Unannounced Care Inspection Report
25 August 2020

Ringdufferin Nursing Home

Type of Service: Nursing Home
Address: 39 Ringdufferin Road, Killyleagh, BT30 9PH
Tel No: 028 4482 1333
Inspectors: Julie Palmer & Helen Daly

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 which is registered to provide care for up to 64 patients.

3.0 Service details

Organisation/Registered Provider: M Care Ltd **Responsible Individual:** Brenda Frances McKay - acting	**Registered Manager and date registered:** Jacqueline Bowen, registration pending
Person in charge at the time of inspection: Jacqueline Bowen	**Number of registered places:** 64 A maximum of 31 patients accommodated in the Dunmore Suite (categories NH-I, NH-PH, NH-PH(E) & NH-TI) and a maximum of 32 patients in category NH-DE accommodated in the Strangford Suite. There shall be a maximum of 1 named resident receiving residential care in category RC-I accommodated in the Dunmore Suite
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 TI – terminally ill DE – dementia	**Number of patients accommodated in the nursing home on the day of this inspection:** 35

4.0 Inspection summary

An unannounced inspection took place on 25 August 2020 from 09.00 hours to 16.10 hours.

The inspection was undertaken by a care inspector and a pharmacist inspector.

RQIA had been appropriately informed of a change in management arrangements since the last inspection.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DOH) directed RQIA to prioritise inspections to homes on the basis of risk.

Prior to the inspection RQIA received an anonymous call to our duty desk alleging concerns regarding early morning rising of patients and also that an excessive night duty cleaning schedule in the home impacted on care delivery. The manager had been made aware of these issues and RQIA had requested a response. As a result of the inspection we evidenced that the concerns raised were not substantiated.

The following areas were examined during the inspection:

- staffing
- personal protective equipment (PPE)
- infection prevention and control (IPC) measures
- care delivery
- care records
- medicines management
- governance and management arrangements.

Patients said:

- “The staff are very good.”
- “Staff are very kind and thoughtful.”
- “I love it here.”
- “It’s alright here.”

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.

The term ‘patients’ is used to describe those living in Ringdufferin which provides both nursing and residential care.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Jacqueline Bowen, manager, and Brenda McKay, acting responsible individual, as part of the inspection process and can be found in the main body of the report.

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 previous care inspection report.

During the inspection the inspector met with 12 patients and nine staff. Questionnaires were also left in the home to obtain feedback from patients and patients’ relatives. Ten patients/relatives questionnaires were left for distribution. A poster was also displayed for staff inviting them to provide feedback to RQIA online. The inspector provided the manager with ‘Tell

Us' cards which were then placed in a prominent position to allow patients and their relatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision. No returned questionnaires or responses to the staff survey were received within the indicated timeframe.

The following records were examined during the inspection:

- duty rotas from 17 to 30 August 2020
- staff training records
- two staff recruitment files
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC)
- COVID-19 information file
- a selection of governance audits
- monthly quality monitoring reports
- complaints and compliments records
- incident and accident records
- four patients' care records including food and fluid intake charts
- care records for five patients requiring a modified diet
- care records for three patients prescribed medication for administration on a "when required" basis for the management of distressed reactions
- care records for the management of nutrition and medicines via the enteral route
- staff medicines management training and competency assessment
- personal medication records, medicine administration records, medicine receipt and disposal records
- management of medication incidents
- RQIA registration certificate.

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

No further actions were required to be taken following the most recent care inspection on 30 April 2020.

6.2 Inspection findings

Staffing

The manager told us that planned daily staffing levels were subject to regular review to ensure that the assessed needs of patients were met. On the day of the inspection we observed that staffing levels were satisfactory and patients' needs were met by the levels and skill mix of staff on duty. We observed that staff attended to patients' needs in a caring and timely manner.

Staff spoken with told us that teamwork was good and that, whilst working through the COVID-19 outbreak had been challenging and stressful, they had been well supported by the then manager and continued to be well supported by the new manager. Comments made by staff included:

- "I like it here, we all work together."
- "I can go to anyone."
- "Management are very supportive and approachable."
- "I like it here, I enjoy it very much."
- "I love my job."
- "It's a nice home."

The manager told us that staff compliance with mandatory training was monitored and staff were reminded when training was due; training was currently being completed on-line due to social distancing guidelines. There was a system in place to monitor that staff were registered with the NMC or NISCC as required. Review of two recruitment records evidenced that the necessary checks were completed prior to staff commencing work in the home.

Personal Protective Equipment (PPE)

Signage had been put up at the entrance to the home to reflect the current guidance on COVID-19. PPE was readily available; a PPE station had been set up in the lobby enabling anyone entering to carry out hand hygiene and put on the recommended PPE. All visitors, including the inspectors, had a temperature check on arrival at the home.

The manager told us that the home had plenty of PPE available and stocks were regularly replenished. PPE stations were found to be well stocked throughout the home.

We observed that staff carried out hand hygiene at appropriate times. Staff were observed to use PPE in accordance with the regional guidance and to put on and take off their PPE correctly. The manager told us that staffs' use of PPE was monitored through observations and audits. Staff confirmed that they had received training in the use of PPE.

