patients completed their prescribed antibiotics.

At the time of the inspection no one was receiving end of life care. Care plans were in place, as appropriate, detailing the 'do not attempt resuscitation' (DNAR) directive that was in place. 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.

4.3.4 Consultation

There were no patients' representatives present during the inspection; however, we met with four patients, three care staff, two registered nurses and one visiting professional. Some comments received are detailed below:

Staff

"The care here is good, we all know them and we are like a wee family".
"The care is brilliant, the residents are well cared for and looked after".
"It is small and homely here, the staff genuinely care about the residents".
"The care is very good, we go by what the residents want to do".

Patients

"It is very good really, the staff are very nice".
"It is fine here, sometimes I get a bit fed up of the food".
"All is ok here".
"I am getting on rightly".

One patient commented to the inspector that the food in the home 'was the only real weakness". This comment was communicated to the registered manager to address.

Visiting professionals

"They are very good here. The manager and staff have a good hold on things, they know the patients very well and recommendations/directions are always followed up on".

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. One patient. one relative and three staff had returned their questionnaires, within the timeframe for inclusion in this report. All respondents indicated that they were wither 'very satisfied' or 'satisfied' that the home was providing safe, effective and compassionate care; and that the home was well led. No written comments were received.

4.3.5 Management and Governance arrangements

Discussion with staff evidenced that there was a clear organisational structure within the home. The staff confirmed that there were good working relationships within the home and that management were responsive to any suggestions or concerns raised. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

Although some action had been taken to improve the effectiveness of the care since the last inspection, one recommendation was only partially met and has been stated for the second time. This was discussed with the registered manager who agreed to prioritise this matter with staff, to ensure that the required improvements were made.

Discussion with the registered manager and observation of patients 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.

Discussion with the registered manager and review of the home's complaints record evidenced 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. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure.

Prior to the inspection, we were informed of two safeguarding matters, where concerns had been raised. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. Discussion with the registered manager and a review of records confirmed that these had been managed appropriately.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails. However, given the inspection findings we were not assured about the effectiveness of the audits and action plans. A recommendation has been made in this regard.

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. The monthly quality monitoring report provided an overview of areas that were meeting standards and areas where improvements were required. An action plan was generated to address any areas for improvement. However, there was a lack of traceability in the report, in relation to the care records that had been reviewed. For example, a statement in the quality monitoring report referred to two identified patient care records that required to be updated. Given that unique identifier numbers had not been used in the report, we were unable to ascertain which specific records had been checked. This meant that we could not be assured that effective actions had yet to be taken to address the deficits identified in the quality monitoring report. A recommendation has been made in this regard.

4.3.6 Environment

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items.

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

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

Areas for improvement

A requirement has been made that the settings of pressure relieving mattresses are monitored and recorded, to ensure their effective use.

A requirement has been made in relation to the on-going management of the urinary catheter care, to ensure that patients are not exposed to risk associated with infection or blockage, due to lack of hygiene and routine bag changes.

A recommendation has been made that the provision of refreshments and snacks throughout the day is reviewed, to ensure that it meets individual patients' needs and preferences. Patients requiring a modified diet should also be offered suitable snacks throughout the day.

A requirement has been made that wound care management is reviewed to ensure that care plans are developed to direct staff on the prescribed wound dressing regime; risk assessments must also be reviewed in response to changes in the patients' skin integrity; and repositioning records must also be maintained in respect of patients who are deemed at risk of developing

skin damage. The care record must accurately reflect any referrals made to tissue viability nurse specialists (TVN).

A requirement has been made that pain assessments are completed (if applicable) for all patients requiring regular or occasional analgesia. This assessment should review the effectiveness of the analgesia and the outcome should be reflected in the patients' care plans. The pain assessment tool to be used must be commensurate with the patient's ability to communicate.

A requirement has been made that no patient is subject to restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other patient and there are exceptional circumstances in keeping with best practice. This refers particularly to the completion of risk assessments and care plans for patients who require the use of bedrails.

A recommendation has been made that accurate records are maintained in respect of the level of care provided and/or refused. This refers particularly to the provision of nail care and showers. Strategies to assist in compliance should be included in the patient care plan.

A recommendation has been made that the system for auditing care records is further developed to address the deficits identified during this inspection. This refers particularly to the management of wound care and urinary catheter care; the use of bedrails and recording of pressure relieving mattress settings; the completion of pain assessments and personal hygiene records.

A recommendation has been made that the regulation 29 monthly quality monitoring report should be further developed to ensure that there is traceability in regards to the specific records that were examined; and continue to monitor requirements and recommendations stated during this and future inspections.

