



Unannounced Care Inspection Report

3 March 2021



Oakmount Lodge Care Home Nursing Unit

Type of Service: Nursing Home

Address: 267 - 271 Old Belfast Road, Bangor, BT19 1LU

Tel No: 028 9146 5822

Inspector: Michael Lavelle

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 41 persons.

3.0 Service details

Organisation/Registered Provider: Dunluce Healthcare Bangor LTD Responsible Individual: Ryan Smith	Registered Manager and date registered: Juliet Green 25 June 2018
Person in charge at the time of inspection: Sabah Abbad – Nurse in Charge	Number of registered places: 41
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 DE - Dementia	Number of patients accommodated in the nursing home on the day of this inspection: 39

4.0 Inspection summary

An unannounced inspection took place on 26 February 2021 from 10.00 hours to 16.45 hours. Due to the coronavirus (COVID-19) pandemic the Department of Health (DoH) directed RQIA to prioritise inspections to homes on the basis of risk.

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the service was well led.

The following areas were examined during the inspection:

- staffing
- care delivery
- care records
- infection prevention and control (IPC) measures and environment
- leadership and governance.

Patients said they were happy living in the home. Examples of comments provided are included in the main body of the report.

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	4	1

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Juliet Green, manager, and Ryan Smith, responsible individual, 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

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
- 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.

During the inspection we met with 11 patients and nine staff. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. The inspector provided the deputy manager with 'Tell Us' cards for distribution to patients' relatives not present on the day of inspection to give an opportunity to give feedback to RQIA regarding the quality of service provision. No questionnaires were returned.

The following records were examined during the inspection:

- staff duty rota for the weeks commencing 22 February 2021
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- care records for three patients
- supplementary care charts, including food and fluid intake, personal care and repositioning charts
- accident and incident reports
- record of compliments
- records of audit
- a selection of monthly monitoring reports.

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 unannounced premises management inspection undertaken on 22 September 2020.

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: Ref: 21.-(1)(b) Schedule 2 (5) Stated: First time	The registered person shall not employ a person to work in the nursing home unless he has obtained details and documentary evidence of any relevant qualifications or accredited training of the person. Ref: 6.0	Met
	Action taken as confirmed during the inspection: Review of recruitment records for a recently recruited staff member evidenced this area for improvement has been met.	

There were no areas for improvement identified as a result of the last care inspection on 4 November 2019.

6.2 Inspection findings

6.2.1 Staffing

A system was in place to identify appropriate staffing levels to meet the patients' needs. A review of the staffing rota for the week of the inspection confirmed that the staffing numbers identified were provided, with the exception of the day of the inspection. Observations on the day of the inspection confirmed that patients' needs were met by the staff on duty.

We discussed deficits identified following review of the staffing rota. We asked the manager to ensure all worked copies of the staffing rota are signed by the manager or a designated representative. The person in charge of the building should be clearly indicated along with the actual hours worked. This will be reviewed at a future care inspection.

Patients expressed no concerns regarding staffing in the home.

We spoke with nine members of staff, who displayed commitment and empathy towards the patients; they had a good knowledge and understanding of patients' individual needs, wishes and preferences.

All of the staff spoke compassionately of the impact of the current COVID 19 pandemic on staff, patients and relatives. Staff said that there was good team working and that there was effective communication between staff and management.

Staff also told us the following:

"We have new staff coming in. With Covid-19 it has been challenging but we always have enough staff. The teamwork is quite good."

"I received a good induction. I think it's a good team (in the home)."

"I really like it. I love the care the staff give the patients."

"We are one care staff down today. It can be tough to get staff at short notice. The teamwork is quite good. We all get along."

6.2.2. Care delivery

We walked around the home mid-morning. The atmosphere in the home was relaxed and well organised. Patients were either being cared for in their individual bedrooms or in the dining areas. Patients appeared warm and comfortable. They were nicely dressed with good attention to detail with their personal care needs evident.

Patients told us:

"They are very good to me. If they didn't treat me well I would soon say. It's not an easy job they have. They are very kind to me."

"The staff treat me with dignity and respect. My privacy is respected. I'm not a fan of the food."

"It couldn't be better. That's the way I find it. They are great. You don't feel lonely. They have time to chat. They are a good wee bunch."

"They are very good to me. It is very nice. The staff are run off their feet but they come to me as quick as they can. It's not home but it's the next best thing."

"It's not the sort of place that would replace home but out of all the nursing homes it is the best. The staff are more than helpful. They will go out of their way to help you."

"I am happy. No concerns."

"The food is good."

We provided questionnaires in an attempt to gain the views of relatives, patients and staff that were not available during the inspection; none were received within the timeframe for inclusion in this report.