Infection Prevention and Control (IPC) measures

We reviewed the home's environment; this included observations of a sample of bedrooms, ensuites, bathrooms, lounges, dining rooms, treatment rooms, sluices and storage areas. The home was found to be warm, clean, tidy and fresh smelling throughout. Fire exits and corridors were observed to be clear of clutter and obstruction. Patients' bedrooms were attractively decorated and personalised.

Domestic staff told us that they had a system in place to ensure frequently touched points were regularly cleaned and deep cleaning was carried out as necessary following the current IPC guidelines. Minor environmental issues brought to the attention of staff were resolved on the day of the inspection.

We discussed the night duty equipment cleaning schedule with the manager who confirmed that no changes had been made to this; staff opinion on the schedule had been sought by the manager during a staff meeting the previous day and no issues had been raised. Staff spoken with during the inspection did not express any concerns with the schedule. We observed that equipment was maintained in a clean condition.

The manager confirmed that all staff and patients had a daily temperature check; we discussed the current guidance which indicated that this should be completed twice daily. Following the inspection the manager confirmed that a twice daily schedule had been implemented.

Care delivery

Patients looked well cared for and were seen to be content and settled in their surroundings and in their interactions with staff. Staff spoke to patients kindly and with respect. Patients spoken with told us that their wishes and preferences were respected, for example, regarding the time they went to bed and got up in the morning, and that living in Ringdufferin was a positive experience; they told us:

- “Staff are very good.”
- “Sometimes there is a bit of a wait for help.”
- “Staff keep an eye on me.”
- “The food is mostly excellent and sometimes there is too much.”
- “The floors are washed two or three times a day, it is nice and clean.”
- “They keep it all nice and clean.”
- “I like to get up at a decent time.”
- “I am an early bird, I get up early.”

Comments made by patients were shared with the manager for her attention and action as required.

We observed that patients who were in their rooms had call bells within reach; staff were seen to be attentive to patients and to answer call bells promptly. Some patients were up sitting in the lounge with social distancing measures followed as far as possible.

The activity therapist assisted patients to make phone calls or facetime with their relatives and was organising planned, risk assessed, visits to commence the following week. Patients were offered the opportunity to take part in activities such as movie time, arts and crafts and music therapy as well as one to one pamper sessions. Patients told us:

- “I like to sing and pick songs for other people to enjoy.”
- “I like crosswords and puzzles.”
- “Vicky arranges calls to my family and also visits.”
- “I find not being with my family very difficult but I have my phone.”

Staff spoken with told us that it was very important to ensure there was good communication with patients and their relatives; they also recognised the importance of supporting patients with their hobbies and interests. Staff told us:

- ‘‘Activities have improved, they are so important.”
- “I love spending time with the patients.”

We observed the serving of lunch in the dining room; the food on offer was well presented and smelled appetising and patients were offered a choice of drinks with their meal. Staff were helpful, they were seen to encourage patients and offer discreet assistance where necessary. Staff demonstrated their knowledge of which patients required a modified diet. The mealtime was a pleasant and unhurried experience.

Care records

We reviewed four patients’ care records which evidenced that individualised care plans had been developed to reflect the assessed needs and direct the care required. Care records contained details of the specific care requirements in the areas reviewed and a daily record was maintained to evidence the delivery of care.

Care plans in place for sleep and personal care reflected individual patients’ preferences in these areas, for example, preferred time to go to bed and choosing to get up, washed and dressed early in the morning.

The care plan for one identified patient required to be updated to reflect occasional challenging behaviour when personal care was offered; this was brought to the attention of staff and following the inspection the manager confirmed the care plan had been reviewed.

There was evidence of referral to and recommendations from other healthcare professionals such as the dietician, speech and language therapist (SALT) and tissue viability nurse (TVN) where necessary. Wound care records reviewed were up to date and reflective of the care directed in the relevant care plans.

In the event of a fall we observed that staff carried out neurological observations and updated the relevant risk assessments and care plans appropriately.

Patients’ weights were recorded on at least a monthly basis; we evidenced that referrals were made to the appropriate healthcare professionals if weight loss occurred and recommendations regarding, for example fortified diets, were followed. Food and fluid records reviewed were up to date.

Medicines management

Personal medication records and associated care plans

Patients in care homes should be registered with a general medical practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients’ needs may change and therefore their medicines should be regularly monitored and reviewed. This may be done by the GP or the pharmacist.

Patients in the home were registered with local GPs and medicines were reviewed and dispensed by the community pharmacist.

Personal medication records were in place for each patient. These contained a list of all prescribed medicines with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals e.g. medication reviews, transfers to hospital. The personal medication records examined had been fully and accurately completed. In line with best practice, a second registered nurse had checked and signed these records when they were written and updated to provide a double check that they were accurate.

Patients may sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines. Records should be kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine was effective for the resident.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions for three patients. These medicines were used infrequently. Directions for use were clearly recorded on the personal medication records and detailed protocols were available on the medicines file. The reason for and outcome of the administration were recorded.

Satisfactory systems were in place for the management of pain, thickening agents and the administration of medicines via the enteral route.