Number of requirements	5	**Number of recommendations**	4

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Jeya Pratsheeka, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements

Requirement 1 **Ref**: Regulation 13 (1) (a) **Stated:** First time **To be completed by:** 13 March 2017	The registered persons must ensure that the settings of pressure relieving mattresses are monitored and recorded, to ensure their effective use. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: The settings of pressure relieving mattresses are now checked and recorded daily. All mattresses are adjusted to correct settings for each resident.
Requirement 2 **Ref:** Regulation 12 (a) and (b) **Stated:** First time **To be completed by:** 13 March 2017	The registered persons must ensure that the on-going management of the urinary catheter care is reviewed and monitored, to ensure that patients are not exposed to risks associated with infection or blockage, due to lack of hygiene and routine bag changes. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: .we have implemeted a new document that ensures that catheter care is reviewed twice daily both during the day and at night.The date of catheter change is now recorded in the care plan and fluid balance chart.
Requirement 3 **Ref:** Regulation 13 (1) (a) and (b) **Stated:** First time **To be completed by:** 13 March 2017	The registered persons must ensure that wound care management is reviewed to ensure that care plans are developed to direct staff on the prescribed wound dressing regime; risk assessments are reviewed in response to changes in the patients' skin integrity; and repositioning records are maintained in respect of patients who are deemed at risk of developing skin damage. The care record must also accurately reflect any referrals made to tissue viability nurse specialists (TVN), **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: Care plans, risk assessment and skin chart have all been reviewed. all referals to the specialist were documented.

Requirement 4 **Ref:** Regulation 15 (2)(a)(b) **Stated:** First time **To be completed by:** 13 March 2017	The registered persons muse ensure that pain assessments are completed (if applicable) for all patients requiring regular or occasional analgesia. This assessment should review the effectiveness of the analgesia and the outcome should be reflected in the patients' care plans. The pain assessment tool to be used must be commensurate with the patient's ability to communicate. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: This has been reviewed and implemented. Staff nurses have been made aware of pain assessment on admission if required.
Requirement 5 **Ref:** Regulation 14 (5) **Stated:** First time **To be completed by:** 13 March 2017	The registered persons must ensure that no patient is subject to restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other patient and there are exceptional circumstances in keeping with best practice. This refers particularly to the completion of risk assessments and care plans for patients who require the use of bedrails. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: All risk assessments and care plans for residents who use bed rails have been completed
Recommendations	
Recommendation 1 **Ref**: Standard 12 **Stated:** Second time **To be completed by:** 13 March 2017	The registered persons should review the mealtime experience to ensure that is respectful and the environment is conducive to eating. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Spot checks are now in place of meal times and a audit is carried out. Meal times are supervised to ensure that the envitoment id conducive to eating.
Recommendation 2 **Ref**: Standard 12.1 **Stated:** First time **To be completed by:** 13 March 2017	The registered persons should ensure that the provision of refreshments and snacks throughout the day is reviewed, to ensure that the patients' individual needs and preferences are met. Patients requiring a modified diet should also be offered suitable snacks throughout the day. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: This have been reviewed and suitable refreshments and snacks are provied for residents.

Recommendation 3 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 13 March 2017	The registered persons should ensure that accurate records are maintained in respect of the level of care provided and/or refused by patients. This refers particularly to the provision of nail care and showers. Strategies to assist in compliance should be included in the patient care plan. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: This has been reviewed and staff have been advised to record when residents have refused personal care. Care plans have been updated to reflect this.
Recommendation 4 **Ref**: Standard 35.4 **Stated:** First time **To be completed by:** 13 March 2017	The registered persons should ensure that the system for auditing care records is further developed to address the deficits identified during this inspection. This refers particularly to the management of wound care and urinary catheter care; the use of bedrails and recording of pressure relieving mattress settings; the completion of pain assessments and personal hygiene records. **Ref: Section 4.3.5**
	Response by registered provider detailing the actions taken: These will be added to the next audits of care files. to ensure that all defcits are addressed.
Recommendation 5 **Ref**: Standard 35.7 **Stated:** First time **To be completed by:** 13 March 2017	The registered persons should ensure that the regulation 29 monthly quality monitoring report should be further developed to ensure that there is traceability in regards to the specific records that were examined; and continue to monitor requirements and recommendations stated during this and future inspections. **Ref: Section 4.3.5**
	Response by registered provider detailing the actions taken: This will now be recorded on the regulation 29 report to show which file has been checked.

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

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