Staff were well informed with regard to patients' needs, what areas patients were independent with and the level of assistance they required in daily life. Staff encouraged choice and independence.

On the day of the inspection no planned visits were taking place in the home. Discussions with staff confirmed systems for safe visiting had been implemented. Precautions such as temperature checks and provision of PPE were in place for visitors to minimise the risk of the spread of infection.

Systems such as regular telephone calls between the home, patient and their relatives were also in place. Face to face visiting was in place for one hour per week and management advised that a small number of care partners had been identified in keeping with Department of Health guidance.

We saw patients enjoying their lunch in the dining areas of the home or in their bedroom in keeping with their personal preference. During our walk around the home mid-morning we saw staff proving patients with fresh drinks.

The home had received numerous letters and cards of support throughout the current pandemic. The following are examples of some of the comments recorded in these letters and cards:

“Thank you and all the staff in Oakmont. You looked after my relative so well during lockdown. When we saw them they looked so well and content.”

“To all the staff at Oakmont. Thank you for what you do.”

6.2.3 Care records

A range of assessments, to identify each patient’s needs, was completed on admission to the home; from these assessments care plans to direct the care and interventions required were produced. Other healthcare professionals, for example speech and language therapists (SALT), physiotherapists, occupational therapists and audiologists also completed assessments as required. The outcomes of these assessments were available in the patients’ notes.

We reviewed four patients’ care records. Whilst it was positive to see evidence of patient centred care plans, some of the records contained repetitive nursing entries with some evaluations of care not personalised. Supplementary care records such as repositioning charts and personal care records were generally well completed; however we saw deficits in recording on topical medicine administration records. Review of daily progress notes evidenced registered nursing staff did not regularly comment on activities delivered to patients in the daily progress notes. This was discussed with the manager; they confirmed they would address this deficit with nursing staff through clinical supervision. This will be reviewed at a future care inspection.

Review of one patient’s care records evidenced care plans had not been developed to guide the staff in the delivery of daily care needs in a timely manner. Whilst there were records of assessment of patient need and associated risk assessments, the care plans need to be completed within five days of admission to the home to guide staff on a daily basis. An area for improvement was made.

Review of care records for one patient with an infection confirmed involvement from the patient’s general practitioners. An appropriate care plan was in place to direct care and the care had been implemented in a timely manner.

We examined the management of patients who had falls. Review of two unwitnessed falls where patients had an injury to the head evidenced appropriate actions were not consistently taken following the falls in keeping with best practice guidance. Examination of daily progress notes confirmed that registered nursing staff did not consistently comment on the clinical and neurological observations taken after a fall. An area for improvement was made.

Examination of patient's care plans did not provide assurances that they were developed in consultation with the patient or patient's representative. This was discussed with the manager who agreed review this. An area for improvement was made.

6.2.4 Infection prevention and control (IPC) measures and environment

On arrival to the home we were met by a member of staff who recorded our temperature; hand sanitiser and PPE were available at the entrance to the home. Signage had been placed at the entrance to the home which provided advice and information about Covid-19.

We found that there was an adequate supply of PPE and no issues were raised by staff regarding the supply and availability of PPE. There were numerous laminated posters displayed throughout the home to remind staff of good hand washing procedures and the correct method for applying and removing of PPE.

We identified inconsistencies in staff knowledge regarding the correct use of PPE and when they should take an opportunity for hand hygiene. Most staff wore face masks appropriately although we saw staff applying and removing PPE inappropriately. There was good availability of hand gels throughout the home. We saw some examples of inappropriate storage in the patient's ensuite area and identified bathrooms; this was limited to where towels were stored and the storage of some patient equipment. We also saw evidence that single use syringes were being washed and reused. These deficits were discussed with the manager and an area for improvement was made.

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 very clean, warm and tidy. We saw damage to a wall in the kitchen area of the nursing unit. This was discussed with the manager who advised this was identified during the environmental audit as an action point.

During review of the environment we saw that food and fluid thickener was not stored in a locked cupboard. We discussed this with the manager and highlighted the potential risk this could pose to patients. The manager agreed to review this as a matter of urgency. We asked the manager to ensure that an activity planner and menus are displayed in a suitable format in both the nursing and dementia units. This will be reviewed at a future care inspection.

6.2.5 Leadership and governance

There was a clear management structure within the home and the manager was available throughout the inspection process. The manager retained oversight of the home and was supported by the deputy manager and clinical lead. Staff commented positively about the manager stating they were available for guidance and support. Discussion with the manager and observations confirmed that the home was operating within the categories of care registered.

We looked at the records of accidents and incidents which occurred in the home; we found that these were managed appropriately. There was evidence that two notifications were not submitted in accordance with regulation.