Medicine storage and record keeping

Medicines must be available to ensure that they are administered to patients as prescribed and when they require them. It is important that they are stored safely and securely and disposed of promptly so that there is no unauthorised access.

The records inspected showed that medicines were available for administration when patients required them. Registered nurses advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

On arrival at the home the treatment rooms were observed to be securely locked. They were tidy and organised so that medicines belonging to each patient could be easily located. The medicines currently in use were stored within medicine trolleys that were also securely stored so that there could be no unauthorised access. Controlled drugs were stored in the controlled drug cabinet.

Medicines which needed to be stored at a colder temperature were stored in medicines refrigerators. The maximum and minimum temperatures were monitored and recorded daily and were within the required range.

Medicines disposal was discussed with the manager and registered nurses. Disposal of medicine records were examined and had been completed so that medicines could be accounted for. We noted that a small number of controlled drugs in Schedule 4 Part (1) had not been denatured prior to disposal. It was agreed that this would be discussed with the registered nurses for immediate action and included in the weekly controlled drug audit.

Administration of medicines

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

Within the home, a record of the administration of medicines was completed on pre-printed medicine administration records (MARs) when medicines were administered to patients. A sample of these records was reviewed and they had been fully and accurately completed.

The date of opening was recorded on medicines so that they can be easily audited. This is good practice. Daily running stock balances were maintained for medicines which were not contained in the monitored dosage system. The stock balances and audits showed that medicines had been given as prescribed. The management team also completed monthly audits.

The audits completed during this inspection showed that medicines had been given as prescribed. However, one discrepancy with an inhaled medicine was observed. It was agreed that daily running balances would be maintained from the date of the inspection onwards so that any discrepancies would be identified without delay.

Management of medicines on admission/re-admission to the home

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information was transferred put people at increased risk of harm when they changed from one healthcare setting to another.

We reviewed the admission process for patients. Written confirmation of their prescribed medicines had been obtained. The personal medication records had been accurately updated by two registered nurses. Medicines had been received into the home and administered in accordance with the most recent prescription. An admission checklist was in place to ensure that registered nurses had completed all the required tasks. This shows that there are robust processes in place within the home to manage transfers of care.

Medicine related incidents

Occasionally medicines incidents occur within homes. It is important that there are systems in place that quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and so that staff can learn from the incident.

The audit system in place helps registered nurses/management to identify medicine related incidents. The management team were familiar with the type of incidents that should be reported.

We discussed the management of medicine related incidents. There was evidence that any incidents had been investigated and the learning shared with registered nurses. This process demonstrated that the appropriate corrective action was taken to prevent a recurrence. Incidents were reported to the prescribers for guidance and to the appropriate authorities including RQIA.

Medicines management training

To ensure that patients are well looked after and receive their medicines appropriately, registered nurses who administer medicines to patients must be appropriately trained. The manager has a responsibility to check that registered nurses are competent in managing medicines and that they are supported to do this.

Registered nurses in the home had received a structured induction which included medicines management. Records of this activity were maintained and showed that medicines related training and competency assessment were completed annually.

Care assistants who were responsible for the administration of thickening agents and topical preparations e.g. creams and emollients, received training on these delegated tasks during their induction. The management team review the management of thickening agents and topical preparations as part of their audit activity.

Governance and management arrangements

As previously mentioned management arrangements had changed since the last inspection. The manager told us that she felt well supported in her role and that good working relationships were maintained in the home.

Review of records evidenced that there were systems in place to manage complaints and to ensure that RQIA were appropriately notified of accidents/incidents that occurred in the home.

A record of written compliments and thank you cards was maintained and staff were made aware of these; comments included:

- “In appreciation for all your care.”
- “You do one of the most important jobs in the world and you all do it with such kindness, patience and expertise.”

Staff were kept up to date with guidance relating to COVID-19; information regarding this was readily available in the home.

A sample of governance audits reviewed evidenced that management maintained a good level of oversight in the home; the audits reviewed contained clear action plans where deficits had been identified.

Monthly monitoring reports had been completed and were submitted to RQIA for review. During the inspection we evidenced that improvements required following enforcement action in 2019 had been sustained; as a result we instructed the manager that copies of the monthly monitoring reports no longer needed to be submitted to RQIA.

Areas of good practice

Areas of good practice were identified regarding staffing, teamwork, use of PPE, IPC measures, the environment, care provided, communication, treating patients with kindness, care records and management arrangements. Additionally, several areas of good practice were observed in relation to medicines management; these included governance and audit, the management of medicines on admission and the recording systems for distressed reactions.

Areas for improvement

No areas for improvement were identified.

	Regulations	Standards
Total number of areas for improvement	0	0

6.3 Conclusion

Improvements noted at the last two care inspections had been sustained; we recognised that the home had been significantly affected by COVID-19 and commended staff for their ongoing efforts during a challenging time.

The concerns raised prior to the inspection were not substantiated during the inspection; the manager also provided RQIA with a satisfactory written response following the inspection as requested.

The outcome of the medicines management inspection concluded that the improvements noted at the last two medicines management inspections had been sustained. The management and staff are commended for their ongoing efforts.

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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