This was discussed with the manager who agreed to submit the outstanding notification retrospectively. The manager confirmed they planned to review the process of notifying RQIA to ensure this was done in a timely manner.

Review of records confirmed systems were in place to monitor staff's registrations with their relevant professional bodies. The manager confirmed that staff training was actively managed. Review of mandatory training compliance rates evidenced appropriate records were maintained.

We reviewed records which confirmed that there was a system of audits which covered areas such as falls, IPC, care records and accidents and incidents. These audits were designed to ensure that the manager had full oversight of all necessary areas. Given the deficits identified during the inspection, we discussed ways the manager could enhance the current governance systems particularly with regards to the falls, care records, hand hygiene and PPE use. The manager agreed to review these. Further assurances were given by the manager who shared an action plan following the inspection which clearly evidenced how the areas for improvement identified on the inspection would be addressed.

We examined the reports of the visits by the registered provider from December 2020 to February 2021. All operational areas of the management of the home were covered. Where any issues were identified, an action plan was developed which included timescales and the person responsible for completing the action.

Areas of good practice

We found good practice throughout this inspection in relation to the warm and supportive interactions between patients and staff.

Areas for improvement

Five areas for improvement were identified. These related to the planning of care, falls management, infection prevention and control practices and record keeping.

	Regulations	Standards
Total number of areas for improvement	4	1

6.3 Conclusion

The atmosphere in the home was relaxed and well organised. Throughout the inspection, patients within the home were attended to by staff in a prompt and respectful manner.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Juliet Green, manager, and Ryan Smith, responsible individual, 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	
<p>Area for improvement 1</p> <p>Ref: Regulation 16 (1)</p> <p>Stated: First time</p> <p>To be completed by: Immediate action required</p>	<p>The registered person shall ensure that initial care plans are developed for newly admitted patients from day one of admission to guide staff in the immediate delivery of care.</p> <p>The care plans should be further developed within five days of admission, reviewed and updated in response to the changing needs of the patient.</p> <p>Ref: 6.2.3</p> <p>Response by registered person detailing the actions taken: The registered manager has adapted a monitoring tool to ensure newly admitted patient/s risk assessments and care plans are developed from day one of admission and further developed within the timeframe set by the company's policies and procedures.</p>
<p>Area for improvement 2</p> <p>Ref: Regulation 13 (1) (a) (b)</p> <p>Stated: First time</p> <p>To be completed by: Immediate action required</p>	<p>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.</p> <p>Ref: 6.2.3</p> <p>Response by registered person detailing the actions taken: The registered manager facilitated supervision with all nurses to discuss adherence to company's policies and procedures in relation to post fall protocol. The supervision also included appropriate record keeping to be in place. Accountability to maintain good record keeping was also discussed. This will be monitored through monthly accident/incident root cause analysis.</p>
<p>Area for improvement 3</p> <p>Ref: Regulation 16 (1) (2) (b)</p> <p>Stated: First time</p> <p>To be completed by: Immediate action required</p>	<p>The registered person shall ensure care plans are implemented and reviewed by registered nurses in consultation with the patient or patient's representative.</p> <p>Ref: 6.2.3</p> <p>Response by registered person detailing the actions taken: The registered manager conducted supervision with all registered nurses in relation to ensuring plan of care for all residents are implemented and reviewed in consultation with the patient or their representative. Ways on how to reflect patient or patients involvement of care was also discussed during the supervision. This will be monitored through monthly care file audit.</p>

<p>Area for improvement 4</p> <p>Ref: Regulation 13 (7)</p> <p>Stated: First time</p> <p>To be completed by: Immediate action required</p>	<p>The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection.</p> <p>A more robust system should be in place to ensure compliance with best practice on infection prevention and control.</p> <p>Ref: 6.2.4</p>
<p>Response by registered person detailing the actions taken: The registered manager had adapted Hand Hygiene observation tool to improve and monitor compliance with company's policies and procedures of Infection Prevention and Control.</p>	
<p>Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015</p>	
<p>Area for improvement 1</p> <p>Ref: Standard 4.9</p> <p>Stated: First time</p> <p>To be completed by: Immediate action required</p>	<p>The registered person shall ensure monthly care plan review and daily evaluation records are meaningful and patient centred. Topical medicine administration records should be fully completed and daily progress notes should reflect on patient activity and meaningful engagement with patients.</p> <p>Ref: 6.2.3</p>
<p>Response by registered person detailing the actions taken: The registered manager facilitated supervision with all registered nurses in relation to monthly care plan evaluation and patient daily progress note is reflective of resident well being and is patient centred. Ways on how to be patient centred on record keeping is one of the focus of this supervision. Accountability on delegating task such as administration of topical creams and maintaining topical records to healthcare staff was also discussed during this supervision. This will be monitored through monthly care file audit.</p>	

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



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